

Prenatal Roots of Attachment in Psychotherapy

Barbara Jakel

Abstract: Otto Rank, a well-known pioneer in the area of prenatal psychology, has emphasized the great importance of prenatal time and perinatal trauma for the psyche of an individual. If we understand “Urwiderstand” (or, Primary Resistance) as the deepest level of existential defence, then the confrontation with the trauma of existential change should have more significance as an important objective in psychotherapy. This lecture outlines the draft of Prenatal and Perinatal oriented Psychotherapy focusing on the search for attachment as a basic tool of identity from the very beginning of life. Human development requires Self-Embodiment which cannot be achieved without relatedness. The function of primary resonance processes during prenatal life will be explained. The Self is to be unfolded on an interpersonal and essential level and I have specified its prenatal roots as Interpersonal and Essential Bonding. It will also be shown how the quality of prenatal attachment can influence the postnatal search for identity. Interpersonal Bonding, which is established within the prenatal time, is dependent on the quality of the primary relationship. If this attachment fails, then the Self tries to protect itself against splitting by creating a sense of wholeness at the core level (potential of the Self named idiom, unique- or core identity). This implies the thesis, that in this way, independent of the depth of early traumatisation, each individual has the potential to transform the trauma of existential change. Béla Grunberger and André Green have expanded on Freud’s ideas of prenatal roots of narcissism. The concept of Bipolar Self (Jakel 2001, 2004, 2008) is associated with these theories. It explains how prenatal trauma may cause “unborn” primary narcissistic states as isolated forms of relatedness. Furthermore, how this will be affected by the conflict of prenatal attachment – versus splitting processes. Therefore, the trauma of birth may result from the existential situation of the unborn within the prenatal bonding space. The theory and practice of Pre- and Perinatal oriented Psychotherapy will be explained with the help of illustrations. The goal of theory and practice of Pre- and Perinatal oriented Psychotherapy will be defined regarding the treatment concept, metodological approach, therapeutic implications and the role of the therapist; PPP postulates bonding-oriented therapeutic work based on the thesis of pre-traumatic wholeness in order to transform the prebirth and birth trauma. This integrative-analytical approach includes also the direct confrontation with the trauma on an implicate memory level when the bonding capacity of the client is already developed. In summary, this question will be elaborated how prenatal and perinatal trauma can cause isolated stages of the Self as a dissociated part of the individual’s personality indicating the prenatal origin of identity formation in the human development.

Keywords: prenatal bonding, pre- and perinatal trauma, Bipolar Self, identity forming levels: Essential and Interpersonal Bonding, primary narcissistic stages, core- identity, prenatal resonance processes: growth-supporting and growth-inhibiting, Pre- and Perinatal oriented Psychotherapy

1. Prenatal attachment: Search for relatedness

Prenatal bonding and its influence on human capacity to relate

Findings show that primary programming takes place in prenatal time and determines later development of the individual (Nathanielsz, 1999). Results of research on affective neuroscience confirm the development-oriented view of psychotherapy regarding human psychopathology (Ledoux, 2002; Damasio, 1999; Panksepp, 1998). Recent findings in brain research deepen the understanding of psychotherapy in the treatment of early trauma. Knowing that anxiety-conditioning starts in prenatal life and that pre- and perinatal traumatization can lifelong remain as early imprints in implicit memory, there is a necessity to confront the neurobiology of prenatal bonding. This contributes to the formation of a new hypothesis for prenatal attachment processes as a basis of postnatal identity development. Interactive prenatal patterns may generate imprints influencing postnatal object relations.

Klaus, Kennel and Klaus (1995, 1998) discovered that at the time of birth, newborns are presenting a Self attachment behaviour, which has prenatal roots. Bowlby's (1982) relationship theory postulates the significance of secure attachment, which could be widened into the prenatal time period. Allan Shore (2001) showed that relational and emotional regulation are deeply connected; on the neurological level a child develops the ability for self regulation, which he describes in terms of interactive regulation of psycho-biological coordination between two organisms. Transferring this into the prenatal time, we can discuss experiences of "umbilical cord affections" (Mott, 1959; Lake, 1980). The fetus tries to compensate for the lack of affective flow at the cost of self contact. Raffai (2006) associates the prenatal interactions of the organism and the psyche of the mother with a monitor. On the screen, the following levels appear:

1. Internalisations of the reciprocal interactions since beginning of implantation
2. The own pre- and perinatal experiences of the mother
3. Intrauterine Maternal Representation

The attachment theory describes four main forms of patterns: secure, avoidant, ambivalent and disorganized attachment. Therefore deficits in prenatal bonding can influence brain development, because the bonding and anxiety systems are linked (Polak, 2005). Lake points out four possible fetal reactions, which could be referred to as four patterns of attachment: ideal-satisfactory, "good-enough", resistance and split, and transmarginal stress. He assumes that resistance and transmarginal stress could build a fetal traumatic response to the negative influences of the maternal organism in order to interrupt the continuity of self perception.

