Parent-Infant Body Psychotherapy between Trauma and Attachment[1]

By Thomas Harms

Translated from the German by Elizabeth Marshall

Abstract

In body psychotherapy with infants and parents we are directly confronted with the baby`s unresolved traumatic experiences. The simplest interventions are enough to invite a few weeks old baby to express the pain it has hitherto held back and to cry bitterly. The baby`s processes of emotional expression often begin when the parents are not capable enough of holding the baby both physically and emotionally. The question of what can be done from a body psychotherapy perspective to establish and support the regulatory and caring capacities of the parents soon arises. Only when these preparatory steps have been carried out can systematic work on the baby`s painful experiences (as for example, birth or separation traumata) in the framework of body psychotherapy begin.

Parent-infant body psychotherapy is always a balancing act between on the one hand strengthening the available attachment resources of the parents (and the child) and allowing the direct expression and reliving of the baby`s unresolved traumatization on the other. In the relatively recent history of parent-infant body psychotherapy there has been little time to develop diagnostic criteria as to which attachment conditions are conducive to dealing with the traumatic experiences of the child and under which conditions this should be avoided.

In this article I would like to show firstly which bodily and neuro-vegetative processes have to take place, if the attachment is to be successful, and secondly what happens when there are traumatic breaks in the relationship between parents and baby. In this context I will present recent research from the American neuro-psychiatrist Stephen Porges, which opens up a completely new perspective on the autonomous or vegetative nervous system. Porges` "polyvagal" observations are of great importance especially for the development of a deeper, physiologically based understanding of the trauma and attachment processes in the early parent child relationship.

In the last section, based on the description of the neuro-vegetative processes involved in successful and unsuccessful parent-child bonding, I will try to show a body psychotherapy approach suitable to the various regulatory states of parents and child.

Keywords: parent-child, trauma, attachment, polyvagale theory, body psychotherapy practice

I. The Early Parent-Child Attachment from a Body Psychotherapy Perspective

All forms of parent-infant counselling and psychotherapy available today agree that establishing a secure attachment relationship between parents and their children is one of their most important tasks (Brisch, 2000, 2010; Cierpka, 2007; Israel, 2007; Papousek, 2004). The means to achieving this goal vary however enormously. Before we go further into the body psychotherapy dimension of parent-infant therapy, we should look at the concept of attachment used here. What is an "attachment" exactly?

The concept of attachment can be traced back to the research of the psychoanalyst and founder of modern attachment theory, John Bowlby. In his research he showed that the human need for closeness or proximity is not a consequence of oral or sexual needs, as the psychoanalytic developmental theory had until then supposed. Bowlby assumed that the attachment needs are themselves a distinct motivation system (Bowlby, 1975). The need for proximity and a feeling of

[1] This article was first published in German in (2013). M. Thielen (Ed.), *Körper - Gruppe – Gesellschaft* Psychosozial-Verlag.

security is just as important for a human being to survive and prosper as are air to breathe and sufficient nourishment. What are the indications of a successful attachment? What is its essence?

According to John Bowlby attachment is an invisible emotional band, which connects two or more people through time and space (Brisch, 2010). Attachment is a special form of relationship. Although every attachment is a relationship, not every relationship is an attachment. The most important characteristic is that for the growing child a sound attachment provides a secure basis. Successful attachment relationships function as a “secure base”, which a person can resort to when they are in difficulties and need support. It isn’t surprising that in times of distress it is not the fleeting acquaintances of day to day life (e.g. distant neighbors, sport comrades) to whom we turn. Rather we seek emotional and physical support from those people, who give us a subjective feeling of security.

For the infant a secure attachment experience is a precondition for being able to let go and relax. Only when the child can sense that the carer is emotionally available is it able to withdraw its attention from the environment and concentrate on its own organism. Equally a recurrent experience of attachment security is an important precondition for the infant’s ability to explore and assimilate the environment.

From the parents’ point of view a successful attachment relationship enables them to understand spontaneously and decipher the non-verbal bodily and behavioral signals of the child. When they are in tune with their child the parents are able to physically relax. They breathe more deeply, the muscles are relaxed and the heartbeat regular.

The physical relaxation and attachment availability of both parents and child are from the perspective of body psychotherapy inextricably interwoven (Thielen, 2009). The security of the attachment creates a release of tension and an opening up and the relaxation of the body prepares the ground for a successful attachment experience. It is exactly this correlation that we make use of in parent-infant body psychotherapy.

