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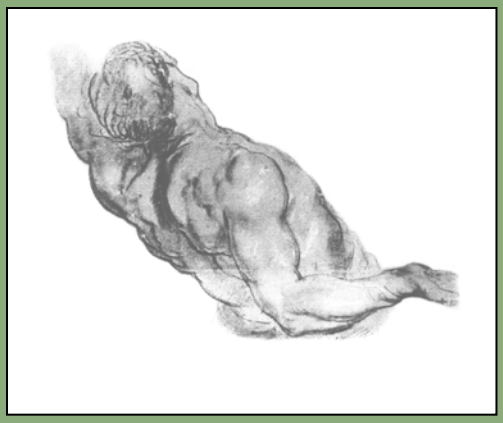

The Official Publication of

THE UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY

Volume 3 Number 2 2004

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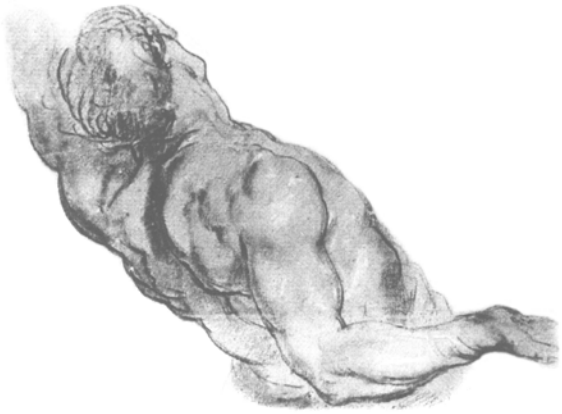


USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Integrating Pre and Perinatal Psychology and Body Oriented Psychotherapy

Marjorie L. Rand, Ph.D.
with Christine Caldwell, Ph.D.

Abstract

A natural affinity exists between the fields of birth psychology and somatic psychology. Their basic tenets, many of their assessment tools, and quite a few of their clinical techniques are strikingly similar. In many cases, a difference of degree rather than kind is operating. Both these fields seem to recognize elemental features of human experience not included in currently dominant paradigms of psychotherapy, and seek to both extend and reorient them. This article begins the process of identifying some of the bridges that naturally occur between these two fields. A comparison of Emerson's birth stages and Rosenberg's Reichian segments demonstrates how birth issues can be recognized and worked with in the context of somatic psychotherapy.

Keywords

Birth Psychology - Integrating pre and perinatal psychology - Reichian - Somatic Psychology

INTRODUCTION

By Christine Caldwell, Ph.D.

A natural affinity exists between the fields of birth psychology and somatic psychology. Though both these fields developed relatively independently, holding only a few of their pioneers and extenders in common, their basic tenets, many of their assessment tools, and quite a few of their clinical techniques are strikingly similar. In many cases, a difference of degree rather than kind is operating. Both these fields seem to recognize elemental features of human experience not included in currently dominant paradigms of psychotherapy, and seek to both extend and reorient them. This introduction begins the process of identifying some of the bridges that naturally occur between these two fields, and suggests ways in which they might coalesce, so that each is nourished and supported.

Four main bridges span these two fields. The first deals with a domain they both address. Put in neurological terms, both fields are interested in human experiences that exist largely outside the neocortical and speech centers of the brain. Prenatal and Perinatal psychologists do so because they are interested in the effect of events that occurred before these brain centers were fully formed. Somatic psychologists do so because their body-centered perspective acknowledges that experiences are routed first through limbic, mid and lower brain centers, resulting in attitudes, orientations, and even behaviors that are well underway before they ever arrive at the neocortex and therefore conscious awareness. Both fields, coming from their own vantage points, eloquently echo current neurological findings that locate significant portions of psychotherapy outside the box of cognitive insight and understanding (Schore, 1994). This results in an extension of the whole field of healing into realms previously thought to be irrelevant, inaccessible or intractable.