Lichtenberg (1991), Stern (1992), and Dornes (1992, 2000) describe the core of psychic structure formation from the aspect of an experience of primary wholeness. Extreme stimuli would destruct the integrity of perception and experiencing which may cause the lack of primary bonding potential.

The splitting processes caused by affective strains evoke dissociative perception leading to disintegration of the self. Transferred into the prenatal time, from my point of view, this understanding of splitting processes explains why specific forms of relatedness may be created: Primary Lack of Bonding and Primary Self Relatedness.

Thus the individual's capacity to relate will be fundamentally determined. (Jakel, 2001)

The psychotraumatology categorizes dissociative processes as trauma-specific defensive phenomena. According to the recent level of knowledge in psychotraumatology research, traumatic events will be described as subcortical, dissociative, sensomotoric perception patterns. (Hochauf, 2007)

“Unmanageable (transmarginal) stress leads to deep-seated changes in structures and functions. A shock reaction sets in. As a result process of closing down and blocking perception ensues” (Unfried, 2003). “The various perceptions pertaining to the traumatic situation become implanted in the developing and adapting neo-cortex in a deficient state. They remain incomplete, stored at the subcortical level of the brain” (Van der Kolk, 1998, p. 98).

These trauma-tied conditions imply a special hypothesis for the treatment of early structure deficiencies. Not a “defect cure” of the structure deficits, but a necessity of trauma reconstruction in the psychotherapeutic process is essential (Hochauf, 2007), as well as a bonding-oriented treatment, including the client's pre- and perinatal history, focused on existential change (Jakel, 2004, 2008).

In the following contribution, I concentrate on both aspects of treatment. A main distinguishing feature between the psychotraumatology and prenatal bonding theory is on one side, development based on trauma compensation and on the other development based on attachment imprints caused by splitting processes.

2. Pre- and Perinatal Trauma. Bipolar regulation of trauma. Identity-forming levels: Essential versus Interpersonal Bonding. Primary states of isolation

This sculpture represents a symbolic triple division of the individual during its existential change: split into prenatal, perinatal and primary regressive Self. Fetal-like positioning indicates an intrauterine state, human head in the birthing position shows an extra-uterine alignment, transparent head of acrylic, sticks out upwards from the middle of this triple connection.

These three elements may signify the existential ambivalence during birth; desire not to be born but remain in the womb and simultaneously the tendency to separate from it. Thus the universal conflict between the polarities of separateness and relatedness will be expressed in a following way: Half-human, half-fetus, full of longing to return into “dual unity”, which means undemanding protective prenatal environment (Graber, 1924).

Rank's (1924) well-known thesis on repression of birth trauma and Graber's thesis on human tendency for “total regression”, have found their artistic expression here: An unembodied human being with the trauma of existential change whose psychic birth failed due to prenatal splitting processes, unborn in this sense. The nature of primary resistance is demonstrated, characterized by strong ambivalence between the Self and object relations.

Grunberger (1971) stated that due to prenatal traumatic experiences the individual's endeavour is always to regain the wholeness, which can be reached by a unique experience of oneness (specified by him as “splendid isolation”), in order to avoid libidinal self regulation.



Fig. 1. Trinity – Triple Divided Self, Levels of Bonding

Based on psychoanalytic concepts of narcissism (Freud, Grunberger, Green), it is assumed that the trauma of existential change can dominate postnatal life, provided that its pre- and perinatal history were characterized by deep splitting processes, which have increased the regressive drive influencing the formation of primary narcissistic stages. The term “primary narcissism” has been created by Freud (1946) and expanded upon by Grunberger (2001) and Green (2000). A motionless state of the organism to regulate the unsatisfied needs, by not agitating, verifies the research of psychotraumatology. It describes the splitting mechanisms and their effects on deficits in structure on a neurobiological basis. Provided that the primary narcissistic stage has already developed as a defence of traumatic pre- or perinatal bonding experiences, a confrontation with the trauma of unsolved existential change is indicated.

The understanding that due to splitting processes, pre- and perinatal traumatization may deeply imprint the individual’s personality, underlines the thesis of great significance for bond-creating communication in psychotherapy. The therapeutic process is initiated at the “point of closing down” (Hochauf, 2007) when dissociative splits occur. Green (2004, p. 107) emphasizes the destiny or fate of “primary occupations”. For him the reduction of object libido seems to be a result of self inversion by which the self may create a closed system (Green, 2000).