The Attachment Continuum

In body psychotherapy work with parents and infants there is a sequence of regulatory and attachment states which build up on one another. This continuum ranges from successful moments of relaxation and bonding between parents and child to experiences of overwhelming feelings of threat, helplessness and alienation in those phases where the attachment between parents and child breaks down. In the following presentation I describe the separate stages of parental attachment experience. What does a young mother experience when she feels connected and close to her baby? And what happens physically and emotionally when in phases of greater stress the connection to the child becomes weaker or breaks down altogether?

State of Strong Attachment

If the attachment and regulatory capacity is well developed then the carers can move freely between phases of contact with the child and moments of self-contact. Both the capacity for matching and attunement with the behavioral signals and needs of the infant and the perception of their own inner bodily states is sufficiently developed. Physiologically in phases of quiet contact with the child – for example while breastfeeding - the mother can let go and relax physically. Breathing is flowing, deep and connected. This capacity for breathing deeply is a direct consequence of the relaxation of the diaphragm, which in its turn is a function of the general opening and relaxation process of the organism. The subjective experience in contact with the child is often described by the parents as a feeling of safety, security and well-being. Although the mother is intimately connected to the child, her attention rests deeply in her own body. It is a sensing of oneself and of the other simultaneously. This capacity for self-perception allows the mother to check *internally* whether the child experiences her offers of interaction as coherent. Harms (2008) speaks in this context of the parental capacity for self-

connection. This self-connection includes the capacity for co-regulation, creating and sustaining an attentive connection to the interior flow of the body and the inner senses. Patterns of attachment described in the attachment theory context are seen alongside comparable patterns of secure, avoidant or ambivalent self-connection or –attachment. Thus the organization of both the inner and outer relationship threads are two functionally identical processes of a stable and sufficiently secure attachment capacity in the parents.

State of Weakened Attachment

In a state of weakened capacity for attachment and contact the dominant feelings the carers experience in contact with the child are insecurity, disorientation and disconnectedness. These conditions are often reinforced, when the parents are unsuccessful in their attempts to calm the infant in phases of crying and agitation. Important characteristics of a developing spiral of stress and anxiety are on the parental side increased muscle tension and bodily agitation, shallow breathing and tachycardia. In such a stress situation their attention focusses increasingly on the screaming baby. Often the parents can no longer shift their attention to their own inner bodily sensations – not even when the child is in a good, relaxed state.

Parents who are in stress and alarm mode are restricted in their crucial function as co-regulators of the child. On the basis of the general stress dominance the parents are less and less in a position to grasp and react to the infant's emotional expression. A process of "negative reciprocity" rapidly sets in: the child feels the loss of parental sensitivity brought about by the tension and reacts to it with increased agitation and screaming (Papousek, 2004). This again heightens the insecurity and bodily tension of the parents and so it goes on. Irrespective of the background and reasons behind the regulatory and relational problems, the main goal of a body psychotherapy intervention is to break through this vicious circle as fast as possible and to return to a process of "contagious health".

In the stress and alarm mode described here the parents still have a certain capacity – even if it is reduced – to maintain the link between inside and outside. Although they are in a state of insecurity and tension, they are still aware of the "real child" and its needs. In the therapeutic work they can also still describe precisely their own inner bodily and emotional experiences. They are able to identify and describe their feelings and bodily states and also to localize them. ("When the baby cries I always have a lump in my throat")

State of Attachment Breakdown

The third regulatory stage of parental capacity for attachment begins when in contact with the infant unresolved traumatic contents of the parents are activated through the baby's stress-triggering behavior (e.g. massive attacks of screaming or chronic avoidance of eye contact). In this stage the amount of stress and agitation is overwhelming and leads to a complete breakdown in the emotional connection of the parents to the infant. The parents can no longer adequately transform the released agitation into activities of the musculoskeletal system or the mind. They experience themselves as trapped in a desperate state of paralysis in their thoughts, feelings and actions. While the baby screams in the arms of the mother the connection to the inner flow of bodily sensation is breaks down. The parents describe this loss of self-connection as a feeling of numbness, paralysis and stupor.

In the course of this dissociative episode the thread is broken in two ways. On the one hand the parents forfeit their capacity for self-connection and self-awareness. On the other they lose the thread of the relationship and the feeling of connectedness to the actual child. Both the fear of dying and the feelings of despair and helplessness emerge almost always when parents are going through these fathomless episodes of the breakdown of contact to their child.