The second bridge uniting these two fields has to do with the body-mind orientation of both. Basic theory building in either field begins with an assumption that soma and psyche are one, and that the physical body and the emotional, cognitive, transpersonal, and spiritual bodies all exist as a web. What happens to one happens to all. Therapy, then, must blend together an understanding of this fact such that a physical symptom, an emotional symptom, and a cognitive symptom can all be expressions of the same historical injury, and can be healed through encompassing techniques.

Third, assessment often bridges the two disciplines. Both tend to assess clients through largely behavioral means, looking at movement, gesture, posture, energy, relational dynamics, physical complaints, and emotional patterns to diagnose and treat. Both fields are fascinated by what a client is doing just as much or maybe even more than what they are thinking.

Last, both fields are highly experiential in their treatment forms. Therapy consists, in many cases, of experiences that are engaged in during the therapy hour, and then applied to daily life. Techniques such as conscious breathing, expressive movement, relaxation practices, bodywork, emotional release, and creative processes form the backbone of both disciplines. It is unfortunate that these two fields haven't crossed over these bridges to interact more often. Many practitioners are beginning to do so. The next sections of this article suggest ways in which they might do so even more.

Potential Contributions of Birth Psychology to Somatic Psychology

Because of its focus on very early life events, Prenatal and Perinatal Psychology extend our psychologically significant lifespan to the cellular level (Chamberlain, 1988). For Somatic psychologists this extension makes a great deal of sense. If we hold all body events as psychologically significant, then both gametes (sex cells) and somatic cells have been affected by experiences that influence organismic development, orientation, and behavior. Yet many somatic psychologists have largely overlooked this view. Many of Somatic Psychology's pioneers were trained psychologists, and may bear the effects of Freud retracting and minimizing his views of birth trauma, while many of Birth Psychology's pioneers came more directly from the field of medicine, which addressed prenatal and perinatal care.

In Prenatal and Perinatal Psychology, the primitive, rapid, global, and enduring form of learning called imprinting has been well explicated and well addressed (Chamberlain 1998, Verny,1981). Imprinting fades as a learning style as the neocortex comes on line, but remains accessible throughout our lifespan, triggered by such strong events as sudden, traumatic, and life-threatening events. Much of what we see in adults as trauma and shock responses trace their origins to imprinting mechanisms in the brain and elsewhere in the body (Dudai, Y. 2002). Somatic Psychology has recently been praised for its work with trauma and shock, yet has not often made the connection to imprinting, and therefore has in some cases neglected to see the possibility that adult trauma patterns may reflect a reoccurrence of very early learning, extending back to intrauterine life (Chamberlain, 1993, 1998). By appreciating and including this possibility, somatic practitioners can get to the root of dysfunctional responses. By adding an awareness of and appreciation for gestational as well as birth and postnatal imprints, somatic psychologists can reach the earliest somatic experiences thereby increasing its effectiveness. Somatic psychotherapists can also treat even younger clients, using many of the techniques they already possess. Somatic Psychology practitioners may also benefit from learning new techniques for treatment that have been developed for pregnant women, gestating fetuses, neonates, infants, and young children. Some of these techniques may include touch, birth reenactments, the use of music and other art forms, hypnotherapy, and warm water practices.

Contributions of Somatic Psychology to Birth Psychology

Somatic Psychology has been influenced either directly or indirectly by occupational and physical therapy as well as dance therapy and Sensory Integration. Because of this influence it possesses a finely developed understanding of developmental movement sequencing, and the developmental delays that occur when movement tasks are thwarted by trauma or neglect. Developmental delays correlate to psychological disturbances as well as learning and memory disorders. Birth psychology practitioners may benefit from this understanding, since they often focus on the emotional sequelae to trauma and may inadvertently minimize the physical repatterning that the body craves. Because of the movement emphasis of many somatic psychologists, this field carries with it many movement assessment tools that can readily be applied to research and assessment with neonates and infants. Movement analysis forms such as Body-Mind Centering (in text Aposhyan, 12999, Hartley, 1995), Laban Movement Analysis (in text Payne, 1992), the Kestenberg Movement Profile (in text Bernstein, L. 1984), and the Bartenieff Movement Fundamentals (in text, Bernstein, L. 1975) can all be applied to infants, and many of their trained analysts understand the correlation of movement behavior to personality and intrapsychic dynamics. These methods go beyond the capabilities of video analysis because they speak to the biological and developmental needs that movement behavior shapes itself to. When the psyche is disturbed, so is movement.

