

# Somatotropic Therapy

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*Where someone, as an adult, is 'at', is often expressed in a topological scheme, which bears remarkable correspondence to precise phases of embryonic morphology. -R.D. Laing*

## *Definition*

Somatotropic therapy is, at its core, a somatic approach to uncovering and resolving the major topological schemas representing unresolved traumas in infants, children, and adults. Somatotropic, according to Webster, is “the principle of organization according to which matter moves to form an object during the various stages of its existence.” During trauma, the somatic (i.e., body) system objectifies trauma in both energetic and physical forms, and the somatotropic process is a broad organization of somatic traumas that manifest in both energetic and physical form. Somatotropic therapy could claim ancestry in ancient shamanic healing practices found in many primitive cultures. In modern times its evolution describes an oblique trajectory from the Freudian launch pad of psychoanalysis, through the work of Jung, Reich, Rank, Assagioli, Fodor, Mott, Lake, Winnicott, Janov, and Laing to the present approach.

## *Historical Development*

Classical psychoanalysis considers the life of the child from birth to age five or six as the origin of personality. Its primary way of working is interpretive, and the reality of prenatal experience and the preverbal period have generally been excluded from the therapeutic context. Development of pre- and perinatal psychology over the last twenty years has opened up a new dimension of psychological reality that focuses precisely on the infant from conception, through birth, and into

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the first years of life. A growing body of clinical research is beginning to establish this period as crucial in the creation of character and personality.

Otto Rank's (1929) *The Trauma of Birth* was welcomed by Freud at first, but was discarded by his circle as a potential threat to the pre-eminence of Freud's theories. One of Rank's patients was Nandor Fodor, who himself became a psychiatrist and brought his clinical attention to the formative experiences of birth (Fodor, 1949). Francis Mott, a British psychiatrist and a patient of Fodor, wrote extensively on the mythological and dream content of prenatal life (Mott, 1948, 1964). Frank Lake (1966, 1980) was influenced by Mott's work, and was one of the first British psychiatrists to emphasize the effects of intrauterine life. Donald Winnicott (1975), the British psychiatrist of the Object Relations school, recognized and worked with the impact of birth on his patients and suggested that the body retained these impacts as memories. Bill Swartley (Swartley and Maurice, 1978) was the founder of the International Primal Association, introduced Primal Therapy to Britain, and considered Winnicott the real originator of Primal Therapy. Winnicott supervised R. D. Laing who explored the fundamental significance of pre- and perinatal psychology in the structure of personality.

### *Founders*

Frank Lake and Stanislav Grof accessed pre- and perinatal material in their patients by using LSD. However, they discovered that similar effects could be obtained by using what Grof calls "holotropic" breathing techniques. Grof, working first in Czechoslovakia and then in the United States, observed that the "biographical realm"- the time from birth onwards and excluding prenatal life - offered an incomplete and inadequate causal ground for the more severe psychological disturbances; he located their roots in the cataclysmic pressures experienced by the baby in the birth process. Grof (1975, 1985), in his prolific writings on the subject, explores the effects of what he calls the birth perinatal matrices (BPMs), or stages in the birth process, with great power and insight. On the basis of his extensive research, he shows how academic psychiatry and psychotherapy, by excluding consideration of pre- and perinatal impacts, cannot accommodate the whole spectrum of human experience or satisfactorily retrace its roots.

Frank Lake applied the insights that Mott had delineated in his work on the pre- and perinatal significance of dreams and myths. Lake

accessed the traumatic affects generated in prenatal life. He subdivided Grof's BPM 1 (the stage where the fetus gestates in the womb) into several distinct stages and worked through the influences on the pre-nate of the parents' physical, emotional, and psychological states from conception to birth. He coined the phrase "toxic womb syndrome" (Lake, 1966, 1981).

Grof (1975) and Laing (1976, 1983) attempted to introduce, demonstrate, and explore the revolutionary realm of pre- and perinatal psychology. They presented their materials from within the fold of orthodox psychotherapy and psychiatry (or from its radical shore).

Grof's contribution to this field is immense. His description of BPMs and the affect relating to each, his exploration of the effects these stages have on later life, his inclusion of the somatic stratum in psychotherapy, and his openness to archetypal and transpersonal realms all give him a key role in this field as discoverer and disseminator.

Somatotropic therapy evolved from twenty years of practice and experimental follow-up done in Europe and the United States. In the late 1970s in England, I (Emerson) collaborated in workshops with Frank Lake and shared research findings with him. It was at this time that I developed my initial somatic approaches to uncover primal trauma. Focusing on the time from conception and working through implantation and gestation to birth, I discovered ways to access the deepest and earliest pre- and perinatal traumas. Gradually, I found a precise methodology for working with infants and children to access and discharge an astonishingly wide array of traumas. In the course of my work, a way of reading the face and posture as a cartography of the client's specific pre- and perinatal trauma began to emerge. Using these physical and gestural traces as indicators of the temporal origins of disturbance, I have developed ways of inducing these experiences in the therapeutic context, and thus the means to discharge the compulsive control they exert on characterological behavior. I have also perceived that in moments of somatic disclosure during therapy, the body will take particular shapes that recapitulate embryonic development. These perceptions enable the therapist to ascertain with a great deal of precision the moment of disturbance in the client's pre-natal life. I have also determined that the birth process tends to re-enact the traumas that occur from conception through implantation and gestation, and that the resolution of these earliest traumas dissipates the effects of the traumas that occur at birth.

### *Relationship to Other Therapies*

Somatotropic therapy has similarities with primal therapy, primal integration, core process psychotherapy, Reichian breathwork, biosynthesis, holotropic breathwork, trance regression, polarity therapy, and cranio-sacral therapy. It differs from some of these in the kinds of somatic techniques and prenatal techniques, as well as depth of access and compatibility with infants and children. Somatotropic therapy, in common with most therapies similar to it, puts as great an emphasis on integration as on the process of uncovering and experiencing unconscious material. It recognizes that integration does not take place automatically, but must be painstakingly woven into the real life fabric of the client's life.