Assuming that the human being is constantly trying to regain its wholeness lost by traumatic experiences, the prenatal space offers unique conditions to avoid the trauma of psychic isolation. Grunberger (1971) pleads with Winnicott (1988) for intactness of self at the very beginning of existence described as True Self, Self Potential, Core Identity, or Idiom. For Winnicott (1988), this is a serene state of “unaliveness that can be peacefully reached by an extreme of regression” (Winnicott, 1988). He emphasized the uniqueness of primary self-states: “At the start is

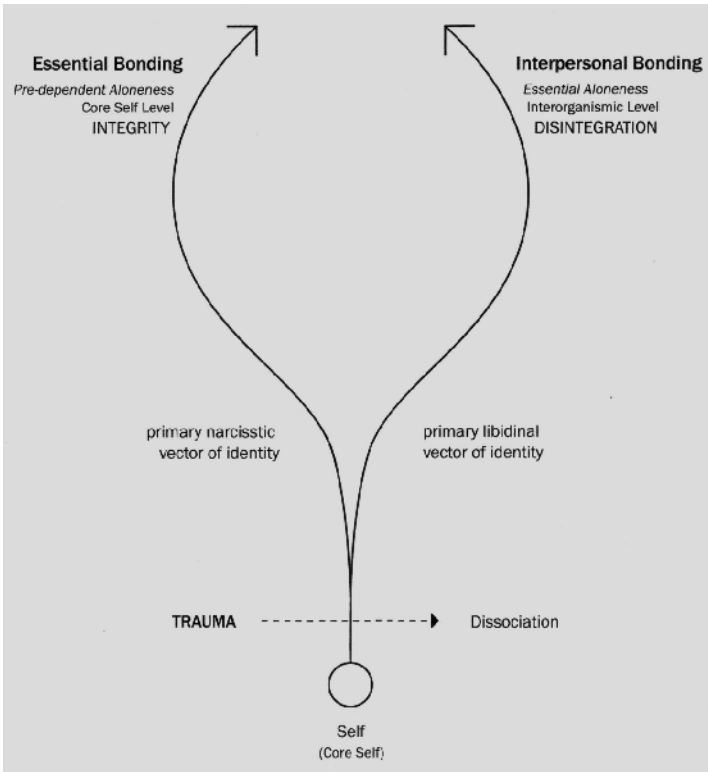


Fig. 2. Prenatal Trauma and Levels of Bonding

an essential aloneness. At the same time this aloneness can only take place under maximum conditions of dependence” (p. 132). Essential aloneness, a positive term for Winnicott, I interpret (on an interorganismic level) as the individual’s capacity of being alone effected by the reciprocal prenatal connection of exchange with the maternal organism. Without positive dependency, a transitional state of the fetus may occur, referred to by Winnicott as pre-dependent aloneness. Even with a dissociative nature, this stage has a survival function because of the connection to the core self. “The progression from prenatal essential aloneness to the adult’s capacity to be alone (the action of Winnicott’s ‘isolate’) testifies to our early self” (Bollas, 1989, p. 21).

In prenatal context, the difference between “Essential” and “Pre-dependent Aloneness” will later be explained by the concept of “Prenatal Trauma and Levels of Bonding”.

Green (2004) describes the primary narcissistic regression as neglecting the psychic trauma of isolation. Based on Freud’s theory, he assumes defence mechanisms existing older than repression: turning against the self, and reversion into the opposition which he describes as a double-turn. The understanding of the dichotomy between narcissistic and libidinal modes of relatedness has deepened with Grunberger and Green, leading in the prenatal context to the following conclusions:

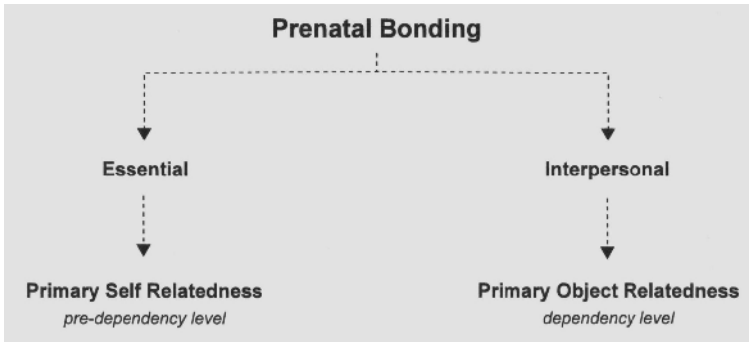


Fig. 3. Prenatal Modes of Bonding

Resonance Experiences in the Womb

Shock trauma interrupts continuity at an interorganismic level between the fetus and the mother. Traumatically caused splits may lead to the “point of closing down” (Hochauf, 2007) or dissociation and simultaneously disintegrating Interpersonal Bonding. The fetal stage of “essential aloneness” of constituting identity value is lost. The self is detached from its primary libidinal vector in order to transgress to the primary narcissistic vector of identity (which I’ve named Essential Bonding), where at the core level, self integrity is maintained.

