Body psychotherapy with parents, babies and infants

By Thomas Harms

Introduction

Research on new born babies and their early relationships has gradually moved into the focus of attention since the middle of the 20th century. The results of contemporary infant, attachment and brain research clearly substantiate the view that the psychic and bodily health of the growing child is fundamentally determined by the quality of its first attachment experiences. The increasing helplessness and bafflement of many parents in coping with their babies has meanwhile found its way into general awareness. Issues such as crises with screaming babies, the ever rising rate of caesarean sections worldwide and news of cruel child murders have come to the center stage of public discussion. The boom in modern baby research and the changed attitude towards the "competent infant" (Dornes, 2011) in the last decade have led to an intensified discussion as to how the essential tools of modern (body) psychotherapy could be deployed in the field of prevention, crisis intervention and trauma therapy with parents and children (Cierpka, 2007, Harms, 2000). It is the intention of this article to outline the practical possibilities offered by the approach of body psychotherapy in building up and supporting stable attachment relationships between parents and child.

History of parent-child body psychotherapy

The beginnings of parent-child body psychotherapy are closely interwoven with the history of modern body psychotherapy. Despite having barely been acknowledged by contemporary infant research, we find significant pioneering work on modern parent-child body psychotherapy in the research on psychosomatic and neurosis prevention of the physician and natural scientist Wilhelm Reich (1897-1957).

At a time when Rene Spitz, John Bowlby and other psychoanalytical researchers were beginning to study the momentous impact on the personality development of children of being deprived of maternal love, Reich was already concerned with the basic preconditions of what constitutes that maternal love: good body contact, and the ability of the mother to empathise with the needs of the child (Boadella, 2008, Bowlby, 2010). Having already made a major contribution to the development of a body oriented psychotherapy in the thirties and forties, from the middle forties on– through the birth of his son Peter - Reich became increasingly interested in the study of the natural expression of babies, the preconditions for the development of emotional armor in the nursing phase as well as the possibility of employing vegetotherapeutic techniques on babies, infants and their parents. In December 1949, together with 40 colleagues from the specialist fields of medicine, obstetrics and social work, Reich founded the interdisciplinary research project "Children of the Future", with the goal of making a long term study of the self-regulatory processes and conditions for the preservation of the primary health in babies and older children.

This comprehensive research project focussed on the following four points:

1. Prenatal counselling and preventative body psychotherapy for pregnant women and parents-to-be
2. Attentive monitoring and supervision at the birth and in the first days of the new born baby.
3. Prophylaxis of early armoring in the first five to six years of life.
4. Long term study and further observation of the children until the end of puberty. (Reich, 1987).

In the context of these researches Wilhelm Reich describes the case of a five week old baby, in which he describes the gentle use of vegetotherapeutic techniques to undo the first signs of an incipient emotional withdrawal on the part of the baby.

„Our infant was pale, its upper chest was „quiet". The breathing was noisy, and the chest did not seem to move properly with respiration. The expiration was shallow.

Bronchial noises could be heard on auscultation. Generally the infant appeared uncomfortable. Instead of crying loudly, it whimpered. It moved little and looked ill. (...)On examination of the chest, the intercostal muscles felt hard. The child seemed oversensitive to touch in this region. The chest as a whole had not hardened, but it was held in inspiration with the upper part bulging forward. (...) Upon slight stimulation of the intercostal muscles the chest softened but did not yield fully when pressed down. The infant immediately started to move vigorously. The breathing cleared up appreciably, and the child began to sneeze (bursts of sudden expiration), smiled, then coughed several times vigorously, and finally urinated. The relaxation increased visibly; the back, formerly arched, curved forward and the cheeks reddened. The noisy breathing stopped. "(Reich, 1987).

In this first practical experience of bioenergetically based baby therapy, alongside the reflection of the child's expression and body language Reich utilized mainly gentle body touch in a playful way to release the tense muscles and tissue blocks and to open up the original expressivity of the child. In this first case study it is the re-establishing of the child's natural pulsation and its ability to relate which is the benchmark of the therapeutic intervention. (Reich, 1985).

