The Baby is in the Shadow: Why Study Prenatal and Perinatal Patterns

By Kate White, MA, LMT, RCST®

A woman contacted me wanting an appointment. Her baby had not slept more than 90 minutes since birth. Now, at four months of age, the baby was having a hard time, and the woman, understandably, was losing her mind. She, too, had not slept much in all that time. I said, "Come in, immediately."

When they arrived, I noticed the baby was bright, cheerful, and quite communicative. However, she held her arms straight out to her sides with her hands splayed, which was unusual for a baby. The mother looked exhausted. Over the phone, she had explained that the baby had been tongue tied and had a frenulum clip at 10 weeks. They had difficulty nursing, which also told me bonding was compromised at the start.

The first thing I did was get the birth story. The woman was an older mom, in her early 40s. She married late and this was a *very* wanted baby. The father was also an older man, in his 50s. She had a premature rupture of the amniotic fluid sac, what is called a 'premature rupture of membranes' at 37 weeks. The mom actually thought the baby was five weeks early, based on her calculations. She did not go into labor immediately, as is often the case. After twelve hours at home (the time most hospitals allow), she reluctantly went into the hospital.

She did not know the on-call doctor very well; they had difficulty communicating. It was clear to her that he was scared; his fear made her feel afraid and threatened. When she didn't go into labor, he started her on a Pitocin drip (*medication used to improve uterine contractions*). She labored a long time but did not dilate. This was a heroic thing to do—to labor without pain medicine while on a Pitocin drip. When the doctor began to talk about a C-section, the mom agreed to an epidural. She dilated quickly and delivered.

While the mom told me this story, she stopped periodically and cried. I sat beside her, with my hand on her back to allow compassionate and empathetic space for her feelings and to do my best to comfort her, all the while watching to see if the baby wanted to participate in the story. The baby had gotten quiet and appeared to be listening with no signs of distress. Because the baby was jaundice at birth, she had been separated from her mother. So I suggested we complete a sequence called 'supported attachment' that allows the baby to tell her story with her body and helps bring mother and baby together after separation.

Originally developed by midwife Mary Jackson (Cerelli, 2013) while working with Ray Castellino, RPP, RPE, RCST® this technique helps to calm the baby. It allows the baby's story to be seen and heard and improves breastfeeding.

I had the mother take off her shirt, and we took the baby's clothes off down to her diaper. I told the baby what we were doing and why and placed the baby on her mother's stomach. The baby began to crawl up toward the breast, all the while complaining—not crying really, more like telling us about something. I empathized with the feeling tone. It sounded like she was scolding us. I noticed she was not using her arms and reminded her that she could use them. Once she started using them, she made rapid pace to her mother's breast. She latched on, nursed, and at the same time, kept telling us about something in an alarmed but calm manner. After a few minutes of breastfeeding, both mom and baby feel asleep on my couch.

I put one hand on the mom's back and one hand on the back of the baby and held them using biodynamic craniosacral therapy, just holding and supporting them. In craniosacral therapy, the therapist is trained to track very subtle but deep tidal movements in the body. The movements are related to an inner health or blueprint that we all have. With my hands on the dyad, I tracked these movements using my own body and a knowing of what the fluid movement is supposed to be, synchronized and amplified the patterns, allowing this inner health to rise. In pre and perinatal work, pregnancy and birth have a healthy pattern: every baby and mother know how to birth. When there have been these disruptions and interventions, the inner healthy pattern and blueprint can be covered over by an imprint of difficulty. Craniosacral therapy can help decrease that feeling and normalize the experience so that it does not continue to overwhelm the person (or in this case persons).

After fifteen minutes, they woke up, dressed, and left. I was quite concerned about them. The next day, I got this email:

The baby and I came straight home and laid down, tummy-to-tummy, and she nursed and dozed, and then we both nodded off for an hour. She seemed content yesterday evening, and we had an easeful bath/massage/ nursing time. She slept in her cradle swing from 7:00 pm to 3:30 am at which point she nursed vigorously for 20 minutes, and then went right back to sleep until 6:45 am. Not only a long sleep for her but an hour later than usual!

Thank you for all your insights and kind words. I felt a sense of relief after our session and a broader understanding of just how traumatized I was after our birth experience. I have a feeling that as I can clear some of this up for myself, the baby will relax as well.