The breakdown of the attachment and the loss of the capacity both for emotional regulation and for bodily self-perception are inseparably interwoven in this stage of the attachment continuum. As the dissociation begins the infant experiences the breakdown of the parental support system. The child falls into the abyss, into nothing. The reactive fear of falling in infants described by Wilhelm Reich (Reich, 1985) has its roots in this sudden, shock induced breakdown of the attachment field.

Strong attachment	Weak attachment	Attachment breakdown
		
Security	Threat	Threat to life
Relaxation	Mobilization	Immobilzation
Attention alternates between contact with the self and contact with the world	Attention towards the outside	Attention not focused
Self-connection is strong	Self-connection is weak	Loss of self-connection
Ventral vagus	Sympathetic NS	Dorsal vagus

Diagram: Continuum of attachment and regulatory states

A Polyvagal View of Attachment

Having described phenomenologically the various regulatory states of the parental capacity for attachment and contact, I would like to look at the neuro-vegetative background of these processes. Now we come to the aforementioned research of the American psychiatrist and Psychophysiologist Stephen Porges. Porges' polyvagal theory offers a comprehensive explanation from a physiological perspective, which corroborates the phases of the attachment continuum described above (Porges, 2010, 2005, 1998). The crux of the polyvagal theory is concentrated in the thesis that the autonomic nervous system (ANS) – unlike in the customary medical viewpoint - consists of three regulatory systems with different functions.

According to the classical view of the ANS the sympathetic NS and the parasympathetic NS are in opposition to each other. For the organism as a whole they are responsible for regulating a wealth of inner organic functions, which are outside our direct voluntary control. The parasympathetic represents the "rest" branch of the ANS, which looks after regeneration, digestion, introspection and the replenishment of energy resources. The sympathetic branch is, according to this view of the ANS, responsible for regulating the release of vitality, which can protect against danger and distress. The sympathetic nervous system activates the musculoskeletal system ("fight or flight"), the expressive organs ("screaming") and the intellectual faculties (search for solutions). In sympathicotonic stress and alarm mode we are highly tensed and our attention is directed towards the outside world (Ruegg, 2007; Reich, 2000; Sunderland, 2006).

The polyvagal viewpoint differs from the classical insofar as Porges assumes the existence of two distinct branches of the vagus (thus poly-vagal), whereby he distinguishes between a younger branch of the vagal system (the ventral vagus) and a phylogenetically older branch of the vagus (the dorsal

vagus). The ventral branch of the vagus is the more evolved younger part of the ANS and springs into action when we feel safe and secure in contact with other people. The activating of the ventral vagus controls our focusing on and communicating with our most important close relationships (Ogden, 2010).

In the physiology of the brain the ventral vagus originates in the nucleus ambiguus of the brainstem. From here various branches separate out and provide the neurophysiological basis for a series of functions, which are particularly significant for social interaction (Porges, 2010).

Important functions connected to the ventral vagus are:

- opening the eyelids
- the face muscles and emotional expression
- the muscles of the internal ear and filtering voices out of background noise
- the masseter and food intake
- the laryngopharyngeal muscles and the voice
- inclining and turning the head, social gestures and orientation

An impressive example of this dominance of the ventral vagal system can be shown in a successful interaction of mother and baby. The mother tries to make eye contact with the child, smiles at it and lifts her head regularly in an invitation to a greeting reaction. In her way of talking to the child, her voice is slightly higher (baby talk) and accommodated to the child`s hearing. Her facial expression is lively and open. Subjectively a feeling of security, trust and wellbeing dominates in the encounter with the infant.

From an evolutionary perspective the infant is prepared to enter into contact with its most important caregivers directly after birth. If the baby repeatedly experiences the partner as emotionally available, then the ventral vagal system springs into action. Thus the vagus dominance becomes the neurovegetative equivalent of the psychic feeling of security, which the child experiences in the attachment to its adult caregivers.

In Porges model the sympathetic nervous system remains the structure, which facilitates direct defense against danger by mobilizing the muscles and locomotor system. In crisis intervention work with parents and their babies the dominance of the sympathetic tone presents itself in the increased motor activity of the parents (agitated activity, not being able to sit still etc.), heightened awareness and increased mental activity (brooding). Subjectively the stressed mother experiences anxiety and feelings of distress. It is important to emphasize, that the sympathetic NS should not be equated with negative feelings of distress. The moderate activation of the sympathetic NS is an essential part of vital functioning. For example the excitement and tension of an important football game are deliberate and positive effects of sympathetic innervation. This pleasurable dimension of the buildup of tension and excitement (arousal) seems to be dependent on a realistic prospect of relief at a later point and when the person concerned is able to let go of the tension when the exciting experience is over.