Esterson (1972) described the isolated closed stage of reversion as an inversion into prenatal life with a defensive and progressive function of dissociative quality. The function of Essential Bonding is to reassure self integrity at the intraorganismic level even at the expense of object relations. Furthermore, it is supposed that Essential Bonding imprints prenatal life affecting the implicit memory of the individual in postnatal life. Thus, we can differentiate between positive and negative splitting functions.

These concepts of prenatal traumatization will be explained with the help of some theories of prenatal resonance processes.

I define resonance processes as the capacity of the maternal representation to resonate adequately to the attachment needs of the prenatal child. “MR” refers to the maternal representation as her unconscious psychological resource. “Existential Response” specifies the resonance experiences in the womb by which the prenatal child will feel accepted in its existence.

The following diagram describes the possible existential situation of the child in the womb. The modes of bonding represent the psychic union between the mother and prenatal child or the psychic separation from her. The existential isolation of the prenatal child can be avoided by the power of positive maternal representation (Interpersonal Bonding). If it fails, the prenatal child reverts to the core self (Essential Bonding).

Prenatal Resonance Processes: Growth-supporting and Growth-inhibiting

Positive response on embryonic/fetal existence will be summarized by the thesis: the response to the fundamental existential needs can only offer a growth-supporting maternal organism.

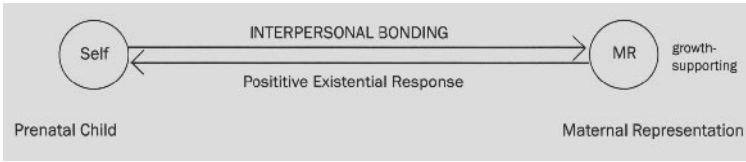


Fig. 4. Maternal Representation: Constituting Developmental Processes

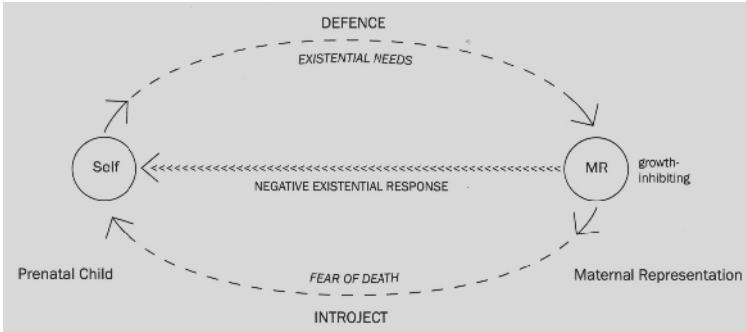


Fig. 4a. Maternal Representation: Inhibiting Development Processes. Introject: Fear of Death

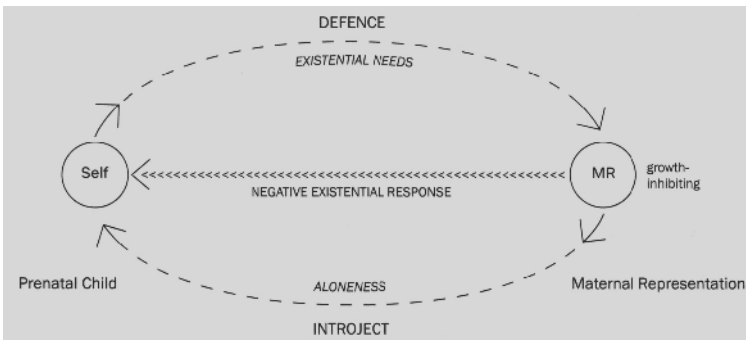


Fig. 4b. Maternal Representation: Inhibiting Development Processes. Introject: Aloneness (defence against fear of death)

If the maternal representation is not sufficiently developed, then the Interpersonal Bonding lacks its base. The self receives no chance to unfold. The lack of attachment or the negative existential response to the prenatal existential needs generate a system of defence.

In states of “prenatal emergency”, the basic existential rights and needs will be split off. The Self is protected by fundamental splitting processes, transitioning into a state of primary lack of bonding which could be a fetal reaction on trans-marginal stress. The connection to the core identity is partially lost generating a fear of death. The intense fear of death may foster the symptom of Primary Resistance (Rank, Graber, 1924).

In the case of negative, inefficient, or false resonance, the Self will descend into the existential stage of Pre-dependant Aloneness. The fetus resists the over-

whelming stress by rebonding to encapsulated stages of isolation by remaining in rudimentary connection to its core self. An autistic-like mode of relatedness is thus created.