### *Central Concepts*

One of the central concepts in this field is the notion that mind pre-exists the nervous system; that there is a level at which the conceptus is aware of essential qualities of feeling present in its inception; and that this awareness records its struggles to survive the hazards of implantation, the history of its gestation, and the detailed drama of its birth at an energetic and cellular level. Prenatal awareness, perceptiveness, and intelligence is currently under intense review, with the inception of these processes starting earlier than heretofore imagined (Chamberlain, 1998). From this perspective, it follows that the intrauterine strategies devised to ensure the prenaté's survival and protect it from the potential spectrum of indifference or rejection on or soon after its embodiment in the womb develop into aspects of the construct of the self.

Strategies and survival learnings, by necessity rapidly adopted, carry with them powerful implications about self-value and worth. Lack of acknowledgement of pregnancy may raise doubts about the right to exist. Outright psychological rejection may create attitudes of worthlessness, inadequacy, impotence, and so on. It may also be one of the contributing factors in miscarriages. Medical drugs, substance abuses, unaddressed anxieties, or external trauma in the life of parents will in most cases be taken on by the fetus. This is what I call participatory trauma, where unborn children participate in the biological and psychological experiences of their mothers (and indirectly their fathers). Frank Lake referred to participatory trauma as the toxic womb syndrome *We marinate in the shadow* (i.e., the denied aspects of the unconscious) of our parents.

The basic stratum of the personality and the associated underlying belief systems that hold it in place derive from a number of factors: the

shadow aspects of parents; the same unresolved elements in the lives of grandparents (the ovum from which the mother sprang was already formed at eleven weeks gestation in the maternal grandmother); a commensurate and immeasurable twine of psychogenetic ancestral memories; the pre-nate's own "baggage" from pre-conception; the experience of the conception itself; the phenomenology of implantation; and the whole duration of the gestation period; all together form layers of affect in this self-forging process.

Most irregularities in the birthing process appear to derive from unresolved conflicts in the lives of the parents relating to themselves, to each other, to their parents, or to their attitude about the infant. There may also be a recapitulation of the mother's own birth history: she may unconsciously be acting out disturbances that occurred to her through her mother's affects and process while giving birth. These irregularities express themselves in such issues as prematurity, breech births, fast births, long labors, cord complications, and birthing positions. Each of these irregularities, as well as a number of medical interventions such as anesthetization, cesarean section, forceps, inductions, and incubations will leave profound and detectable characterological traces in the behaviors of the recipients. They are all amenable to treatment through regressive and integrative work.

Three further key concepts in this model are regression, catharsis, and integration. They are touched on here and developed as part of the change process in the following section. Regression means to go back in time, to uncover memories of experiences that were formative (either positive or negative), and to release any unresolved, blocked, or negative affects associated with these experiences. Catharsis is the major process of release, usually involving intense emotional discharge: crying, raging, moaning, sobbing, grieving, and so on. The deeper the catharsis, the more likely that core aspects of the psyche will be touched at the level of transformational and/or spiritual energies. By "transformational energies" we refer to the essential energies that connect us to the Self, energies that we can access through meditation, or other spiritual disciplines.

In the context of somatotropic therapy, individuals and their styles of healing are deeply respected. Both cathartic and transformational processes, which interact and support one another, are accommodated in this work. Some individuals heal primarily through catharsis, others through transformation, and others through a combination of both. Ultimately, when trauma is healed, the transformational process becomes integrated into the psyche and made available in a way that was previously unimaginable.

Integration acknowledges that certain affects (called secondary, as compared to primary processes) accompany traumatic or ecstatic experiences, and that these secondary processes need to be identified and dealt with in order for the individual to be free from them. In somatotropic terminology, traumatic experiences are the primary processes that impact the individual somatically. But traumatic experiences enfold a number of secondary processes as well, and these co-occur with trauma and remain as established parameters of trauma. The secondary processes are in and of themselves capable of impacting the personality and development of individuals, even after traumatic experiences have been catharted. An example has to do with trauma posture. Through close observation of children going through traumatic experiences, we have found that certain postures tend to be associated with trauma. These postures remain as somatic memories, and reside as embodied shapes throughout life, until the foundation trauma is resolved and until the postures are identified and repatterned.

These postures support what is called response-produced emotion. The postures themselves, once crystallized in the body, create the same traumatic feelings that the cathartic process releases. This can be experienced directly, albeit in a minor way, by creating a fist, for example, and holding it for a long period of time. Angry feelings are likely to emerge. In this sense, postures (and other secondary processes) create a replicating supply of traumatic energy, and this replicating energy is not resolved until the secondary processes are acknowledged and repatterned. The depth of somatotropic therapy accesses these secondary processes and allows them to be altered in a way that is consistent with the basic nature of the individual, and with the energies of the higher Self.

As trauma and their secondary affects are resolved, the tenets of the old belief systems begin to shift and loosen their grip on dysfunctional facets of the personality. New choices become available and awareness starts to grow exponentially. This has outcomes that were hitherto unthought of or unheard of. This is because the process of resolving trauma requires a systematic approach incorporating a spectrum of levels of integration. When this resolution is attained, the result is the spontaneous emergence of the true Self, and simultaneous contact with the psyche at the most profound level, unencumbered by coaxial, coexistent presence of traumatic memories or energies. This brings with it the capacity for the unfolding of full human potential. Ultimately, the quintessential outcome is contact with one's essential being, unencumbered by traumatic and/or conditioned experience.

### *The Cause of Suffering*

We have implicitly indicated that lack of awareness causes suffering, which is consistent with the Buddhist concept of ignorance. This lack of awareness has two aspects. The first is repression or forgetting, wherein unresolved suffering resides in the unconscious, out of awareness. In order to be externalized and healed, unconscious material forces itself into conscious experience and into awareness in dreams, symptoms, or behavior, causing suffering in the here-and-now.