The third regulatory circuit that Porges describes in his polyvagal model, the dorsal vagus, is phylogenetically older. The dorsal vagus provides control of the descending inner organs, above all the heart, the lungs and the intestines. The dorsal vagus system takes over when the stress level becomes overwhelming and a life-threatening situation emerges. Physiologically this state of regulation corresponds to shutting down the whole system into a stand-by mode. Only the internal organs are adequately supplied, while the periphery of the organism is practically disconnected. We can see this in a particularly obvious way in shock paralysis after an accident, when the legs collapse, the skin is pale and bloodless and the person can`t think clearly.

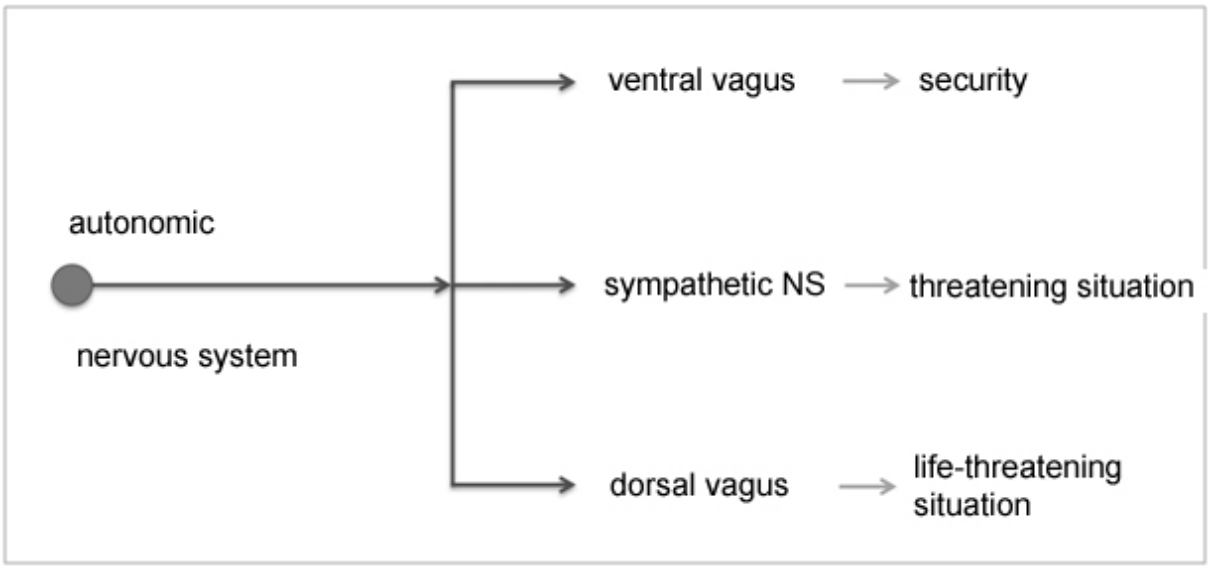

Diagram: The tripartite autonomic nervous system according to Porges

In his polyvagal model Porges describes a hierarchical order of the neuronal regulatory circuits. The feeling of security allows us to have intimacy, social interaction and contact with other people. This search for attachment is consistent with the basic evolutionary-biological make-up, which we bring with us as human beings. If a feeling of security within the attachment can`t be established, then the sympathetic stress and alarm system takes over. Only if the various strategies defending against danger are unsuccessful does the phylogenetically oldest regulatory circuit of the dorsal vagus with its shutdown automatism kick in. Depending on the extent of the dangerous or threatening situation older and more basic systems will take over in order to guarantee the survival of the whole system. While the system of the ventral vagus still supports complex communication strategies (making contact with and speaking to the aggressor in a conflict situation), the sympathetic nervous system reacts to a dangerous situation in a much less differentiated manner (fleeing, screaming, fighting). In comparison the immobilization strategy of the dorsal vagus (paralysis, freezing) is even more limited in scope and in order to centralize the remaining energy and ensure the support of basic physical and organic functions, important psychic, perceptive and intellectual faculties are shut down. (Levine, 2010).