The self transitions into the primary stage of isolation at the expense of interorganismic bonding. Tustin's (1990) research shows that autism is a result of early traumatic separation, experienced as destruction of self. Autistic children are then in a state of "encapsulated ego" to protect the core self. The withdrawal into the primary narcissistic bubble to prevent the destruction of interpersonal bonding was also emphasized by Francois Dolto. In infant research, she observed a temporal connection between the prenatal traumatic event and early postnatal symptoms. Symington (1993) used the term "life-giver" to describe the psychic object which cannot exist independent of the other. In terms of prenatal attachment, "life-giver" would correspond to unconscious maternal representation. If the life-giving power of the prenatal mother-child attachment fails, then the self protects its wholeness by inversion to its core. Meltzer (1982) understands autism as a psychic structure of dismantling, giving the fragile self coherence. It is supposed that, as described by Rank and Graber, the stage of primary resistance serves a fundamental defensive function, preventing disintegration due to the earliest traumatization.

3. PPP: Pre- and Perinatal Oriented Psychotherapy

PPP works with these primary narcissistic forms of relatedness. The aim is to support the psychic birth in order to revert the primary regressive drive of the self into a progressive one. This implies confrontation with prenatal roots of narcissism which is described by Symington (1993) as a condition that lies at the roots of all mental psychopathology.

The closed primary narcissistic system of the client aims at averting pre- and perinatal trauma with the tendency to recreate the conditions of interuterine life. Without psychic birth there is no capacity for object relations. Work with primary resistance is aimed at leaving the narcissistic bubble. The nature of primary resistance can probably be recognized in the following constellation: primary fear – primary pain – primary resistance effectively hindering the psychic birth.

The Theory model of PPP will be presented here: Figure 5 shows the developmental process of an individual from conception to psychic birth. This process is of bipolar nature; it unfolds along the vectors of self and object relatedness (primary narcissistic and libidinal vectors). The unbroken line explains the progression of bonding and the dashed line represents the defence of bonding.

The model of Bipolar Self will here be explained with the help of the following illustrations:

The sculpture of the birthing woman (Fig. 6) exemplifies the traumatic situation for the birthing self. The psychic aspect of birth will be symbolized by an emerging transparent empty bubble. From the body center of the birthing mother, a wooden umbilical cord rises as if she herself would need life-giving bonding. The picture outlines the dissociated stage of the birthing woman as well as the stage of the unborn.

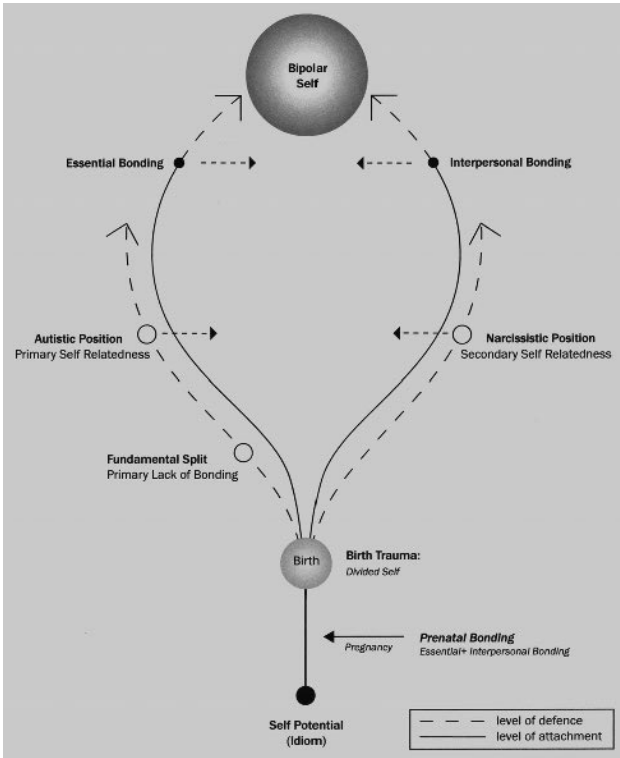


Fig. 5. Bipolar Self: Modes of Relatedness and Self Integration

The trauma of existential change (ref. Birth Trauma) is defined by Rank (1924) and Graber (1924/1978) as a self split (ref. Divided Self). One part of the self is not progressing but remains tied to prenatal modes of attachment. To the left we see the vector of Essential Bonding. My thesis is that this connection is of prenatal origin. Due to negative resonance in the prenatal bonding space, the Essential Bonding will be established. To prevent disconnection, the self disintegrates to the Core Self Level. The Essential Bonding functions as a survival resource. As a part of prenatal imprinting, it remains latently stored in the implicit memory. Thus, Essential Bonding prevents self disintegration.

If Essential Bonding fails, the rejected self descends to a level of disconnection (ref. Primary Lack of Bonding) resulting in a loss of wholeness. The intensity of rejection forces the self to exist in an objectlessness world. “Dagger” (Fig. 7) exemplifies the fate of a divided self as described by Laing (1972).