The physician and obstetrician, Eva Reich (1924-2008) continued the tradition of her father's bioenergetic baby and infant research (Reich, 1993, 2006; Overly, 2005). In the butterfly touch baby massage, which she developed, important elements of the vegetotherapeutic work were systemized into a specific treatment sequence; she also introduced neurosis prevention into the work with expectant women, parents and new borns (Reich, 1993; Deyringer, 2008). In Scandinavia the Norwegian student of Reich, Nic Waal, developed and popularized Reich's concept of a somatic psychotherapy in the field of child and adolescent psychotherapy, particularly for the treatment of autistic children (Waal, 1970).

From the beginning of the eighties on, influenced by recent infant and attachment research, the first integrative models of parent-child psychotherapy were developed,

which combined the approaches of attachment theory, prenatal and depth psychology and mindfulness based psychotherapy with concepts of body oriented psychotherapy (Diederichs, 2009; Downing, 2003; Harms, 2008; Terry, 2007; Trautmann-Voigt, 2011).

Body and attachment

All modern approaches to parent-child psychotherapy are in agreement about the need to improve the regulatory and attachment capacity of parents and babies. Their various ways of achieving this are however very different. A distinctive feature of the body psychotherapy approach to this work is the consideration of the neurovegetative basis of early relational and attachment processes between babies and parents.
Wilhelm Reich had already seen that the ability to communicate of the infant and parents was firmly rooted in the regulation of the autonomic nervous system (ANS) (Reich, 2000). The two fundamental branches of the ANS, the parasympathetic and the sympathetic, can be divided into basic behavioral strategies. The stress and alarm mode of a young, insecure mother expresses itself in hyperexcitation, motor agitation, pronounced hypervigilance (constant scanning of the environment for danger) and a permanent concentration of her attention on the child. Feelings of distress and harassment in contact with the child are other phenomena of the stress and alarm division of the ANS. A secure attachment between parents and child in contrast presents itself in a predominately relaxed body, an enhanced awareness and sensitivity as well as an increased receptiveness and willingness to be in contact with the child.
One essential focus of body oriented parent-child psychotherapy consists of utilizing the body to access and influence directly the vegetative response of both parents and child and the disposition to open up connected with it, (Harms, 2013).
The American psychophysiologist, Stephen Porges, shows in his recent research that the classical perspective of a two-branched ANS needs to be comprehensively rethought (Porges, 2011). In the polyvagal theory he differentiates **three** neural circuits

involved in regulating stress and safeguarding the survival of the human organism, which come into operation in hierarchical sequence.

Next to the sympathetic nervous system he describes two different strands of the vagus nerve. The phylogenetically younger branch – the ventral vagus - is seen alongside the older, dorsal branch. The ventral branch of the vagus controls those bodily functions which are necessary for communicating with others: amongst others the function of gaze-direction, spontaneous facial expression, turning the head in the direction of the partner we are relating to and modulation of hearing to the frequency range of the human voice.

In contrast to these functions of the "social nervous system" (Porges, 2010) there exists an older - in terms of evolutionary biology – variation of survival safeguarding, which comes into effect when younger adaptation strategies (social contact or the fight-or-flight strategy have failed to avert danger. In this situation, when the stress is overwhelming, the older branch, the dorsal vagus, regulates the shutting down and "switching off" of the organism. This freezing mode, such as people experience in a state of shock paralysis, is the organism's oldest and most inflexible adaptive system. Thus in his new concept of the autonomic nervous system Porges describes a continuum of different regulatory organismic states, which are connected to conditions of safety, threat and mortal danger (Porges, 2005).

In body psychotherapy work with parents and children, we utilize an exact diagnosis of the body and behavior of both parents and child, which enables us to track and evaluate continually the vegetative regulatory states in the course of the therapeutic process (Ogden, 2010). By determining the regulatory mode of the body within the parent-child relationship in a situation where they are holding the screaming child, we can for example, determine more specifically when the small window of tolerance, which the parents have for contact with it in this state is going to collapse and also what must be done to maintain the parents as adequate co-regulators of the baby.