In a polyvagal understanding we don`t refer to a “good” ventral vagus and a “bad” sympathetic NS. In fact we are dealing with a neuronal continuum. Depending on the external situation and the challenge it presents the separate regulatory circuits can take control. An emotionally and physically healthy person is able to move freely between these regulatory states as necessary. Thus it is quite harmless when a young inexperienced mother quickly feels insecure and threatened by her baby`s screaming fit. It starts to become a problem if the mother still feels threatened when the child is already sleeping peacefully in her arms. From a neurovegetative perspective this parental behavior is a sign of being “stuck” in the danger branch of the ANS, while from a psychological point of view it shows that the mother is subjectively experiencing an insecure and threatening situation.

Parental Sensitivity and the Optimal Window of Tolerance

We know from modern infant and attachment research that a successful attachment relationship depends on the sensitive attunement of the main caregiver to the needs and behavioral reactions of the baby (Downing, 2006; Siegel, 2010). From a body psychotherapy perspective one could add that

this sensitive parental competence presupposes an organism which is able to relax. By the fact that they can attain a receptive and open state often enough, the adult carers are in a position to connect internally to the non-verbal communication of the child and to respond adequately to it.

As already described this mode of parental attachment-readiness is physiologically grounded in the predominance of the ventral vagus function. On this basis it`s possible for the carer to respond to the child`s various modes of behavior with inner composure and calmness. The successful experience of attachment and the function of the ventral vagus connected with it inhibits the activation of sympathetic stress and alarm responses and dissociative trauma reactions. To express it differently: the feeling of attachment security calms the heart rate, the breathing and racing thoughts of the parents. If the secure feeling on the basis of the ventral vagal reaction persists, then “negative contagious reactions”, so common between parents and infants, don`t appear. In a certain sense when the parents are in this open functioning state, they act as “lightening conductors” for the stress reaction of the baby. While acute attacks of screaming and restlessness in the night are tiring, however the accompanying phenomena of a crisis such as hyper-arousal and threatening feelings are absent.

If the parents can maintain an open state, ready for attachment, the infant has the experience that while it is in a restless and screaming phase there is someone present. The parents thereby act as “lighthouses” for the child. As long as the parents stay in contact with themselves - self-connection – they act as important back-up systems, which modulate the child`s affective and aroused state. But if the adult carers are themselves overwhelmed by their emotional experience, then they exit the narrow window of tolerance of optimal awareness for the child. At this point the child loses its co-regulator. The screaming isn`t heard and the needs and affective states which underlie it no longer find an adequate response. Consequently the screaming becomes more desperate and has an uncontrollable quality to it. If the carers don`t succeed here either in building a bridge to the infant, its stress and alarm state segues into resignation and freezing. The child gives up and falls into a paralyzed state.

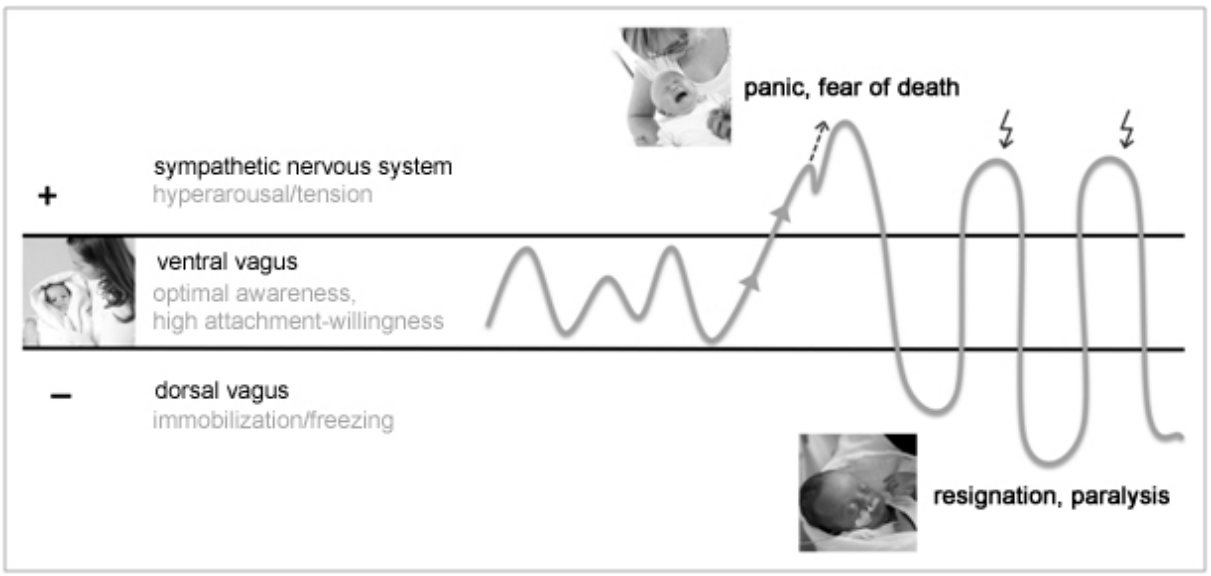

Diagram: Attachment breakdown and the loss of the optimal window of tolerance

In this neurovegetative consideration of the attachment process between parents and their newborn babies all forms are possible. A serene, affectionate mother tends to a highly tense, alarmed, screaming infant. An uncontrolled and angrily screaming baby has a dissociated carer with it or a