By looking rigorously at movement behavior we can assess pre and post treatment issues, and test for observable outcomes. Somatic psychologists are in increasing numbers licensed in some form of mental health counseling or psychotherapy, and the field is increasingly aligning itself with most forms of mainstream as well as alternative healing. This training ethically enables a therapist to deal with more highly disturbed clients, as well as guarantees at least some training in family systems, assessment, group dynamics, research, multicultural counseling, diversity issues, and
professional ethics. It includes training in verbal therapy techniques, enabling practitioners to blend verbal and non-verbal states, thus increasing overall integration. It also guarantees clinical internships and internship supervision.

Ways Both Fields Can Go Forward Together

Both fields can benefit from the trend towards increasing professional training and standards. If we call what we do psychotherapy, or even counseling, and if we believe that we positively influence the psyche, it can only benefit us to train rigorously, in formats that can cull out unethical or incompetent practitioners. Somatic

psychologists can now train at several accredited universities that enable graduates to apply for state board licenses as psychotherapists or counselors. Prenatal and Perinatal psychologists can also get advanced degrees in their field. The two fields may also want to consider joint projects in training, research, publication, and marketing. By dialoguing with each other in both official as well as informal ways, our two fields can enrich and extend each other.

THE BIRTH STAGES

By Marjorie L. Rand, Ph.D.

There are several schools of birth therapy. Among them is Stan Groff's method, which employs breathing techniques to access birth material and tends to emphasize the transpersonal aspects. Another is Leonard Orr's technique of "rebirthing" which often uses hot tubs to evoke birth states. Lisbeth Marcher's Bodynamic therapy uses its understanding of somatic development to coincide with psychological development in pre, peri and post natal issues. The work of Frank Lake in England developed theories relevant to the nature of the baby's reaction to stress in the birth situation. Dr. William Emerson is one of the pioneers in the field of Pre and Perinatal Psychology along with Thomas Verny, David Chamberlain and others. His work, called Birth Re-facilitation, was influenced by the work of Lake. Emerson categorized the fetal stages of birth upon which this paper will focus. These stages were first formulated in the late 1980's [1]. They are presented from the fetal perspective and not from the usual obstetrical viewpoint, which focuses on the mother. Of course the bodies of the mother and the fetus are interacting at all times during the birth. But it is important that we explore the process of birth from the baby's perspective and not from the doctor or midwife's point of reference.

Since birth is one of the most powerfully physical experiences in life it must be accessed through the body. This section will examine the basic physical shaping process of the body during its movement through the birth canal and will detail the positional and movement changes and variations in pressure which the baby experiences. It is the intention of this paper to show how these stages fit into the Reichian theory of the segments and how this can be used to deal with pre and perinatal material during a somatic psychotherapy session.

BIRTH STAGE ONE: DESCENT

Birth stage one is called descent and as the baby enters the birth canal, its head must rest against the mother's spine with one side on the lumbar sacral promontory (the lie side) and the other side against her pubic symphysis. This causes lateral pressure on the fetal cranium at certain conjunct points; the temple area on the lie side and the jaw area on the non-lie side. If there is trauma or stuckness (cessation of descending movement), there will be lesions on the conjunct points, and lateral compression of the fetal cranium. The psychological correlations of trauma in this stage include life positions such as: "can't go forward, can't go back", "no exit", and "double bind".