The second aspect refers to a historical disregard of prenatal consciousness from the time of conception onwards. So long as we refuse to acknowledge the consciousness of the prenatate, we cannot make the protective discrimination between what we as parents are feeling as compared to our feelings for and toward infants in the womb. This lack of awareness has also affected us when we absorbed the shadow aspects of our parents, grandparents, and so on through the generations. Unawareness of the generational nature of consciousness keeps our patterns of suffering and blindness in place; through it, we maintain the seemingly endless repetitions of behaviors that are reactive, governed by fear, grasping, and aggressive.

By acknowledging the budding and determining consciousness of children in the womb, we can make discrete differences between our own state and the state of children that we are welcoming into the world. This knowledge ushers in the opportunity to make profound changes in the cycle of ignorance; we can prepare the ground for the seed of new awareness. By relating consciously and lovingly to prenatates, we create the potentiality of a new dynamic. The new being can be acknowledged and made welcome. A prenatal bond is forged between prenatate, mother, and father, probably helping to ease the birth process. In this relationship paradigm, the mother and father deepen their feelings for each other and for prenatates. They also promote in themselves and each other a greater sense of responsibility towards each other, the baby, and the birthing process. In so doing, they learn to challenge the unquestioned authority and power of the medical profession, which frequently treats pregnancy as illness. Thus a positive ecology of loving awareness can take the place of perpetual cycles of ignorance, in which growing babies are perceived as unfeeling objects. The knowledge that newly conceived infants and neonates are conscious beings can and will have growing effects on babies, parents, and the world. It will help to ensure our survival as a species, in a web of interdependency throughout the planet.

### *The Change Process*

As traumas are uncovered, habitual behavior patterns become more visible, and their compulsive components begin to lose their power. Thus, dysfunctions decrease, and life becomes more harmonious and balanced. Personal success and happiness seem much more attainable; relationships tend to flow more smoothly; work gets easier. But these are just the superficial changes. More significant are the shifts that have to do with one's relationship to the inner Self. In psychoanalysis, therapeutic progress occurs when the ego relates to the world in realistic terms, when the ego subjects itself to reality. In somatotropic therapy, however, the ego becomes subject to the inner core of being, to the influences of the higher Self. The change process can be divided into several major areas, all of which are readily discernible from the central concepts, outlined above. First of all, individuals must be regressed so that unresolved trauma can be uncovered and confronted. Regressive experiences usually occur according to thematic patterns, and it is important to collect all the major experiences that fit a common theme. For example, one young woman uncovered her birth trauma. She recalled that she was trapped for a long period of time. Subsequent to this, she uncovered entrapment in other life experiences: she was locked in a closet by her brother for six hours; she was trapped in an automobile as a result of a car accident when she was eleven years old; she was forcefully held during sexual abuse by a neighbor; and she was enmeshed in a long-term romance when she was a teenager. Once all these experiences were uncovered and catharted, the integrational process began.

Integrational processes usually cover five areas: Connections; Decisions and Conclusions; Belief Systems; Proaction and Counteraction; and Somatotropic Treatment. Each of these is covered in more detail below.

### *Connections*

In the course of the therapy, we examine the connections and parallels between regressive experiences and current patterns of perceiving and relating to oneself and the world. We explore ways in which the presenting systems derive from those fundamentally formative experiences. For example, in the case of those delivered by cesarean section, intense feelings are likely to arise about doing things in their own way and in their own time, and not being pushed or rushed; there might also be latent expectations that others would help them complete projects.



### *Decisions and Conclusions*

Through close observation of infants and children, it has been established that unresolved traumata are spontaneously and unconsciously keyed into the linguistic system at about the age of three years or earlier. Stated differently, in the preverbal stage, traumas remain in the unconscious as diffuse feeling states and their effects cannot be cognitively interpreted. It is only with the onset of language that these states are encoded. In the encoding process, several things occur:

1. the traumas and their effects can be interpreted;
2. the quality of the language learning will affect the interpretation and attach to it;
3. the traumas become more deeply engraved in the psyche;
4. once entered into the linguistic neurology, the cognitive process can trigger and activate them at any point in life.

So, for example, as the baby gets stuck in stage one of birth, where immense pressures force it towards the cervix before dilation, it reacts experientially, either by remaining in the pushing state (hypertonic) or by giving up and going flaccid (hypotonic). In the verbal phase, though still at the level of the unconscious, what develops is one of two decisive encoded messages: "Under pressure, I struggle through" or "Under pressure, I give up." These newly articulated decisions will feed into the belief system, becoming more enduring perceptions.

The subtlety or crudeness of these perceptions will be influenced by the degree of complexity of the language skills the child acquires. If language development is sparse or illogical, interpretations and decisions will be of the same caliber; whereas if the development is rich and varied, the descriptions and decisions will be rich and varied. As the child in the above example grows up, pressures on its system will then activate one of the two reactions noted in degrees of subtlety or crudeness that depend on the linguistic skills acquired during the period of primary language learning.

### *Belief Systems*

Perhaps the most crucial and important of the secondary processes are belief systems. To understand these, one must comprehend what is meant by prenatal consciousness. Prenatal consciousness has recently manifested from Spirit and is aware of any and all circumstances that surround its major waking experiences. Prenatal consciousness is also a particular kind of consciousness that involves a nonverbal awareness of the events surrounding traumata. It is somatic in nature and has the capacity to register experiences

and feelings of the pre-nate, or to register experiences in the womb surround, i.e., the mother and her spatial /emotional field. Along with these experiences, belief systems form.

Belief systems might best be described as the domain of non-cognitive and unarticulated “knowings” that form during pre- and perinatal life, particularly during stress, trauma, or ecstasy. They embody a primal, preverbal set of perceptions about the nature of life, the world, and the parents. The memory traces of these belief systems are constantly available, and when language begins to form, they are spontaneously filtered through language and adopt linguistic models appropriate to their experiences.