A matured level of relatedness marks primary narcissism, referred to as Autistic Position, where the self withdraws into a primary existential stage of radical encapsulation at the expense of Interpersonal Bonding, resisting object relatedness (ref. Primary Self Relatedness). The supposed prenatal situation is illustrated by the shape of the child captured in an amniotic-like bubble (Fig. 8).

On the vector to the right, we observe the progression of Interpersonal Bonding. If the prenatal child cannot be nurtured by supporting maternal representation, then this bonding fails, by which the Narcissistic Position will be established.



Fig. 6. The Birthing Woman (ref. Birth Trauma)

Symington's view is that narcissism is a habitual attitude which can be reversed (1993). This level of bonding is named Secondary Self Relatedness.

This illustration symbolizes the secondary narcissistic position described by Winnicott as False Self. If Interpersonal Bonding fails, the Self tries to attach to this level of defence. The ornamental, mandala-like shapes in the mask indicate the prenatal origin of narcissistic positioning, which could correspond to perinatal matrices 1 and 2 (as identified by Grof, 1975).

The supposed prenatal experience was the child's care for emotional deficits of the mother on an organismic level. This prenatal situation may have generated patterns in relationships of "placental-dependant" quality, characterized by fear of death, panic fear with intimacy, and therefore avoidance of object relations. The psychoanalyst N. Symington emphasized the narcissistic position as an attitude of rejecting the own "life-giver". In the concept of Bipolar Self, the corresponding autistic and narcissistic positions are related to Freud's terms of primary and secondary narcissism. Thus, the core of narcissistic positioning is autism. For Symington, the emotional birth of the individual is based on a choice; psychic birth means reconnecting to one's own "life-giver".



Fig. 7. Dagger (ref. Fundamental Split)

4. PPP Practice: Treatment Concept, Methodology, Therapeutic Implications, Role of the Therapist

The goal of PPP is to constitute bipolar relatedness on both vectors of identity.

Methodological Approach: integrative analytical method, attachment as a basic concept, body as a symbolic language of early experience, visualization, and art therapy. Within the analytic setting, the healing relatedness should be established by symbolizing of relational trauma and not primarily by forcing of regressive experiences. The methodology of PPP it aimed at creating a birth-like transition from the stage of self relatedness (primary narcissistic vector of identity) to one of object relations (primary libidinal vector of identity). This implies an intense confrontation with the phenomenon of primary resistance, not only as defence of covered pre- and perinatal trauma, but also as a generalized resistance against the existence as well. Therefore it is indicated to work with the deepest existential themes such as being unwanted or unborn in psychic and emotional aspects.

Therapy Treatment: Modified Analytic Long-term Therapy focused on confrontation with primary narcissistic stages. The therapeutic situation is a womb-like state (Rank, Graber). The setting has a function of holding and containing the

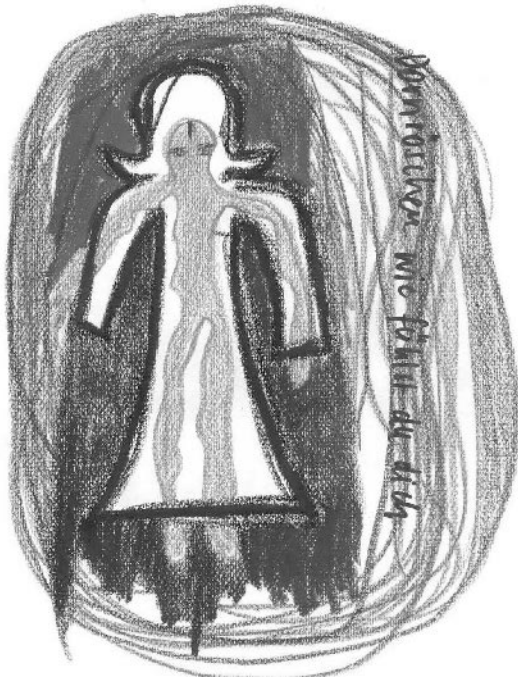


Fig. 8. Sleeping Beauty (ref. Autistic Position)

continuity of attachment, ideally releasing psychic birth (separation from isolated womb-like state).

Introspective Approach:

- a. Relaxation techniques
- b. Self-perception: inner imagery, visualization and body feelings
- c. Expression: intuitive drawings and writings

Exploration of data:

- d. Analysis of inner and outer experiences: Body language, free verbal association
- e. Synthesis (by interpretation): aspect of prenatal and perinatal experiences, data survey of documented life history and associated facts.

The therapeutic methodology is based on discoveries in brain research; the thesis of implicit prenatal memory can be utilized in the treatment of early trauma, making the activation of episodic memory possible (Hüther, 2005).