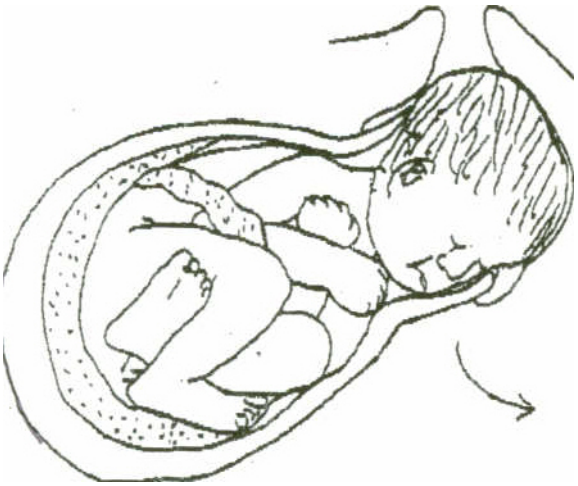
Figure 1 – Birth Stage 1

[1] I learned this information in training groups with Dr. Emerson for eight years and in my own practice with adults and infants. Although this information remains unpublished, his papers and videos can be obtained from Dr. Emerson at 707-7637024 or e-mail: wemerson@home.com. Further information is available through the Journal of Pre and Perinatal Psychology (PO Box 1398 Forestville, CA95436) or through the American Association of Pre and Perinatal Psychology and Health at: apppah.aol.com or www.birthpsychology.com

BIRTH STAGE TWO: ROTATIONAL DESCENT

Birth sage two is called rotation. Because the pelvic inlet is an oval on a horizontal plane, like an egg on its side, the fetal cranium must enter the birth canal sideways. The pelvic outlet however, is an oval on a vertical plane, so the fetal cranium, but not the body, must rotate in the birth canal in order to navigate through it. If there is delay during the rotation stage, there will be compression in a spiral pattern on both the front and back sides of the fetal cranium, since the fetus is also still descending. Stage two is the most common stage where trauma occurs and the most dangerous (Emerson). It is difficult to navigate, and there may be complications if the umbilical cord is involved. If the birth canal is too narrow, trauma to the neck, chest and shoulders may occur. Some of the psychological correlates of trauma in this stage are issues of transition, changing over, turning the corner, and longing for direction but resistance to it.

Figure 2 – Birth Stage 2



BIRTH STAGE THREE: ANTERIOR-POSTERIOR DESCENT

Birth stage three has two stages, flexion and extension. After rotation, the fetal head must bend forward (flexion) with its face against the maternal sacrum in order to fit under the mother's pubic bone. Next the fetal head must bend upward (extension). If the cervix is fully dilated, it is in stage three extension that crowning will occur. Crowning is when the top of the fetal cranium can be seen through the opening of the cervix. There will be anterior/posterior compression of the fetal cranium if this stage lasts too long. The psychological life positions if there is trauma in this stage can be issues of productivity, difficulty sustaining effort and penetrating to the depth of the task.

Figure 3 – Birth Stage 3A

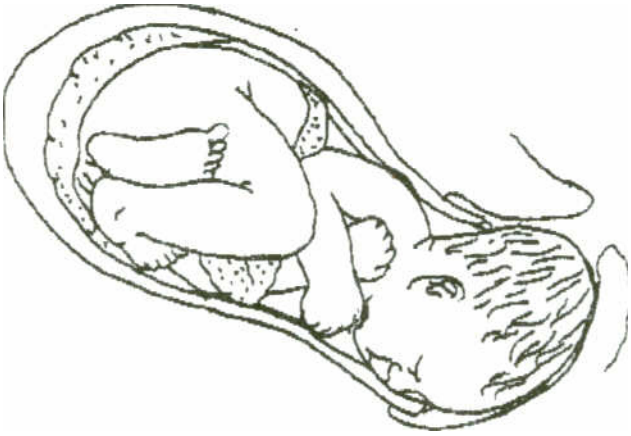


Figure 4 – Birth Stage 3B

BIRTH STAGE FOUR:
HEAD RESTITUTION, BODY BIRTH AND BONDING

Birth stage four is the delivery of the head, shoulders and body. The fetal cranium has to turn back to its lie side and be in alignment with the fetal body in order to deliver the shoulders. Trauma to the neck, clavicle and shoulders as well as the pelvis can occur in this stage if complications arise.