Because belief systems form the deepest strata of the mind, they form the underpinning for all cognitions and thoughts. Their impact on the psyche is like a mental tincture, so pervasive and constant that it is barely noticeable, though it affects the color and tone of everything. Belief systems are nonverbal and are omnipresent in the cellular, tissue, and postural organization. They influence one’s perceptions and relationships to the world, far beyond the realm of cognition and language. This was illustrated by one of my (Emerson) patients, Peter, who was attempting to break through a block that he had with women, an “intimacy barrier” as he called it.

Peter’s trauma postures and trauma tonicities were diagnosed, and he was regressed via activating these postural and tonic patterns. He immediately contacted an experience at five months of gestation, when his maternal uncle was dying from alcoholism. Highly embarrassed, his mother sent the uncle to a distant treatment institution where no one would know him. But it was too late, his liver would no longer function, and he soon died. His mother was grief-stricken and depressed for several months and even contemplated suicide, although no attempts were made.

Peter uncovered these memories and also uncovered rage at his mother for hiding his uncle’s alcoholism, for abandoning his uncle, and for his mother’s self-indulgent depression (after all, he was the wonderful pre-nate who would soon be born). His rage poured out, as well as his mother’s embarrassment about alcoholism (he recognized that he wasn’t at all embarrassed, but that his mother’s energetic relationship to alcohol had gotten into him).

His belief systems were also activated through somatic means, and, as is common, he exhibited nonverbal but intense feeling states. He was quickly able to image the belief systems and uncover the corresponding language system that formed at nineteen months. His belief systems were that he was

no good, that his mother didn't want him around, that other men were more important than him, and that mother-women couldn't be trusted. With regard to the latter, it was interesting that he never chose nurturing women (i.e., nurturing in a motherly sense), because his belief system was a somatic tincture implying that he couldn't trust them. So he was constantly "hungry" and "untouched" in heterosexual relationships.

Another of his belief system involved hangovers. He frequently had prenatal and nonverbal feeling states that paralleled his perceptions of the uncle's hangover. His belief was that he, like his uncle, must be hungover because both were rejected (Peter's hangovers were culturally unbiased and uniquely his, involving cold feet, cold nose, and gut aches). He was totally shocked that he held these beliefs, and while his external relationship to other women and alcohol would have changed with his cathartic work, his inner relationship to women and alcohol would not have changed without the work on this substratum and would have emerged as shadow material in any intimate heterosexual relationship. Belief systems hold incredible power - power that frequently needs to be brought into awareness and changed.

### *Proaction and Counteraction*

Most dysfunctional behaviors will spontaneously change when belief systems are uncovered and repatterned because the basic primary energy underlying the behavior - its deepest underpinning - has been unfastened. However, a few will not, either because they have become independent and ego-attached, or because they serve some other purpose outside the belief system. In such cases, clients are asked to specify behaviors that are opposite to those that are dysfunctional (counteraction), and behaviors that will bring them what they really need (proaction). These behaviors are then adopted, and regular evaluations with support partners or therapists assist them to become firmly rooted.

### *Somatotropic Treatment*

During intense experiences of any kind (positive, ecstatic, or traumatic), the body enacts certain tonicities, certain postures, and particular movements. When the experiences are overwhelming, the tonicities, postures, and movements are unable to be processed by the nervous system and reside in the deeper layers of somatic consciousness until the psyche is ready to confront and integrate the experiences. The tonicities, postures, and movements can easily be observed and accessed at any time, with permission.

I (Emerson) discovered these somatic principles quite by accident when I was sixteen years old. I was working the night shift at a restaurant. I was alone and was cleaning up after closing hours. I heard a terrible crash outside the back door and rushed out to find that a car had run headlong into a tree. I opened the car door to see if I could help the driver. Her head had crashed into the steering wheel, which had smashed several of her front teeth into her tongue. She was in shock, but would periodically turn her head to the left and slightly up, while moving it toward the steering wheel. Each time she did so, she moved into reverberations of terror and pain. She continued to repeat these movements every two or three minutes, interspersed with periods of silence, when she was in deep shock.

Later, when she was recovering in the hospital and talking about the accident, her head and upper body would quite unconsciously go into the same postures and movements. At these times, she would become emotional and feel the physical and psychological pain of her accident. Following her hospitalization, these movements became less and less obvious, more and more subtle, but continued into her life following the hospitalization.

I've since observed the same phenomena time and again with people going through various kinds of traumas, from skiing and car accidents to physical abuse, sexual abuse, birth, and other traumas. The psyche not only stores the cognitive memory of traumatic events, but also stores the memory of accompanying tonic patterns, postures, and movements that were linked with it. Through close observation, I have come to find that if trauma is pre- or perinatal, these tonic patterns, postures, and movements actually contain the trauma and hold the memory. In contrast, post-verbal memories may not be contained by somatic patterns, but are contained by the central nervous system as cognitive memories. The exception is that post-verbal traumas may be contained by the somatic processes mentioned above, if they also reenact or symbolically represent prior pre- or perinatal traumas.

It has been interesting to note that catharsis alone, without the somatic interventions of somatotropic therapy or other body-oriented approaches, frequently fails to release the somatic holding of traumas. When catharsis without somatic technique is finished, the tonic patterns, trauma postures, and trauma movements still remain, and when activated, arouse the depth of primal pain that was associated with the original impact. This suggests that trauma is not only a central nervous system memory, but a somatic memory as well. To resolve trauma completely, both need to be dealt with and somatic memories take primacy, i.e., if somatic processes are dealt with, then both somatic release and cathartic release of trauma take place. If trauma is

released emotionally, without the appropriate bodywork, then only a portion of unresolved trauma will be dealt with.

Tonic patterns, postures, and movements associated with trauma reside within the energy system - and for related and post-verbal events, in the central nervous system as well - and are called somatic memories. Tonic patterns, postures, and movements surround all events, but they do not become imprinted as somatic memories unless trauma occurs. Specialists in hypnosis say that traumas and stress induce trance states in which the traumatized person is highly suggestible and unconsciously takes in whatever is happening at the time of stress or trauma.