Implication for the Therapy

It is essential in the treatment that the therapist gives adequate resonance and responds to the core identity of the client. Thus there is no need to cause regressive states of body and mind, but to work on early attachment modes. The closed primary narcissistic state is probably caused by traumatic prenatal and/or perinatal experiences. Its defensive function is rejection of object relations in order to protect the wholeness of the self. Therefore the aim is to change the isolated



Fig. 9. Mask (ref. Narcissistic Position)

existential stage by creating healing relatedness within the therapeutic relationship of prenatal bonding quality. It will be established by symbolizing of relational trauma. This process takes place within the transference and counter-transference relationship where early experiences may be reactivated. Thus, step by step, the pre- and perinatal trauma should be confronted.

The Role of the Therapist

The therapist must react on early existential needs of prenatal quality to make possible womb-like “learning experiences”. Krens (1999) specifies prenatal deficits of bonding developing from the deficiency of maternal representation. The following needs the prenatal child will be listed:

- Holding
- Organismic integrity
- Existential security and continuity
- Organismic autonomy

In the case of denial, risk factors will be established for later psychopathology. Hoचाuf (2007) defines the deficit of structure as a consequence of early trauma-

tization in neurobiological and psychodynamic aspects, whereby the splitting processes support the development of that deficit.

PPP postulates bonding-oriented therapeutic work to create healing relatedness. The therapeutic response to the client's core self enables him/her to leave the primary narcissistic state.

The holding nature of the therapeutic relationship takes prenatal quality. The therapist functions like a pregnant mother by:

- permitting nidation (by supporting symbiotic tendencies)
- nourishing the client until extra-uterine impulses occur
- giving sufficient space for autonomic impulses
- fostering the urge of separation
- supporting the psychic birth (resulting in separation from the isolated stage of the self and finally from therapy)

The progressing capacity to relate enhances feelings of primary fear strengthening primary resistance. Regressive urges for symbiotic modes of relationship may occur. The progress in therapy will be impeded. The unnurtured self requires emotional fulfilment by remaining in the womb. The client tries to maintain his/her regressive state while developing because of the uncovered prenatal trauma. Defensive states of reversion may occur.

The thesis of PPP is that of a pre-traumatic wholeness, corresponding to the core identity of the self. Thus the potential to transform early trauma is provided. This idea implies the dual nature of defence not only as a deficit but also as a resource. Therefore, the conflict between defence and traumatic caused destruction of attachment is solved by expanding the bonding potential.

This view clarifies the focus on primary bonding processes: primary resource as a tool against primary traumatization.

Illustrated Case History

The exploration of data from art therapy is based on inner experiences of the client's process. The analysis of intuitive drawings may show aspects of pre- or perinatal experiences. It is crucial to differentiate between documented life history and associated facts.

Five rasters (tools) will be utilized in the evaluation of Art Therapy, on the basis of which it should be valued how the pre- and perinatal life history of the client has probably influenced the postnatal identity process.

Marina, 33, art student, unemployed, no children, in a relationship, 4 years therapy, increasing frequency of settings from 2 to 4 times weekly. She came bald having extreme symptoms of trichotillomania since the age of 10, suicide attempts, extremely low self-esteem, fear of death connected to separation, and deep depression. The anamnesis showed deeply abusive parental care, severe punishment by isolation, and sexual child abuse.

1. Supposed prenatal situation (Fig. 10)

Here we see the supposed intrauterine situation of the embryo intuitively drawn in a stage of existential depression of the client. The umbilical cord which runs



Fig. 10. Emerging Shapes from the Deep

behind the embryo shape is disconnected. The environment gives a feeling of dangerously experienced objects: black forceps, drops of blood, jaw-like shape below the embryo, sharp/pointy edges, and various liquid-like bubbles. Documented prenatal data: Successful conception from hormonal treatment after seven years of failed attempts at pregnancy (one spontaneous abortion and one tubal pregnancy), client was born from a caesarean section due to intoxication of amniotic fluid. Associated prenatal data of client: Fantasized deep experience of having lost a twin, supposed intrauterine experience of violence.

2. *Imprints* (Fig. 11)

In this case, the expression of the client's early imprints is connected with repeated drawings of various brain images. The symptom represented by the fragmented root structure is placed below the brain-like form.

3. *Symptoms* (Fig. 12)

In prenatal psychology, the symbolism of the tree of life is associated with the placenta. We understand the uniqueness of Trichotillomania symptomology in the act of uprooting. The forceps unendingly destruct the growth of new life by symbolically destroying placental dependency. Marina's tree of life symbolizes the history of abusing her life-forces. Tweezers become the instrument to sustain her primary resistance.