The Skill Base for a Pre and Perinatal Professional

Working with families and babies who have had overwhelming experiences requires a certain skill base. I have been working in the prenatal and perinatal realm for over 15 years, over 20 years as a body worker, and over 25 in maternal and child health. In the last 14 years, advances in the fields of interpersonal biology, epigenetics, fetal origins, trauma resolution, affect regulation, neuroscience, and attachment have created more acceptance that babies have experiences in utero, during birth, and postpartum (neonatal). My work is about healing moms, babies, and adults with early trauma; prenatal and perinatal therapeutic approaches focus on giving babies the best possible start.

Every baby needs layers of support.

In the womb, the embryo is supported by the amnion and the chorion.

The baby is then supported by the mom and her partner.

Once the baby is born, the family is supported by extended family and community.

Art by Jane Delaford Taylor
http://
janedelafordtaylor.weebly.com/

Pre and Perinatal Health and Healing

William Emerson (1999a) is one of the pioneers in pre and perinatal psychology (PPN). His work is pivotal because he was one of the few who created articles, papers, and tapes on the subject, and eventually a training program for professionals. He divides birth into four stages and teaches practitioners how to help heal the psychological and emotional stresses that result from difficulty or overwhelming experiences that happened at each stage (Grof, 1976; Lake 1981). According to Emerson, these imprints create lifelong patterns that often go undetected because they lie in the unconscious of the individual.

Expanding our consciousness around these imprints and bringing them into awareness out of the unconscious loop of the brain's automaticity will lessen their impact on our lives and thus decrease our suffering. Emerson correlated his four stages of physical imprints from intense experiences in utero, as well as the mental and emotional states and belief patterns that happen at each stage, with overwhelming experiences that can occur at each stage (Emerson, 1999b).

- Stage I: The feeling of No Exit. Contractions are felt within a closed system. Examples of psychological correlates here include claustrophobia, boundary violation, anticipatory anxiety, and endogenous depression.

- Stage II: No Man's Land. Full dilation and descent into the pelvis.

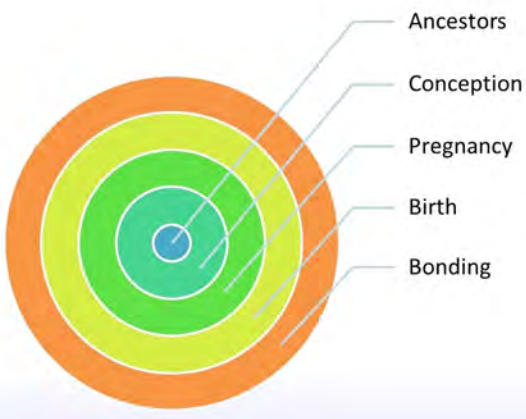
- Stage III: Life Death Struggle. If overwhelm is felt here, the client can feel exogenous depression, and distressed by shared boundaries, among other patterns.

- Stage IV: Dysfunction and Distressed Bonding. Separation is a possible theme here.

Differentiating trauma from shock (Emerson, 1999b), Emerson said that a person can have a present day experience that awakens an unconscious trauma or shock from the prenatal and perinatal period—the 'baby self' is reliving a terrible time from long ago that becomes activated in the present.

Pre and Perinatal Practice

Ray Castellino, RPP, RPE, RCST® in conjunction with Myrna Martin, RN, MN, RCC, RCST® , current PPN trainers and practitioners, recognized that ancestral history can be felt in the person and family and needs attention if there are overwhelming parts. They teach therapists how to discern, differentiate, and heal a concentric ring of relationships starting with these ancestral patterns. Although the rings are more in-depth than portrayed, I will often sketch a simplified diagram with clients so they can see their patterns and discern how they relate to the present day. It can be illuminating. Patterns that arise may include: difficulty breastfeeding or bonding; separation from mom; twin loss; maternal stress; toxic chemicals in utero of all kinds; difficulty conceiving, previous miscarriages, abortion or still births; and difficulties at birth including chemical and surgical interventions.



Martin and Castellino begin their trainings with preconception and attachment experiences rather than with Emerson's four stages. They are expert in teaching about 'double binds'—the baby is presented with a situation that feels like a life or death struggle and any decision they make will likely be difficult and/or overwhelming. Many of these experiences can exist and can reactivate an early pattern in the nervous system if left unhealed.

Tipping Points: Three Case Studies

Recent advances in fetal origins, epigenetics, affective neuroscience, and more support the importance of the baby's experience. There are several important points that pre and perinatal psychology educators can make when talking about the impact of difficulty on babies. Research supports the notion that babies feel pain, that babies can get post-traumatic stress if their mothers experience it, and truly, separation from the mother at critical times of development can have a devastating effect.