Three levels of parent-child body psychotherapy

Body psychotherapeutic work with parents and children is based on three fundamental principles:

a. observing behavior
b. focusing on mindfulness
c. touching the body

The **first level** of therapeutic work with babies and parents consists of the non-judgmental observation of the body language and expressive language of the relevant partner in the interaction. In the context of "reading the baby" the work focuses mainly on ascertaining the behavioral and regulatory condition of the child. When does the baby refuse eye contact? How does it react to being touched on specific zones and segments of the body? Which activities trigger stress (when the baby is picked up abruptly and without warning; when the caregiver comes too close too fast etc)? Is the baby capable of returning to a state of bodily relaxation after moments of stress? Reading the body signals of the baby becomes an important source of information in determining whether the child is in a receptive or a withdrawn state. When working with the parents we explore the spectrum of their behavior in contact with the child in the initial phase of the therapeutic process. The focus of this behavior-oriented perspective is on the degree of sensitivity the parents show in their responses to the body and behavioral reactions of the child. Do the parents show a direct or delayed response to signs of distress in the child? Are their responses appropriate to the respective developmental stage of the baby or are they in length and intensity overwhelming and inappropriate for the welfare of the child?

When exploring the behavior of the parents we concentrate on those critical moments in contact with the baby when they reach the limits of their coping strategies. For example how does a young mother react when continuously offering the breast is no longer enough to calm the agitation and crying of her three week old baby? What does she do exactly when the baby's screaming gets worse and her experience of stress and

disorientation increases? By observing the behavior of the parents, their breathing patterns, the way they use eye contact, forms of emotional expression, we can make initial assumptions about their characteristic stress and attachment patterns and develop suitable therapeutic procedures.

The **second level** of body psychotherapy work with parents and babies consists of supporting the parents in developing their connection to themselves and promoting their perceptive abilities. In this mindfulness based approach the parents focus their attention on observing and identifying their different bodily sensations in the various relational contexts with the child (e.g. the baby's screaming fit). While the insecure mother is cradling the child, she can feel the constriction in her abdomen, the increased agitation in her chest and how the breathing flattens. In this approach it is important to link specific parental behavior with corresponding reactive body states. As in the observation of behavior, establishing an accepting, non-judgmental attitude in the mindful observation of the body is crucial for both parents and child (Harms, 2013; Levine, 2005; Weiss, 2010).

The **third level** parent-infant body psychotherapy includes the application of various forms of body touch, which we use to improve the capacity for contact and attachment of both parents and child. We can differentiate between two areas of body work here: on the one hand the classical methods of skin- and body-stimulation (e.g. the butterfly touch massage of Eva Reich, the biodynamic massage of Gerda Boyesen etc.), which essentially focus on developing the ability of parents and child to relax (Wendelstadt, 2000; Claussen, 2000). These approaches use touching the body above all to strengthen the parasympathetic, releasing function in both parents and child. By supporting the relaxation and regulatory quality of the body we can improve the capacity of the parents and the child for opening up and relating.

On the other hand in the contemporary approach of parent-infant body psychotherapy touch is used as a medium to establish a state of secure and safe attachment (Harms, 2013; Renggli, 2013). Especially in working with the parents touch

is used to open up an inner state, which makes intuitive contact with the baby easier. In this method the use of touch to foster attachment is always combined with mindfulness techniques. The goal is not to achieve an externally induced relaxation, but rather to encourage a subjective awareness of the altered state of openness and capacity for relating, which have been activated in the course of the attachment facilitating body work.

Parent focus versus infant focus in parent- infant body psychotherapy

We can differentiate modern concepts of integrative parent-infant body psychotherapy according to their focus in the work with parents and children. In the pre- and perinatal baby therapies (Emerson, 1997, 2011; Schindler, 2011; Terry, 2006) direct body and relational work with the baby play a major role. In a safe relational situation babies are invited to recapitulate their unfinished pregnancy and birth experiences and express them through body language. In this baby centered approach the child sets the pace, chooses and processes the various themes in therapy. The accompanying work with the parents integrates cognitively the developmental origin of the body and expressive processes of the baby. The goal of this method is to enable the adult caregivers to re-evaluate the child's expressive language with empathy. (Now I can see how distressed my daughter was, as she was stuck in the last stage of birth. I see her desperate screaming fits in another light now.)