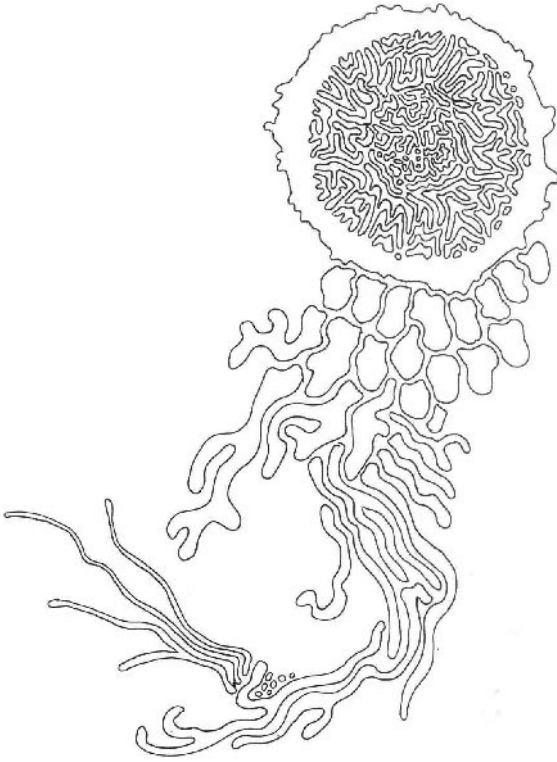


Fig. 11. Brain Root

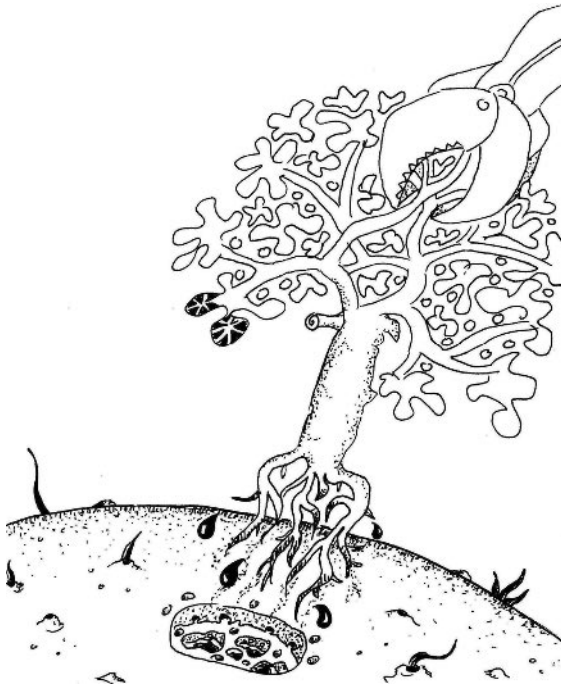


Fig. 12. Tree of Life



Fig. 13. Gold Marie or Black Marie?

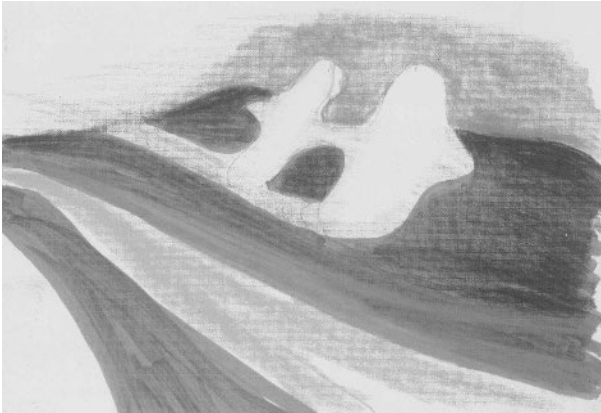


Fig. 14. Dual Union

4. Body Perception (Fig. 13)

The body of a prenatal traumatized person often appears emotionally hungry, with large passively appearing hands exemplifying an attitude of victimization. The bodily split is illustrated by the divided scalp, symbolically filled with the light of Essential Bonding which here has a survival function.

5. Bonding Capacity (Fig. 14)

Here we see a unified pair of angels flying just over the earth, expressing the urge of the unembodied self to attach. The term “dual union” (Graber, 1924) refers

to the stages of oneness (as described before) experienced during prenatal time. Dornes might interpret this union as “seeking refuge in symbiosis” (1997, p. 30). The longing for symbiosis should not only be valued as a primary defence but also as a search for the individual’s lost pretraumatic wholeness. The capacity to attach can be reactivated within the therapeutic process of bonding.

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Barbara Jakel, Prenatal and Perinatal oriented Psychotherapist living in Vienna and working as a private practitioner. She is trained in Integrative Gestalt-, Body- and Psychodynamic Psychotherapy and is also an art therapy trainer. Among other topics, she specializes in publications on prenatal attachment theory and has created her own concept called Bipolar Self (*International Journal of Psychotherapy*, 2001). This is a theoretical foundation of PPP (Prenatal and Perinatal oriented Psychotherapy). She is an active member of ISPPM delivering lectures, publishing and giving seminars to introduce her concept of PPP. Correspondence address: Eisenhüttelgasse 22, 2380 Perchtoldsdorf, Austria
E-Mail: b.jakel@aon.at, Internet: www.ten0.net/jakel/index.htm

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