relaxed and attachment-ready infant is with an adult carer who is emotionally insecure and unapproachable.

For body psychotherapy work with parents and infants neurovegetative concepts offer an important diagnostic tool. In practice the therapist in parent-baby body psychotherapy can recognize early on through the body signs of both parents and child, whether they have left the narrow corridor where they are receptive and capable of attachment. When for example a young mother in a short interaction and observation phase suddenly starts to fixate the baby, only breathing shallowly and her whole body stiffening, these are signs that in contact with the child she has lost her feeling of security and is moving into a sympathetic stress mode. In the therapeutic process work, this moment could be a first marker for the exploration of the stress experience of the mother. (I will go into this point more deeply in the second part of this article, where treatment techniques are dealt with.)

What must happen so that parents don`t permanently leave this sphere of optimal awareness and tolerance in the interaction? How could a body psychotherapy approach help such parents in times of crisis, to maintain or re-establish this narrow corridor of capacity for attachment? In the second part of this article I will clarify the principles of those treatment techniques, which in the framework of parent-infant body psychotherapy can help support parents and children, who are under extreme pressure, to develop the capacity for openness and attachment.

II. The Practice of Parent-Infant Body Psychotherapy

Parental distress and therapy motivation

We can distinguish three different motivations which lead parents to seek psychological support with their infants. The first and most common motive is a general feeling of disorientation with regard to what the child is trying to express. The parents concerned are helpless in the face of their child`s behavioral statement. They are not able to decipher the signals the child is sending adequately and to put them into a meaningful context. They react to this loss of orientation by hectically trying to change the symptoms the child is showing. So that they try out in quick succession various strategies to calm the child. The principle behind this is “trial and error”. As the parents` capacity for self-awareness is severely reduced because of their own high degree of inner tension, they can only rarely develop a coherent search for a solution. Their feelings of self efficacy are reduced. The pacifying of the child only happens randomly without the participants being able to grasp why the child has calmed down. The consequence is that they frequently change their calming strategies.

The second reason that parents name for coming into therapy is that caring for their babies triggers in them an overwhelming emotional arousal. Here it is above all the infants` screaming to which they respond with anxiety, anger or disappointment. Especially when they react to the child with feelings of aggression or rejection, parents feel extremely insecure and uncertain. Many parents report that during their baby`s screaming attacks they feel the impulse to shake the child or to use some other form of violence (“I wanted to bang her against the wall”; “I wanted to strangle him”). These violent fantasies that the parents have – in some cases there is real physical abuse – lead to deep feelings of shame. Many parents are extremely relieved when they can communicate their fantasies and impulses, which are treated without judgment in the therapeutic relationship. Parent-infant therapy focusses in these cases on improving the capacity of the parents for regulating their emotions. To the extent that the parents learn to grasp their own emotions and to defuse their own excessive stress reactions early enough, their psychological strain is considerably assuaged.

The third reason why parents go to a parent-infant therapist is their inability to react adequately. Here the uncertainty has more to do with the method. How as a mother do I hold my baby when it cries bitterly every evening? Should I lay it on my belly? Should I stabilize the child`s head with my hand?

In these cases we show the parents how to do these things practically – how to regulate crying, feeding, sleeping. Here the therapist assumes an important model function for the parents. Practical demonstrations are an essential part of helping these parents.

Although it makes sense in parent-infant therapy to explore more deeply the cognitive, affective and behavioral origins of parental distress, in reality the various levels are often mixed together. For example an inexperienced mother reacts to the crying of her baby with intense fear of failure ("I will do everything so well that my child doesn`t need to scream!"), which in turn affects her intuitive competence to decipher the signals of the child adequately. And so in consequence she is limited in her ability to react and doesn`t have a practical way of successfully calming the child. It is important to note here that working too early on behavioral strategies without sufficient improvement of the parents` capacity for emotional self-regulation will rarely achieve a sustainable change.