Optimal bonding also occurs in stage four (Rand,1996). Because of the hormone oxytocin, the infant should be placed in the mother's arms prior to the cord being cut, and allowed to suckle. Some possible psychological attitudes and belief systems that could arise from trauma in this stage are: "I am not welcome", "the world is a cold place" "there is something wrong with me", "life is dangerous" "life is hard" "I have caused my mother pain and must spend my life attempting to make up for it". It is possible to "read" the body of a newborn and even that of an adult, to diagnose birth trauma if the therapist can recognize these patterns. Of course, there are other patterns as well, such as breech and caesarian section, and which create completely different patterns, which will not be discussed in this paper.

Figure 5 – Birth Stage 4

THE REICHIAN SEGMENTS

Wilhelm Reich is considered the father of Body Psychotherapy. He was a disciple of Freud whose views about the body and energy were considered revolutionary. Reich knew that energy traveled vertically through the body. This is similar to the meridians in acupuncture, although we have no way of knowing if Reich was exposed to Chinese medicine. Similarly, Reichian segmental theory also parallels the Chakra system of Hindu spiritual practice. Chakra is Sanskrit for wheel or energy center. We also do not know whether Reich knew about the Chakra system.

Reich called blockages to the flow of energy caused by muscular contraction armoring. This muscular armoring runs horizontally across the body front and back (Reich 1973). Hence, the human body becomes segmented like a worm. This section will concentrate on the segments of the body, and how they can be used to diagnose birth trauma. Rosenberg and Rand (1985) have adequately described the Reichian segments. What is new here is their connection to pre and perinatal material and how to work with these issues.

OCULAR

The first segment is called the ocular segment and encompasses the top and back of the head including the forehead and eyes. The function of this segment is presence and contact. Reich believed it was necessary for the therapist to face the client and to be in contact with him/her. This is especially important when birth trauma issues arise as contact with the therapist can replicate and correct the bonding experience with the mother in stage four. When a person is not present and grounded in his/her body, it can be seen in the eyes, which may look fixed, empty, or glazed over. The ocular segment needs to be open in order to make contact, so the ocular segment is usually attended to first in a therapy session. If a person suffered conception trauma, or was not wanted or survived an abortion attempt, he/she may have likely chosen not to be present in his/her life and be dissociated from his/her body. Consequently a lack of presence shown in the eyes can be indicative of this kind of trauma. If anesthesia was used during the birth process, the fetus may have been unconscious and thus not present for the birth process. This will often show up in an ocular block. Pressure on the top and sides of the head and the forehead as well may indicate stage one trauma. The ocular segment is also related to the feet and the function of grounding. Energy must connect from the head to the feet. When the feet and legs are not connected to the rest of the body, it may reveal that the legs could not push during the birth process due to anesthesia or other trauma. Light to moderate pressure on the frontalis, temporalis and occipitalis muscles may elicit birth issues. Having a client lie on the floor with his feet on a wall (at a ninety degree angle) with the therapist placing a pillow on the crown of the head and applying resistance may activate the legs and the feet by pushing with head and feet, and thus replicate stage one descent.

ORAL

The next Reichian segment is the oral segment, which contains the lower portion of the face (mouth, jaw). While these structures are certainly used for expression, they are also used for retention, e.g. taking in food, or inhibiting expression. They are essential for survival. A baby born without a strong sucking reflex formed in utero may not have survived in former times. It is also essential to optimal bonding that the mouth tongue and throat of the newborn be functioning well. Armoring in theses areas could indicate stage one, two or three trauma. The jaw might indicate trauma to the conjunct point on the non-lie side during stage one. While everyone's face is asymmetrical in some way, when the top half and lower half of the face do not match each other it is often indicative of stage two rotational trauma. Release techniques for the oral segment include among others, sucking, making sound and biting. The rooting reflex, which involves turning the head leading with the mouth, may have to be re-patterned as a stage two rotational pattern.

CERVICAL

The cervical segment consists of the neck in the back and the throat in the front. The throat is functionally connected to the oral segment as well. The cervical segment is strategically located connecting the head to the rest of the body. Because of this it is extremely important. The cervical segment is reciprocally related to the pelvic segment, since both ends of the spine reside in these segments. The digestive tract also begins and ends in these segments. The throat is important in the function of swallowing and making sound. It can also serve the function of expression. Many fragile glands, arteries and structures are located in the throat. While the neck is heavily muscled and can be worked with in a deep manner, the throat must be approached delicately. Sound is the least invasive way to release the throat. Movement and stretching of the neck are good release techniques. There can be throat and neck compression trauma in all birth stages, and these will also show up as blockages in the cervical segment. When the umbilical cord is wrapped around the neck at any stage it will be shown in the cervical segment as a blockage.