Tonic patterns, posture, and related movements are three major elements of trauma imprinted at the time of a traumatic event. None of them is imprinted unless there is a high degree of stress or trauma, in which case they become relatively permanent aspects of the person.

One can observe this process very clearly in newborn babies, all of whom have cranial molding (i.e., specific cranial shape) and patterns of movement after birth. This is entirely normal, since the head must adjust its shape in order to come through the birth canal. However, one can observe vast differences in the extent to which molding recovers, and this depends on the duration and degree of birth trauma. Conversely, one can observe when treating birth trauma in babies that heads spontaneously return to "normal" as birth traumas are resolved. However, the process of normalization decreases with age. As babies age, heads are less likely to return to normal unless specific interventions such as cranio-sacral therapy are also utilized. This is due to adhesions that form between tissue and bone as the aging process progresses, fixating the trauma postures of birth.

It should be mentioned that the postures and movements associated with trauma do not adhere in their actual physical state, but remain in what are called representational states. Representational states are mini-representations of the actual trauma postures and trauma movements. So, for example, if a shoulder were pulled back ten degrees from its normal position during trauma, and this were the actual trauma posture, the representational state or representational posture might be only one degree out of true. However, during life events that are symbolic of the trauma, or are similar in some way to the trauma, the representational posture contains all the electromyographical and neural impulses that make up the trauma posture itself, except that the impulses are of lower intensity.

When individuals are regressed to traumas, these representational states intensify and approximate the trauma postures themselves. In a majority of

cases, somatotropic therapy is required in order to resolve trauma postures and trauma movements. Furthermore, in working with infants and children, or with adults who have difficulty accessing traumas, I (Emerson) found that somatotropic treatment was the easiest, the most reliable, and the most thorough way of accessing unresolved trauma. In its most basic form, somatotropic treatment engages the trauma tonicities, the trauma postures, and the trauma movements, and these greatly facilitate the uncovering and the somatic integration of trauma. Since the body holds preverbal memories in this way, contact with the traumatic processes induces a complete, deep, and thorough release of traumatic memories. Furthermore, engaging the somatic processes spontaneously allows the body to integrate the experiences and to find a neutral ground in which trauma-free postures and movements can be initiated.

For example, seven-year-old Johnny had a conventional trauma posture, i.e., his right hip was higher, his right leg shorter, his right shoulder lower, and there was cranial compression on the right side, resulting in a cranial syndrome called side-bending rotation. This is a common postural pattern found in unresolved birth trauma. By slowly and progressively placing Johnny into these postures, and by increasingly engaging the cranial and tonic patterns, he proceeded to uncover his birth trauma and at the same time resolved the emotional and somatic bases for it. When his body returned to its normal state, repatterning processes were initiated to provide him with an optimal basis for free and harmonious functioning.

When the body can be entirely released from its somatic trauma, it is possible to realize deeper states of meditation and deeper states of consciousness. So one of the subtle outcomes of this work is that clients are able to function better in life and are also able to develop spiritually. The spiritual process cannot progress until the traumatic aspects and the shadow aspects of the person are dealt with, a conclusion that Freud and Jung both came to and which has become an underlying basis for Jungian psychoanalysis.

### ***Practitioners***

#### *Role of the Therapist in Working with Adults*

The facilitator is active in promoting regressions and in promoting somatic and verbal techniques to uncover trauma. It is essential to know various approaches to regression and to conduct them in cooperative and collaborative relationships with clients. It is not necessary for therapists to apprehend what clients are experiencing, but rather to let clients report what

is happening. A prerequisite in the therapist is an ability and willingness to be open at the level of the heart and to respond with genuine empathy and compassion to the emerging content. This prerequisite has nothing to do with technique, but rather with a state of mind and heart. As the client uncovers and discharges trauma, it is the therapist's state of empathy, compassion, and objectivity that most dynamically promotes the healing process. Once the traumatic experiences and their reverberations are uncovered and catharted, the facilitator takes on an educational role, sharing with the client various integrational procedures and guiding the client through these in a supportive way.

### *Role of the Therapist in Working with Infants and Children*

The therapist performs three primary functions: to contain the reality of the trauma, to hold it with compassion and love, and to facilitate its expression and integration. With infants the therapist acts as the baby's advocate and/or means of articulation. He or she will voice the baby's traumatic feelings, which may or may not include feelings about the medical staff, medical procedures, the birth, the mother, the father, and/or the siblings.

The practitioner gains acceptance from the baby and the parents before initiating or continuing any technique, explains to the parents what he or she is doing, and encourages them to allow the baby to express what it is feeling. In that role, the therapist is also mediator between the baby and its feelings and perceptions of the world. Through a thorough understanding of the pre- and perinatal stages, and the somatic topology of the baby, the therapist broadly reconstructs and reflects the history of the birth from conception onward. The therapist contains and mirrors the prenatal biography, and by voicing the baby's feelings, gives them a substance of equal stature to the parents. This process demonstrates the acute consciousness of the baby, and in that respect alone, significantly improves and/or deepens the quality of relationship between the baby and the parents.

In this process, the parents may access some of their own birth material. While it may be vital for them to work with it to facilitate their parenting abilities or to assist in their baby's release of participatory trauma (babies frequently hold the trauma of their parents), the therapist maintains clear boundaries between the baby's material and the parents' and between the times that baby works and parents work. One or preferably both parents are required to be present during sessions, as it is their level of love and empathy that is responsible for the ultimate healing bond. With children the facilitator

is initially a friend or peer. The child is engaged at its age level with playfulness and loving respect. After deep contact is made the roles will move between friend, playmate, advocate, observer, and adult, shifting as required and sometimes overlaid, depending on which of the many games or techniques are being employed. Parents are required to attend sessions, because it is their love and the depth of their actual or potential empathy that is most healing for children.