Babies Feel Pain

It is hard to believe that there was a time that people, especially medical professionals, thought babies did not feel pain. In fact, it was the prevailing theory that babies were objects, blank slates, born into the world to be scripted. We now know that babies have big experiences in utero, that their senses become vivid as the baby grows. We know that they can learn and be spoken to utero, and that prenatal bonding can increase birth and perinatal outcomes. The science of fetal origins and many

research studies from infant laboratories show that babies learn about the world while still inside the womb and come out with preconceived notions and also abilities to make discernments. Several studies that played an important role in changing hospital policies about babies and their needs for anesthesia were done by a brave neonatologist named Kanwaljeet Anand (called Sunny). He documented that babies who had surgery often had extremely high levels of cortisol in their bodies showing how stressful the procedures are (Paul, 2008). Pain relieving medicine was not given to babies having circumcision, hernia repairs, even open heart surgery, just drugs to paralyze them so they did not move. His studies eventually helped change hospital policies, but many did not fully support the baby's needs for pain medicine until the late 1990s. Many adults today have had those surgeries as infants, and these memories are in their bodies in a procedural way. Some youth and adults cannot visit hospitals without severe anxiety, panic and fear, many because of their hospital experiences as babies (Monell, 2011).

Post-Traumatic Stress in Babies

Scientists are able to measure the impact of the mother's experience on her baby while she is pregnant, and nowhere was this more poignant than the 9-11 tragedy. With the fall of the twin towers, researchers began to track the impact of the experience on many different kinds of people, including pregnant women. In a study, they were able to gather 38 women who were pregnant during the fall of the twin towers and measured their cortisol levels. These women measured low in cortisol, a result often seen in people who have posttraumatic stress. The researchers tracked the babies that were born, and found that they had the same level of cortisol, showing how stress could be passed to the future generations (Constandi, 1999).

The Unabomber

Those of us who are old enough to pay attention to the news during the 1980s will remember Ted Kaczynski, also known as the Unabomber. While it is unknown what exactly prompted Kaczynski to send letter bombs that killed 3 people and injured over 20 others, writer Robyn Kerr-Morse (2012) speculates his disturbance started as a baby. She recounts his story in her book, *Scared Sick: The Role of Childhood Trauma in Adult Disease*. At nine months, Kaczynski was isolated in a local hospital for a strange rash for one week. His mother was only allowed to hold him one hour a day. She said that he totally changed in the week that he was there. "He became limp like a rag doll," she says, and lost interest in human relationships after that. She added, "He was a different baby." The isolation away from family, especially his mother, at a time when stranger danger naturally develops in babies could have affected this man's world view as a dangerous place.

The Skill Base for a Pre and Perinatal Professional

Working with families and babies who have had overwhelming experiences require a certain skill base. In addition, the prenatal and perinatal practitioner works with adults seeking to heal early trauma. Along with specific training in prenatal and perinatal approaches from Emerson, Castellino, Martin, and John Chitty (2013), these are some common tools:

Trauma Resolution, such as Somatic Experiencing®

Ideally, a pre and perinatal therapist is trained in some trauma resolution therapies and has a good understanding of developmental trauma, or early childhood abuse. There are several good approaches. Somatic Experiencing® (SE) involves deep inquiry of and renegotiation of the autonomic nervous system (ANS). Survival, or that feeling of life or death, is a common experience during the prenatal period and birth. SE provides an excellent basis of ANS recognition and verbal skills to slow down the pace, acknowledge

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resources, titrate into difficult material, and pendulate so that the client stays present and doesn't go into fight/flight or dissociative states and can be resourced enough to discharge the trauma held in the body (Levine, 2010).

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This approach is somatic and also verbal. The therapist also has a grasp of the right kinds of questions to ask and how to ask them, bringing finely attuned attention to the "felt sense" of the experience. The therapist can take the client into an overwhelming situation with safety. Trauma resolution skills are necessary to keep the client in the now, allow enough support for awareness of the pattern without overwhelming the person, and discharge through the client's body.