THORACIC

The thoracic segment, which includes the chest, upper back, shoulders, arms and hands, is also vulnerable to compression trauma. Certainly the vital organs and glands found in this segment are of existential importance. The heart and lungs must function at birth or the baby may not survive. The chest is compressed during stage two, but will expand in stage four since the bones of the fetus are malleable. However, if the baby spends prolonged time in the birth canal, it is possible for the chest to remain contracted, thus foreshadowing breathing disorders. Since many somatic psychotherapy modalities use breathing as a primary tool, blockages in the thoracic segment can often be traced to pre and perinatal issues. The shoulders, arms and hands can be traumatized during stage four due to awkward positioning or shoulder trauma during delivery. So blockages in these areas may also be considered as arising from antecedent early injuries, perhaps involving birth. Prematurity is another trauma which affects the functioning of this segment, since the structures and organs may not be fully developed. During birth re-patterning sessions clients often experience a breathing release after successfully renegotiating the birth process through movement. They usually experience freer and deeper breathing and a feeling of expanded aliveness, often for the first time in their lives. Some release techniques for the thoracic segment include raising the arms over the head and to the side to open the chest and release the shoulders, depressing the chest and working on the intercostal muscles of the ribs to facilitate movement.

DIAPHRAGMATIC

The diaphragmatic segment is also crucial to breathing and is sometimes thought of as the lower chest. The diaphragm is often contracted to control anxiety and other unwanted feelings. Thus a chronic pattern of holding the breath can occur. The diaphragm is one of the most important muscles in our bodies. Without proper functioning of the diaphragm, the heart and lungs as well as the digestive system will be affected. The diaphragm separates the top and lower halves of the body both structurally and functionally. During inhalation, the diaphragm drops and thereby allows the lungs, which are not muscles, but merely air sacs, to expand. Upon descent it also massages the intestines and organs below it, so the proper functioning of the digestive system is dependent on the movement the diaphragm. If the diaphragm does not move well, oxygen delivery to the body will be affected. The fetal diaphragm and lungs are already developed in utero, and the fetus is practicing breathing in order to be

able to breathe at birth. If there is compression trauma during birth stage four, the action of the diaphragm may be limited. In somatic psychotherapy it is important to open the diaphragmatic segment to facilitate breathing. This can be done by pressing on the rib cage forward and down, working on the intercostal muscles of the ribs, and approaching the diaphragm directly under the ribs where it attaches in the front. Any re-patterning or movement which increases breathing, can bring up existential issues, since breathing is so essential to birth and life.

ABDOMINAL

The abdominal and pelvic segments are not structurally separate, but they differ functionally. The abdominal segment consists of all the organs and muscles under the diaphragm, mostly having to do with the function of digestion. In this way the abdominal segment is connected to the oral segment. Symptoms having to do with digestion can reveal very early oral bonding issues (Rosenberg, 1985). As Fritz Perls states in his theory of dental aggression (1969), both emotional and physical food must be digested and assimilated by the organism in order to become part of it. Various release techniques include kneading the rectus abdominus and massaging the large intestine. However, in terms of pre and perinatal issues, what is of most importance in this segment is the navel. The umbilical cord is our lifeline for nine months. It is where we take in nutrition and where we eliminate waste. In a way, it is our first mouth and breathing organ. All manner of physical and emotional material is taken in through the umbilicus in utero, including hormones, neuropeptides and chemicals. It may be in this way that the fetus is exposed to what the mother experiences regardless whether these experiences are positive or negative. This center can be blocked against negative input, and yet once the cord is cut, it is usually neglected for the rest of one's life. If it is cut prematurely, before it stops beating, the negative energy may be experienced as invasive and can cause trauma and blockage. Negative umbilical affect (Emerson) can be worked with in a somatic psychotherapy session by releasing the navel energy center front and back, either by touch or energetically. Experiencing the negative umbilical affect can help to release it psychologically.