### ***Sequences in Somatotropic Therapy***

#### *Phase 1*

In working with babies, as with children, the first phase or step is to establish rapport with the baby and its parents. But in the case of babies, this requirement is magnified: it is the essence of the field of communication between therapists, babies, and parents that is at the heart of the treatment process. The essential and underlying presupposition is that babies are sentient and capable of precise communication. This becomes swiftly obvious to those who learn to fine-tune their responses and proprioception. Frequently, release from pain occurs simultaneously with babies' perceptions that they are being heard, seen, and felt, perhaps for the first time.

Once deep contact has been established, the practitioner makes an initial scrutiny of baby's face, head, facial shape, and body, observing postures and movements that embody the birth schema. In this way evidence of the trauma's impacts begin to emerge. Communication with parents to ascertain and confirm participatory trauma is also evaluated. Examples of participatory trauma are prenatal disturbances such as moving, a death in the family, financial crises, injuries, accidents, wars, relational upsets, dubious or negative feelings about the conception or the pregnancy, and so on. The parents are then joined in articulating these events and contacting their feelings about the distressing events. The potential impacts on their children are also discussed.

Parents are then guided in making extremely clear distinctions between their own feelings and reactions and their baby's feelings and reactions. Once these distinctions are grasped, they need to be articulated by the parents in the presence of the baby and the distinctions owned. This articulating process is often a powerful catalyst for the baby, who frequently responds to what is being verbalized by crying, screaming, or other actions through which it will demonstrate and release its memory of the traumatic experiences and work through the effects of the participatory trauma. This



process will often precipitate major changes in the baby's behavior and its relationship to the parents.

### *Phase 2*

The second phase focuses heavily on observation of the bones and tissue structures of the face and head that were impacted by birth pressures. In rare cases where trauma does not occur during birth, the visible effects of these impacts will spontaneously resolve within a few hours or days. As the vast majority of births, however, contain traumatic elements, each stage of birth leaves very specific indications of traumatic stress on the head and facial features of the individual baby. It is here that precise and detailed knowledge of the pre- and perinatal birth stages and their subdivisions are required, as well as a knowledge of the traumas and feelings associated with each stage. This is where babies' traumas are accessed, as distinct from participatory trauma. In addition to the facial features, the visual cues, and the cranial/bodily indications mentioned above, the whole skeletal-muscular structure carries the signature of the birth trauma. These are evaluated by palpation, using what is called "near touch," in which the baby is palpated off the body, feeling for indications of trauma in the energy field around the impacted areas. When the energy memories are thus located, and the hands connect with these leaks, the baby begins to respond, either giving permission for the work to continue, even though it is often painful, or clearly indicating that the work should stop.

An essential element in this work is its procedure under the control of the baby. This cannot be stressed too heavily. The baby in this process is engaged; it is informed that it will be in charge of the cathartic process, which it can stop at any time. When such a contract is made, the work can take place. The baby will often endure bouts of relived pain of some intensity and between rests will often guide the practitioner's hand to the areas that require work and adjustment. The skin on the head, neck, or body may occasionally change color and/or temperature, or it may swell. These are all clear signals of the physical impact of birth trauma retained at an energetic, cellular, or tissue level in the body.

### *Phase 3*

It is in this third phase that the deepest aspects of the trauma are uncovered. This is accomplished by a process called birth-simulating massage, a technique that focuses on the infant cranium and shoulders. In order to do birth-simulating massage, practitioners must first have knowledge of the

journey of the cranium through the pelvis and all the places of juncture where maternal pelvis and infant cranium meet. These journeys are reproduced by practitioners, utilizing their hands to simulate the precise movement of the head through the maternal pelvis, thereby simulating the birth and uncovering the deepest aspects of birth trauma. The contact, now using direct touch to simulate the birthing, releases the memories and the traumas they embody. During this process, the other approaches already discussed are also used simultaneously. The essence of this work, birth-simulating massage, resonates all through the work with children and adults, since it forms the basis for the surest, most precise, and deepest contact with unresolved trauma.

### *Management and Technique*

In times of resting, the baby can turn to the mother for the breast, for comfort, for love, and for reassurance. Dramatic changes in behavior, posture, eating, crying, sleeping, and relating usually occur quite early in this work, sometimes after several sessions. The length of treatment depends on the number and degree of prenatal traumas, the seriousness of birth trauma, and the length of the mother's labor. As a rule of thumb, four times the length of labor is required for the full course of treatment. If the only trauma is birth trauma, the average number of sessions required to complete treatment is twelve.

One of the immense benefits of resolving birth traumas in infants is that the traumas are dealt with and dissipated before they have a chance to be crystallized into the verbal realm, where their hold otherwise becomes much more tenacious. With children, as with babies, empathic communication and rapport must be deeply established before work can commence. With children, the array of techniques is much more extensive and complex. It involves prenatal games, conception games, birth games, sand tray work, bodywork, cranio-sacral therapy, artwork, guided imagery, and regression through contact with somatic processes, as described above. (Winnicott called a child's re-enactment of this journey "serpensation.") The training for this aspect of the work is the most rigorous, as it is the most complex. The work is used with children from the time of language development and right into adolescence.

In working with adults, a number of regressive techniques are used, including guided imagery, birth simulation, verbal regression, trauma postures, tonic energizing and de-energizing, birth-simulating massage, trauma movement, and others. The work is usually done in group settings,

where the focused dynamic energy of the group amplifies the potentiality for regressive journeying and the potency of integrative work. Emphasis is once again laid on the need for a therapeutic support system when this work is undertaken. So deep and powerful are the contents encountered, so much alienation is indigenous to the process of trauma, that loving and skilled support are requisite for dealing with and resolving traumata. Once deep regressions have taken place, the door opens for an entirely new dimension of work to take place. The client can and should return to his or her own therapist, who need not be a specialist in this work. Provided that the therapist can comfortably allow and accommodate intense somatic and emotional expressiveness, and provided that she or he is alive to the need for keeping the client's attention on the somatic reality they will reexperience in their work following the first regression, deep and rapid progress will be made.