In contrast other parent-infant body psychotherapy methods approach the work from the outset from both sides, paying equal attention to the parents and to the baby (Diederichs, 2009; Harms, 2008, 2013). Body psychotherapeutic breathing, touch and awareness techniques are used with the parents to heighten their perceptiveness and sensitivity towards the child. In turn the focus moves to the infant, if the baby changes from a relaxed condition to a fit of screaming, while the therapist explores the stress situation with the parents.

We find the strongest focus on the parents however in those body psychotherapy approaches, which combine body based techniques of psychotherapy with specific video-analytical methods (Downing, 2003; Trautmann-Voigt, 2010). Here microanalyses of video sequences are used to study how well the parents interactively match or miss the child and the internal, psychosomatic and experiential content this produces.

Instruments of parent-infant body psychotherapy

1. Body awareness and stress exploration

Mindful body awareness is utilized in parent-infant body psychotherapy to explore the bodily and emotional experiences of the parents during specific attachment and regulation difficulties. By targeting particular body perceptions, objective behavioral processes of the caretakers (e.g. hectically rocking the baby in their arms) can be connected to inner emotional and bodily states (Harms, 2008; Levine, 2011). We can show an insecure mother how, in contact with her baby, to concentrate on her inner bodily and organic sensations instead of on the mesmerized, questioning gaze of the child. We thereby connect the parents' specific coping strategies ("rocking the baby in the arms") with inner bodily states ("tightness in the chest") and with affective aspects of their attachment experience with the child ("feelings of helplessness and estrangement").

In contrast to classical neo-Reichian therapy with its emphasis on the expression of repressed affective states, the attachment based approaches of body psychotherapy focus on perception and integration of unconscious and preconscious experiential content. As the parents learn to "somatically mark" and localize (Damasio, 2006) positive and negative states of being with their child, they are then able to recognize earlier when they are on the verge of losing the attachment or the contact and can work systematically to prevent this happening. Body perception in itself is used as a tool to help develop a state of inner calmness and dual awareness. In the course of the

therapeutic work parents are trained to use guided attention to perceive the body as a source of inner information, and thus to care for and modulate the current contact. Together with behavior observation and the reading of the body this "body scan" is one of the most important tools in re-establishing sensitivity and the capacity to relate in the parents.

2. Respiration and strengthening attachment bonds

Respiration has always played a central role in the spectrum of methods used by body psychotherapy. Originally breathwork was used to soften the psychic defense system and to facilitate the expression of repressed feelings. In the framework of parent-infant body psychotherapy breathwork is utilized in various ways. We can differentiate between three basic areas:

Encouraging the ability of the body to relax. Parents are trained to shift their attention during the inspiratory phase to their abdomen while in contact with the baby. Modulating the breath in this way strengthens the parasympathetic division of the autonomic nervous system. Bodily relaxation, a general slowing down of external activity and an improved capacity for resonance and contact in the parents are direct results of this method. Respiration functions here as a means of influencing the deeper vegetative regulation of the body, so that the intuitive competence of the parents is more able to assert itself. In his attachment oriented concept Harms (2000, 2008) emphasizes abdominal breathing, while other authors (Diederichs, 2000, 2009; Wendelstadt, 2000) focus more on supporting the expiratory phase. Ultimately both methods seem to function well. Unlike expression oriented methods of body psychotherapy, this work is less concerned with releasing repressed emotions and more about developing an inner frame of mind, which facilitates parental contact with the child.

Respiration as a means of guiding attention. Breathing can be used also to guide the attention mainly towards the inner life. The parents are trained to align the breathing with direct body perception. With the baby lying on the mother's belly, she tries to sense **from the inside** how when she breathes in, her belly snuggles up to the child's

body. The breathing helps the mother to focus her attention on the interior of her body. Even after only a few breaths the mother, who earlier was feeling very insecure, has a softer face, her shoulders relax and her respiratory movements are more flowing and connected. She is amazed and says: "I suddenly notice how my belly is full of warmth, just as if a warm liquid was flowing through me. Now I feel intimate and close to my baby. It's as if the outer borders weren't there any more." The vagotonic effect of the respiration facilitates the inner perception of the body. It becomes easier for the client to identify and describe inner bodily and affective states.