PELVIC

The pelvic segment consists of the sexual organs, organs of elimination, and by extension, the legs and feet. So its function has to do with reproduction, elimination, movement and grounding. Since the pelvic segment is the end point of the digestive tract, it is also related to the oral segment. The pelvic segment should not be opened prematurely, since it can hold much trauma. The pelvis is intimately connected to prenatal and birth experiences; the uterus is our first universe. We emerge from the ovaries and the testes and travel down the fallopian tubes to connect to our new home in the uterus. It is through this connection that birth and conception trauma can influence attitudes toward sexuality. Experiences such as rape, incest, miscarriage and abortion can be held in the pelvis and transmitted to the fetus. Therefore, it is important to release the energy of these experiences. These are all physical experiences and cannot be resolved through talking alone. There are many ways to work with the pelvis, but it is preferable to work with noninvasive means. The least invasive method is awareness of holding patterns without necessarily confronting or removing them. Other methods may include gentle or stressful movements or postures of the pelvis, such the pelvic rock or the bridge. The most invasive methods would include touch of any kind, which should always be done judiciously when approaching the pelvis. A full description of these methods can be found in Body Self and Soul; Sustaining Integration (Rosenberg, et.al., 1985).

VIGNETTE

Colette had been a client for one and one half years. She had previously had two years of somatic psychotherapy several years before. She is a fifty five year old woman who returned to therapy for treatment of depression after the death of her husband. Her history was one of neglect and rejection by her mother. She was an unplanned and unwanted child who was conceived when her mother was in her forties. Her only sibling was a brother fourteen years her senior with whom she has no relationship. She remembers always feeling and being alone. She was delivered by emergency Cesarean section after a long and painful unsuccessful labor. During the delivery, the doctor cut her on her cheek with his scalpel from which she still has a scar. In this vignette, Colette accesses memories of experiences of her own Cesarean birth, as well as the removal of a fibroid tumor, a previous abortion, abandonment issues by her mother, her feelings about being a good mother, and the dissolution of her anger toward her mother.

In the following transcript Colette began the session by scanning her body and reporting her awareness. Spontaneous imagery emerged from body to mind, not mind to body. This imagery represented both her own stuckness in the birth canal and subsequent delivery by Cesarean section. When birth images emerge from a holding pattern in the pelvic segment, later traumas to the pelvis can also be released. In Colette's case the first memory was of a fibroid tumor being removed from her uterus which she compared to giving birth by Cesarean section. This lead to a memory of an abortion. Finally, the memory of the abortion allowed her to come to some acceptance of her relationship with her mother which allowed her to begin some inner healing. The therapist did not touch her during the session, although Colette was instructed to perform self-release techniques (such as massaging her belly). The depth and resolution of this session has to do with the therapist constantly referring Colette back to her body where the awareness arose.

T: What are you aware of in your body?

C: I feel a sensation in my abdomen

T: Can you describe it?

C: It is a dark space

T: Stay with the awareness and tell me what happens in your body

C: It seems like a room a large room and it's locked

T: Describe the body feeling of the room being locked

C: It feels so stuck. It's very tight there and it's growing

T: The space in your abdomen is like a large locked room and it's growing

C: Yes and now nothing is happening

T: Stuck and nothing happening

C: Oh my God!!

T: What are you aware of now?

C: I'm aware of a circle, a sphere

T: Where is that in your body?

C: It's hard for me to put my awareness there because I'm numb there from surgery. I had a large fibroid tumor
removed in 1990.

T: Put your hand on that area and massage it.

C: I gave birth in that surgery to a very large tumor and it was a cesarean

T: Keep massaging it.

C: I can always feel pain; you know that line between numbness and pain

T: Pain is feeling

C: Don't you think having a growth there has to do with old stuff?

T: It sounds like it could have a relationship to your own birth.

C: (Starts to cry)

T: What is happening?

C: I'm remembering the abortion I had that has never been processed. I feel guilt.