### *Does It Work?*

From 1964 to 1974, I (Emerson) conducted over 8,000 hours of intense and ongoing regression sessions with adults. Profound changes in clients were observed, and these observations invited the possibility of beginning treatment much earlier, with infants and children. The hope was that, by starting treatment early, the development of adult symptoms could be prevented and the treatment process could be completed more efficiently. In 1974, I began to develop therapeutic approaches and to conduct exploratory treatment of pre- and perinatal trauma in infants and children. This work was followed up to determine the long and short range outcomes of therapy. The treatment of infants and children was evaluated in terms of a pre-test/post-test model, using changes in presenting symptoms as well as standard questionnaires to evaluate therapeutic effectiveness. A control group (infants and children who were referred for treatment, but who did not receive it) was also included for purposes of comparison.

### *Therapeutic Outcomes with Infants and Children*

One of the major successes of the experimental work with infants and children was the development of a broad range of therapeutic techniques. These were successfully used to deal with traumas ranging from conception to Oedipal conflicts at age five.

The work with infants and children indicated that not only could they be treated, but they could be treated far more effectively and economically than adults (in terms of time and outcomes). Infants and children required an

average of only twelve sessions to discharge birth traumas, and their work yielded a broader and deeper range of outcomes than adults. There were significant changes in the treatment group (but not in the control group) on ten dimensions:

1. resolution of presenting symptoms
2. resolution of somatic symptoms
3. prevention of potential symptoms (follow-up has been eighteen years to date)
4. degree of emotional maturity
5. extent of mutuality and empathy
6. degree and type of non-aggressiveness
7. degree of self-awareness and ability to communicate
8. level of individuation
9. manifestation of unique human potential (passion and ability in unique talents and skills)
10. connection with the Self

*The quintessential possibility of regressive therapy is spiritual opening and the emergence of a volitional relationship with one's higher Self.*

- William R. Emerson

Several comments about these outcomes are warranted. With regard to somatic symptoms, it was common to find reversals or remissions in various pediatric diseases. In most cases, psychosomatic disease patterns resolved; occasionally other pediatric illnesses (such as bronchitis, asthma, dermatitis, colitis, and others) also responded to psychotherapeutic treatment. In addition, temperamental behaviors in infants were very responsive to treatment: "fussiness," extensive crying, breast-feeding difficulties, nocturnal or frequent waking, irritability, hyperactivity, and lethargy were often rectified. In several dramatic cases, autism and attachment disorders responded to treatment. Learning disabilities, developmental delays, and emotional handicaps in children would often show marked improvements.

The most universal outcome, and one that was not anticipated, had to do with transpersonal phenomena, or Self-manifestations. Treated infants and children were significantly more adept on dimensions of the Self. The Self refers to qualities that have been called "magical" by Pearce

(1980) and “radiant” by Armstrong (1985). In addition, a number of treated infants and children had transpersonal experiences, e.g., visions, peak experiences, meditative phenomenology, conversations with God, clairvoyant experiences, etc., either during or following completion of treatment. None of the children in the comparison group had such experiences. This finding is significant since there is considerable debate within transpersonal psychology about the possibility of transpersonal experiences occurring prior to full ego development. Contrary to consensus opinion, the data reported in this paper suggest that transpersonality occurs prior to full ego development.

There was another unexpected finding, having to do with human potential. During or shortly after the resolution of trauma, there were dramatic expressions of unique human potential, vivid manifestations of passionate interests, talents and abilities. The somatotropic treatment process appeared to open the psyche to considerable depths, where the seeds of human potential reside. When there were no unresolved traumas to obscure their expression, latent talents and abilities surged into consciousness where they could be acknowledged and acted upon. Because of this, treated children were more likely than untreated children to have “found themselves” and to have identified their unique qualities, frequently without parental support or encouragement.

For example, one three-year-old boy completed his trauma resolution and immediately began to exercise a passion for balls. He played with balls for two hours each day on his own and with much talent and enthusiasm. His parents were academically oriented, had never engaged in sports, and were very surprised by the focus and intensity of his new interest. Their boy grew up to be an exceptional athlete. In another example, a three-year-old girl first began to express an interest in sewing as she was resolving major traumas, ended up selling tapestries at the age of five, and was an accomplished artist by the age of ten.

The list of exceptional characteristics is long: a four-year-old reading fluently; a three-year-old painting landscapes with oils; and a five-year-old repairing electrical equipment with no training or modeling. These activities were self-chosen and pursued with a degree of concentration and attention that did not require parental initiation, encouragement, or praise (although all these were appreciated by children). Furthermore, these specialized areas of interest accompanied a breadth of development in other endeavors: children were well-rounded and competent in academic and social areas.

### *Therapeutic Outcomes with Adults*

During research with infants and children, approaches were discovered that made major contributions to work with adults. These approaches elicited deeper and more accurate contact with regressive content and gave access to transformational material in ways that had previously not been possible. Results with adults were similar to the results with infants and children, although the full range of outcomes (mentioned above) were rarely attained. For example, human potential (in adults) was only actualized in about 50% of cases over a five-year follow-up period and in 70% of cases over a ten-year period. This was because many adults found it difficult to make life changes that were consistent with their newly found human potential.

### *Case Study*

The following case shows how somatotopic therapy heals trauma and facilitates the emergence of human potential. The case involves a thirty-year-old woman who completed twelve years of psychotherapy, none of which included regression techniques. An interview revealed that she suffered from anorexia, low self-esteem, claustrophobia, depression, career frustration, and highly unsatisfying relationships. Career frustration was fueled by the feeling that she couldn't get anywhere in her career, despite the fact that she was making rapid rises up the corporate ladder, far exceeding her male counterparts. Her depression centered on her inability to consummate intimate and satisfying relationships with men. Every man she had been in relationships with exhibited varying degrees of weakness, dependence, narcissism, and irresponsibility. She said, "I keep hoping that they will be responsible, strong, and independent. But no, they don't pursue jobs or keep commitments, and they want to be taken care of all the time. I seek men and end up with little boys."