Respiration as an early warning system. When the parents have learnt to observe their breathing continuously from the inside, it becomes an early warning system for the imminent breakdown of their relational capacity. For Harms (2008, 2013) the inner connection to the abdominal breathing is a parameter for the existence of an adequate receptivity and capacity for contact on the part of the child's caregivers. Losing the connective thread to the breathing is a signal that the stress and alarm system of the organism is beginning to take over. So when the parents are coping with their agitated and frantically screaming child, they can ensure that they stay available as co-regulators for the baby through repeatedly making contact with their own abdominal breathing. One mother described it in a session in the crybaby clinic: "When my baby's crying gets so strident and shrill, after a certain point I only function automatically. I rush around the room, sit on the gymnastic ball, moving around all the time. In this phase I cease to exist, I'm not myself any more. When I then concentrate on the breathing I can get myself back down. I have a focus where I can concentrate in all this craziness with my baby. Through the breathing I find a certain kind of safety and I start to sense myself again. Even if my child goes on crying, I don't feel so alone with it all." For many parents two things are important: on the one hand they can integrate the abdominal breathing technique into their everyday life. On the other they can do something in those difficult phases, they can experience self efficacy and that they are in a position to influence their own relational capacity constructively.

3. Body touch and security

In contemporary parent-infant body psychotherapy body touch is used to improve the parents' experience of security and bonding. In the model "safety stations" (Harms, 2008) therapists collaborate with the parents to find a specific part of the body which when touched conveys an optimal feeling of safety. The search process is in itself an important exercise which encourages parental sensitivity. By actively trying out various areas to be touched, the clients not only identify safe and coherent places on the body but also an inner state of secure attachment, which is then communicated both directly and through "emotional contagion" to the baby.

Another area where body touch can be employed is in body psychotherapeutic work with trauma burdened parents. Their traumatized parts are often reactivated by the crying and agitated state of the baby, leading to temporary dissociative states. This intermittent freezing interrupts the relational thread between parent and child. In these cases the body and breathing techniques already discussed are of little practical use. Harms discusses in this context a further method whereby the therapist utilizes the established "safety station" to "log in" to the parental system. In practice this means that through contact with the "safety station" the therapist continuously monitors the inner situation of the client. If the contact thread grows "thinner" or "breaks off" this represents the weakening of the bond in two ways: firstly it is a sign of the loss of the alignment between therapist and client and secondly it represents the weakening of the "umbilical cord bond" and an instable connection between the parent and child. By continuously observing, naming and evaluating the "umbilical cord bond" in this process of dual awareness, the therapist can help to reveal and resolve any imminent breakdowns in contact with the child. Thus through body touch the therapist temporarily assumes the regulatory function of the overwrought parent. To put it another way: the professional helper becomes the bodyguard and auxiliary ego of the temporarily overwhelmed caregiver.

4. Strengthening the bond through imagination

One difficulty in parent-infant psychotherapy is that the problem with the child, described by the parents, does not directly present itself in the treatment setting. This is especially true of regulatory disturbances in the child's sleeping patterns. It applies similarly to crying fits which occur in the evenings and overwhelm the parents then. Often it happens that, while they describe the stressful crying and sleep situations, the "real" baby behaves perfectly quietly. In these cases various approaches of parent-infant psychotherapy utilize imaginative techniques to gain access to those moments, when parent and child are well bonded. Here the visualizing of "successful" relational moments plays an important role. Parents are asked to imagine a lovely situation with their child and at the same time to observe the inner reactions in their bodies. Imagining the early morning cuddling situation with the new born baby leads to an "expansive" sensation in the chest connected to a spreading feeling of happiness and contentment. Those parents, who have almost permanently lost the relationship thread to the baby, have particular difficulties in carrying out this exercise, even though there may still be "successful" and encouraging moments with their infant. Positive imagination weakens the hold of negative self judgment and can introduce a more realistic re-evaluation of the relationship to the child.