Mindfulness Based Training, such as Interpersonal Biology

There is a wealth of clinical and research data that support mindfulness approaches for healing. Dr. Daniel Siegel and Dr. Richard Davidson are two practitioners and researchers who combine mindfulness approaches and neuroscience. Siegel's approaches are easy to understand and start to practice. We now know that we biologically develop interpersonally, so therapists who work in the pre and perinatal realm will need to have a strong enough container inside themselves to meet a client where they are and provide that safe, secure presence that many clients with early trauma did not get. Practices like body scans including the relaxation response introduced by Herbert Bensen (1975), the 'body-low-slow loop' practiced by Chitty (2013), and Heartmath (www.hearthmath.com) are also good. Mirror neurons are a significant part of how healing happens in relationship, so the therapist is also a model for the client to take in and try on. Mindfulness practices also engage the prefrontal cortex and can bring social engagement back on line if the client's baseline is in sympathetic or parasympathetic reaction to threat.

Touch Therapies, such as Biodynamic Craniosacral Therapy

Touch is important when working with implicit somatic memory. Biodynamic craniosacral therapy (BCST) is a subtle but powerful form of bodywork arising from the osteopathic tradition. It is an important part of prenatal and perinatal therapy because it focuses on the health in the client's system and an optimal pattern referred to as "the blueprint." As the tree grows from an acorn without the need to focus on how, so do we grow from a fertilized egg into a complex and highly functional organism. We know that how the embryo develops influences us today, as the roots of our patterns in the present come from how we developed in utero. This is not to say that overwhelming events later in life and many positive developmental aspects don't also leave their imprints.

In BCST, therapists can feel subtle movements and rhythms with their hands; their clients' bones and membranes respond to cerebral spinal fluid flow. This intervention is meant to find places where there has been compression or restriction of flow and return the body to its healthy state. There is a saying that there is wisdom in the body, or "the health in the system." Through this lens, all acts of compensation in the body (and therefore psyche and the mind) are acts of health as the body adapts to overwhelming events.

There are many teachings from this healing art that help reframe and support healing in the pre and perinatal field, such as the understanding of embryonic patterns from preconception through birth. Also, the therapist has to do significant personal work to slow down and be present; the best experiences in this therapy happen when therapists can create the right conditions within themselves.

Overwhelming experiences, especially those that lie in the unconscious, can create significant tension. Many times, the best route is simply to be able to sit with this tension and "do nothing," and simply "be present." Careful attention is placed on being with the client at just the right distance, right pace, and right depth. Much of what needs to happen is unspoken, which again is very compatible with pre and perinatal work.

In addition to this form of light and still touch, are other forms of hands on therapy. Deep compression, especially into bigger muscles and stronger parts of the body help clients who are in dissociative or freeze states. Deep but still, slow touch on the legs can help ground a client, for example. Squeezing the joints of the shoulder can release

shock literally held in joint capsules because that is their job (joint capsules are the shock absorbers of the body). Moving touch can help the client relax and also move energy that is stuck. For bodyworkers, advanced education in understanding how shock and trauma are held in the body is ethical. Our best authors and researchers in trauma now write and speak about how the body "bears the burden" (Scaer, 2014), or "keeps the score" (van der Kolk, 2014). I will often teach parents how to give bodywork to their babies and children, and I have seen it dramatically affect the child and transform the parent-child relationship from misattuned and dysregulated to attuned and bonded.

An Interweave

Prenatal and perinatal psychology and healing principles have progressed exponentially since Otto Rank first published his book, *The Trauma of Birth*, in 1924. Practitioners have transitioned from early regression work and altered states (primal scream, holotrophic breath work) to more subtle body oriented therapies. The sciences have contributed their support, especially with the human genome project competed in 2003 that revealed we only had 25,000 genes instead of the expected 130,000. The science of epigenetics, fetal origins, and prenatal bonding also known as prenatal stimulation, have clarified the long standing nature versus nurture debate. With magnetic imaging and ultrasound technology, we are able to see and more fully understand how our earliest experiences help shape who we are, our perceptions, and world view. We are currently weaving affective neuroscience and interpersonal biology into our understanding of human development as studies with rats prove positive outcomes when 'babies' are provided attentive and high functioning mothers (Weaver et al., 2004). Preventative measures, i.e., promoting relaxation techniques, prenatal bonding, intrauterine communication, skin-to-skin contact with mom and newborn, and secure attachments, are possible to support an optimal prenatal and perinatal constellation of early life patterns/imprints.

It is an exciting time to be a practitioner in the prenatal and perinatal field as we acknowledge a full, round picture of what babies experience and are capable of. A team of leaders gathered by the Association for

Prenatal and Perinatal Psychology and Health is bringing more information, education, and practice forward. All these efforts are contributing to bringing the baby's experience to consciousness, out of the shadow and into the light.

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