T: Where in your body do you feel that?

C: The pain isn't there anymore. I keep going to that spot inside my uterus where life began and life ended.

T: Stay with your awareness of that spot.

C: I could not have a child because of my fear that I would bring a child up the way I was brought up. I had the abortion after my mother had just died. I drove myself there by myself; I drove myself home by myself. I had no support.

T: When your mother died, you had to give up hope that your relationship with her would ever be healed.

C: Immediately my back went out. Crying out for support and attention, I was flat on my back for five weeks. So, I processed it in an aborted way (begins to laugh).

T: What is going on?

C: I'm remembering when my mother died and I had a vision in which she came to me and kissed me goodbye, and I never saw her again. She left. There was no way for her to help me when she was on the earth or when she departed.

T: What are you feeling?

C: I had no idea this stuff was still there. I'm not angry at all. I have to stop treating myself the way my mother treated me.

CONCLUSION

What we today consider "normal" obstetrical practices, deny the actual trauma of the birth experience, although midwife-attended and natural births do occur in hospitals today. Alice Miller tells us that this denial of the baby's experience allows these practices to continue without awareness of their possible consequences (1990). Since birth is first and foremost a somatic experience, it seems difficult to believe that practitioners could treat birth and prenatal trauma with out accessing the wisdom and intelligence of the body, which holds our experience from conception onward throughout life. It is time for somatic practitioners to be aware of these primary patterns which are imbedded in the body when the baby or fetus is nothing but body. If practitioners in the field of Pre and Perinatal Psychology were exposed to schools of Somatic Psychotherapy which are not yet known to them and taught some of their methodologies, the practice of working directly with the bodies of adults and babies would be enhanced. Somatic psychotherapists need to be apprised of and learn the importance of pre and perinatal periods of development. This would expand their knowledge and repertoire enabling them to work with earlier primary holding patterns and life belief systems.

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Biography

Christine Caldwell, Ph.D., LPC, ADTR - Founder and director of the Somatic Psychology Dept. at Naropa University in Boulder, Colorado. She lectures and trains internationally, and has authored two books: Getting Our Bodies Back, and Getting In Touch. She offers trainings in somatic evolution (the Moving Cycle), with specializations in addictions, play, movement sequencing, therapist training, and birth and death.

Marjorie L. Rand, Ph.D., has been a practicing somatic psychotherapist for thirty years. She developed Integrative Body Psychotherapy (IBP) with Dr. Jack Rosenberg and co-authored Body, Self and Soul; Sustaining Integration with him. She is a certified Master IBP Trainer and Practitioner. As Director of New Institutes for IBP she started and taught at ten IBP Institutes in the United States, Canada and Europe from 1986 until 2002. She also contributed a chapter to Christine Caldwell's book Getting In Touch; A Guide To The New Body Psychotherapies. She is presently co-authoring a book about the somatic side of vicarious traumatization with Babette Rothschild, LCSW (author of The Body Remembers; The Psychophysiology Of Trauma and Trauma Treatment and The Body Remembers Casebook. She has contributed many articles to professional journals including the Journal for Association For Pre and Perinatal Health (APPPAH) and The Journal of The International Association for Pre and Perinatal Medicine.Dr. Rand is on the Advisory Board of USABP as well as being active on several other USABP committees. She may be reached at www.drrandbodymindtherapy.com

USA BODY PSYCHOTHERAPY JOURNAL

The Official Publication of
United States Association for Body Psychotherapy
Jacqueline A. Carleton, Ph.D., Editor (jacarletonphd@gmail.com)

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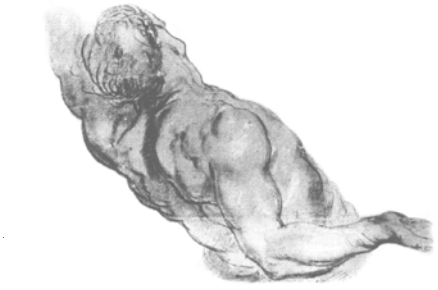

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VOLUME 3, NO. 2, 2004 Printed in the USA
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