Body Psychotherapy Methods for Strengthening Parental Sensitivity

In the following I will present several body oriented treatment strategies to demonstrate how body psychotherapy concepts can be utilized to strengthen the sensitivity and capacity for self-regulation of the parents. By including the polyvagal considerations we can develop criteria for when in parent-infant body psychotherapy we should strengthen the attachment and when we should be working more trauma oriented.

Step 1: External exploration – observing the behavior of parents and child

In the first phase of body psychotherapy work with parents and infants the emphasis is on observation of their behavior. After having given a detailed medical history the parents are invited to show how they normally behave with their child. If the parents have come for therapy because they feel helpless in the face of the excessive screaming attacks of their baby, then they should show which calming strategies and behavior they normally use to deal with this. While the mother skips uncertainly around the room rocking the crying baby in her arms or repeatedly offering it the breast, we evaluate precisely which coping and calming strategies they find best and how they use them in everyday life. Typical physical and behavioral patterns often already show themselves in this first observational phase. For example a mother will quickly give her four month old baby a pacifier as an oral stimulator as soon as the child becomes agitated or starts to cry. While she presses the pacifier with her finger and the child is forced to suck, her movements as she walks around the room become increasingly hectic and nervous. It is now essential to work with the parents towards a transformation in the way they cope with the child´s screaming in day to day life. Is what they are doing now typical for their usual approach? What would be a typical aspect of the strategies they are using? How does the child´s agitation escalate exactly? Which bodily reactions show that the screaming is about to escalate? How do the parents help the baby when their other calming strategies are not working? (Harms, 1999, 2008; Diederichs, 2010).

At the outset of parent-child body psychotherapy we screen a wealth of information: through observing the breathing patterns, eye contact behavior, muscle tone and emotional expression we find many clues as to the characteristic stress and attachment patterns of both babies and parents. Can the parents attune themselves to the signals of the child? At what point does the attunement with the child break down? And are the parents able to reestablish the connection to their child without outside help?

Irrespective of the concrete etiology of the problems (e.g. overwhelming experiences during the birth, postnatal separation of mother and child) in this phase of therapy we focus exclusively on behavioral sequences and what is visible *now.*

Step 2: Internal exploration – the subjective experience of weakened attachment

The next step is to explore the physical and emotional self-experience of the parents with the goal of determining systematically their subjective experience of their crisis dynamics. Through a guided perceptual process we will show the parents how they experience themselves and their bodies during the stressful phase of weakened attachment to the child.

Just as in the previous exploration of behavior it is of crucial importance that we create a space of non-judgmental self-observation. The parents are often amazed when they succeed in becoming aware of their bodies in those strained circumstances, when their attention is normally completely absorbed by what they experience as the child`s difficult reactions (e.g. constantly whining). Thus through stress evaluation the parents concerned can recognize at what point they go into stress and alarm mode and when they lose contact to the baby. The parents can see for themselves how their availability weakens or breaks down altogether. The insecure mother for example realizes that she holds her breath and has a feeling of agitation in the chest as soon as her baby stiffens its legs and starts to arch its back. She is convinced that these body signals are evidence that the child is going into a screaming fit. She starts frantically to rock the baby, but now she can connect specific somatic markers (tightness in the chest) with the incipient weakening of her receptivity and capacity for contact (Damasio, 2006). By localizing and identifying her physical and emotional state the mother not only develops an appreciation of her own distress, but also creates a system of orientation through which she can recognize the weakening of her capacities for regulation and contact in good time.

From a neurovegetative perspective the desperate attempts to calm the child, the tightness in the chest, the subjective feelings of helplessness and the loss of attachment to the baby are all just functional variations arising from an underlying activation of the sympathetic stress and alarm branch of the autonomic nervous system.

Step 3: Breathing, Self-connection and Strengthening the Attachment

A fundamental difference between body psychotherapy attachment work and other approaches to parent-infant therapy, such as those of depth psychology or behavioral psychotherapy, is found in the direct use of body oriented interventions to improve the capacity for attachment and regulation of both parents and child. By using an example I would now like to show how, in the framework of parent-infant body psychotherapy, we work with breathing to directly improve the parents´ capacity for sensitivity and emotional regulation. As I have already described the development of a secure bond allows all participants to relax. If a young mother feels secure and well bonded to the child, the muscle system of her arms relaxes and the breathing deepens. As the parasympathetic tone is dominant a calm abdominal breathing takes effect. This is the result of the relaxation of the diaphragm and the expansion of the breathing into the abdomen.