Her initial regressions involved prenatal memories about her older sibling (a brother) and were facilitated by trauma postures and tonic energizing of tissue memories. She discovered that while she was in utero her brother took all of her parents' time and attention. He felt very threatened by her presence and did not want her to live. She felt totally rejected by him, dominated by him, and "short-changed" by her parents' attention to him. (Many unborn children have psychological relationships with their born siblings. This case, and many other cases like it, have underscored my opinion that prenatals need protection, attention, and love, and parents should plan children so that the healthy but primary narcissism of a birthed child does not overlap the gestation of an expected child.)

Her memories were very intellectual and trauma postures were essential in helping her to uncover and feel the pain of her unmet needs and her rage at and distrust of her brother. She discovered that her continual choices of “little boys” instead of men were recapitulations (i.e., repetitions) of her relationship with her brother who took all and gave little. At the same time, she was frightened of strong men for a related reason; if they were strong they might be able to take from her. Her birth regressions were facilitated by trauma postures and birth-simulating massage.

She discovered the terror she had felt when the doctor, in an attempt to save her mother from tearing, had pushed and held her back. She associated this feeling with the way she felt about the men in her corporation. She was subsequently able to see her own progress and to see her male colleagues’ support of her. She experienced her endogenous depression, which stemmed from being held back and stuck for thirty-six hours and unable to progress. She said: “I realize now that I’ve always been depressed, I just didn’t know it. I thought everybody felt that way. The hopelessness and helplessness I felt during my birth were the same feelings I carried to my work and my male relationships.” Her depression gradually lifted and as an added bonus she discovered that her eating problems, particularly anorexia, were a recapitulation of her emotional starvation while in utero. To summarize her therapeutic experiences, she said:

I’d done it all, every therapy imaginable, but I still couldn’t be close. Then I started regression therapy with William Emerson. He did what he called “reading my cranium and soma-postures.” He then guided me into some postures that felt very unusual and quite uncomfortable emotionally. Feelings began to come, and I was in the middle of an experience. It was very intense, almost overwhelming, but at the same time it felt right, it was my gestation experiences with my brother. He took all the attention that I needed, and I almost starved to death emotionally. For many sessions I had different memories and feelings. Then I found some postures, and Dr. Emerson did some cranial stroking which brought up the most amazingly strong feelings I’d ever felt. They were my birth feelings and I was totally stuck, just jammed up and totally hopeless. I was really depressed in there.

After many months of feeling my womb despair and my depression, I began to feel deeply quiet. I noticed almost immediately that my capacity for intimacy had changed. Never before had I really felt a hug, or been able to engage in deep eye contact. I can see “little boys” from a mile away, and I stay away. I’m beginning to date men who are self-reliant, and it’s scary but exciting. I’ve been having strong images of myself, and daydreams, which I never before had. I see myself doing things I would love to do, but could never consider doing. Mostly they are images of horses, of owning and racing horses. Gradually, by working with belief systems, I was able to let go of limiting beliefs and to acknowledge my deep longing to own and race horses. I have since left my corporate job,

except to act as an occasional consultant for them, and embarked on a highly successful and exciting career: training and racing horses. My life is totally transformed.

### *Pitfalls*

A client needs to be in a safe therapeutic support system, such as ongoing therapy, which contains the regressive process in a way that honors the client's processes and defenses. When clients regress, they frequently enter deep, altered states of consciousness in which they can filter whatever material emerging from deeper levels they are prepared to work with. The more that clients are in control of the process, the deeper they can progress because control and safety are intricately intertwined.

The regressive process must be conducted in a way that respects the boundaries and capacities of clients. If the process does not empower clients, if it does not honor their boundaries and capacities, then there may be pitfalls. In such cases, the major problems are that (1) clients are unable to access deeper memories; (2) they are only able to access screen (i.e., protective) memories; (3) they are unable to remember the regressive experiences; and/or (4) their life is disrupted by the power of the emerging content that intrudes in dreams and during waking consciousness, making work and concentration difficult.

These problems are more likely to occur with certain clinical syndromes, namely those involving borderline personality disorders, hysterical and conversion disorders, and psychotic disorders. Special regressive procedures are necessary for individuals with multiple personality disorders, dissociative personality disorders, and schizoid disorders, particularly schizo-affective types.

### *Note from Dr. Emerson in the original 1994 book chapter*

This chapter is dedicated to my dear friend and colleague Stephan Schorr-Kon who co-wrote this with me. He died unexpectedly on 31 December 1992.

### *Further reading*

Emerson (1987) describes the use of somatotropic therapy with infants and summarizes his research on treatment outcomes.

Emerson (1989) describes the basic parameters of psychotherapy for infants and children. Fundamental techniques are discussed and research results from fifteen years of development and evaluation are summarized.



Grof (1975) summarizes his pioneering research over an eighteen-year period, exploring the phenomenology of birth, the nature of schizophrenia, and interactive dimensions such as art, religion, personality dynamics, and the treatment of emotional disorders through regressive experience.

Lake, F. (1966) (abridged 1986). The 1966 edition is preferable and outlines in entirety Dr. Lake's findings from regression therapy over a twenty-year period and its implications for theology.

Sills (1990) is a thorough introduction to a system of energy medicine that can be utilized for the uncovering and treatment of trauma. The concepts and techniques may be most useful to those in the somatic professions, such as chiropractors, cranial osteopaths, nurses, bodyworkers, midwives, and massage therapists who wish to uncover and resolve traumatic memories in the body. Many of the techniques are similar to and compatible with the integrational techniques utilized in somatotropic therapy.

Ward (1987) describes the stages and content of prenatal development and how the work may be applied to infants and children.

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