Imaginative techniques are also used to observe problematic situations from a "safe" distance in a neutral way. This method alternates in the imagined situation continually between external observation of behavior and the body and an exploration of inner bodily and emotional experiences. A mother imagines the screaming fits of her 4 month old son, while the child has fallen asleep at the breast. In her imagination she can recognize how the imagined body is expressing tension and distress. During the imagining of the situation, she can, through a change of the focus of attention, also perceive her present bodily and emotional state. As she watches the inner images, the mother can feel the constriction in the chest and the faltering breath. With the help of the therapist she can connect the "now-experience" of the body with the evening stress situation with the child. Another possibility is to connect interventions on the

bodily level with the imaginative work. The mother is asked to transfer her awareness to the quiet, expansive breathing movements of her abdomen. After she has felt how a state of warmth and relaxation has spread out in her body, she is asked to "take this up" into the imagination of the stressful evening situation. The mother can now see how she holds her crying baby in her arms in an attitude of inner communion and at the same time how relaxed and calm she looks. By combining imagination and body experience the client develops a new perspective for dealing with problem situations in daily life (Harms, 2008).

5. The baby as the focal point of parent-infant body psychotherapy

Next to the body oriented consolidation of the sensitivity and relationship capacity of the parents, the body psychotherapeutic work directly with babies shows the essential difference of this modality from the cognitive-behavioral approaches in parent-infant psychotherapy. In order that the body and relational work with the child be the focal point it is necessary that the parents have sufficient capacity for self connection and emotional regulation. Only this can ensure that if regressive states are activated through the baby, the parents will not founder in a maelstrom of dissociative and projective defenses against negative parts of their personalities.

Various methods of baby oriented body psychotherapy

Strengthening the bond and catharsis. Babies react quite differently to stronger self connection and capacity for contact in the parents. In one aspect the easing of tension in the parents and their increased availability is "contagious" and affects the baby, who reacts to the heightened parental sense of safety by letting go in contact with them and surrendering to the relaxation process.

In another variation the baby responds to the improved receptiveness of the parents with strong affective-bodily abreactions and expressive processes. In other words the return of the parents to a state of enhanced openness is the starting signal for the child to bodily express hitherto repressed experiential material. In clinical work with parent-infant therapy this often leads to a paradoxical situation: while the parents are feeling

better and experiencing an increase in security, the baby is going through an intensive process, in which the pain, helplessness and existential distress of the bonding and developmental traumata are expressed through body language.

In parent-infant body psychotherapy the above mentioned methods of breathing, perception and grounding work are used during the baby's massive crying processes to keep this window of optimal attentiveness and emotional availability open. At the same time it is important to support the parental capacity for self connection continuously for two reasons: on the one hand the bodily attachment and the "staying put" of the parents creates a framework, which allows the baby to recapitulate the internalized separation, birth and pregnancy injuries in a securely bonded and contained environment.

On the other hand maintaining self connection creates a security system for the parents, so that during the baby's screaming cycles they are not overwhelmed by the "ghosts" and traumata of their own attachment biography. Preserving the inner thread of contact creates the basis for the baby to be recognized and mirrored with empathy in its reliving of feelings of helplessness, abandonment and pain.

The recapitulation of terror. As soon as the parents' co-regulation capacity is sufficiently developed, babies begin in contact with them and the therapist to "tell the story" of their pregnancy and birth. Prenatal baby therapists focus on specific bodily signals and expressive processes of the baby, which provide an indication of the time, form and content of the stress in the particular phases of pregnancy and birth.

Babies relive spontaneously in the therapeutic birth experiences those body positions, which were connected to particularly high stress experiences during the stages of birth. They communicate with body language where it was "too much" for them and they were in real distress, but also what support they would have needed in order to complete the birth process themselves.

In baby oriented process work the therapist remains in constant dialogue with the child. He/she "mirrors" the body language of the baby and translates it into a

language, which enables the parents to see the origin of the respective "problematic" behavior (e.g. the baby's uncontrollable and never ending crying) from a different perspective and to experience it emotionally in a new way. Due to space restrictions this can only be a brief description of baby centered work in parent-infant body psychotherapy.

Conclusion

Nowhere can the self regulation of life be so vividly and directly experienced and "health" understood so directly as in the work with babies and infants. Babies are masters of the present moment, of slowness and of the essential encounter. The physician, Eva Reich, wanted to make it a condition of training in (body) psychotherapy, that all students should work for a while with babies, so as to gain a deep impression of their expressive language. Experiences gained in the work with babies create a new perspective on the people we encounter in psychotherapy. They give us an idea of the wounds, which originate in the earliest phase of human development, but also a vision of the healthy, the authentic self that exists in each of us.

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