In parent-infant body psychotherapy working with the breathing becomes the most important vehicle in strengthening the capacity for attachment of both parents and child. By using the breathing we have at our disposal a tool to consciously influence the involuntary processes of the vegetative nervous system and the capacity for contact connected with it.

The method of attachment-strengthening abdominal breathing that I present here was already used and described in detail in the 1990s in the framework of bonding work with infants and small children (Harms, 2000). The parents are instructed to position their babies so that they are lying prone on the parent`s abdomen and then to withdraw their attention from the child and focus on the flow of the breath in the direction of the abdomen. During each inspiration phase they should sense how their belly connects to the belly of the child. Through this approach insecure parents experience within minutes a complete transformation of their inner experience. The calm and centered breathing process leads to an increased activation of the parasympathetic branch of the ANS. The consequences of this readjustment of vegetative dominance manifest themselves in various functional areas of the psychophysical entity. Many parents describe that during the breathing exercise they experience a sense of inner security, a warming up of the skin, a feeling of space and expansiveness in the chest,

feelings of streaming in the pelvis and belly and an incipient feeling of attachment and intimacy with the child.

The connection to the abdominal breathing is in parent-infant body psychotherapy an important indicator for the availability or non-availability of the parental bonding capacity. Many parents describe it as follows: “If I can feel my belly I can feel my child”. But this formulation is correct in the negative version too: “If I lose my belly, then I`m no longer in contact with my child.” The observation of their own breathing becomes for the parents a helpful early warning system through which they can test directly whether in contact with the child they are “online” or not. From an attachment point of view the loss of contact to the centering abdominal breathing is equivalent to a loss of the optimal area of tolerance in the encounter with the child.

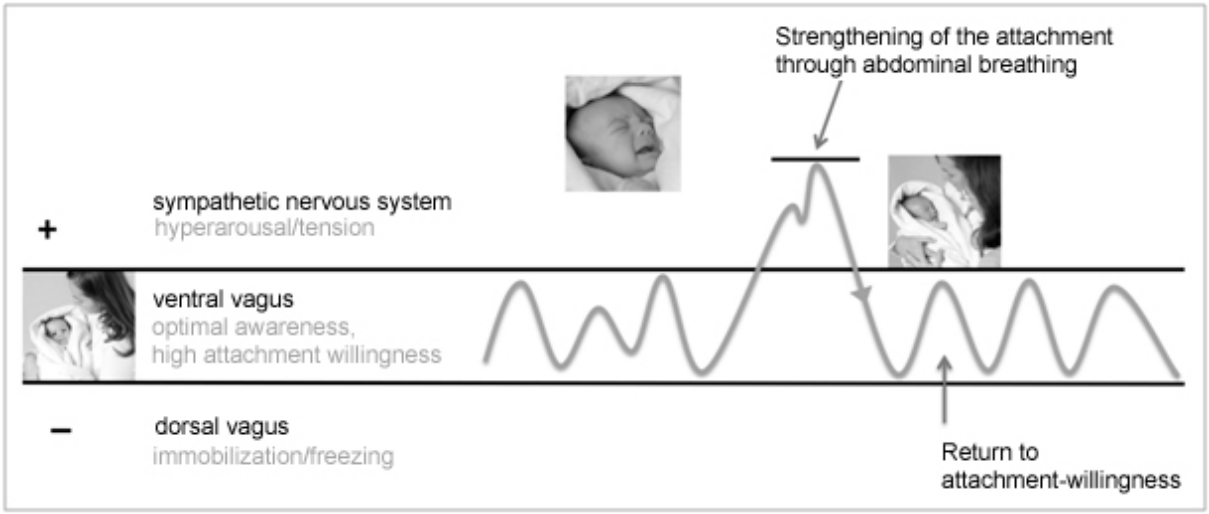

Diagram: Strengthening the attachment through abdominal breathing

An important advantage of this breathing technique is the fact that the effects can be directly felt and tested. With the mindful observation of their own breathing parents have a powerful method of defusing tense and stressful situations in everyday life themselves. The technique of abdominal breathing is very popular with parents, because they can use it at any time in contact with the child. They don`t need any kind of special equipment and can use the method anywhere in all the various situations where they are in contact with the baby. It is truly amazing how quickly they grasp the deeper logic of the approach in a practical manner. For many parents the abdominal breathing technique becomes an important guideline: by observing the breathing they learn something about their current capacity for contact on the one hand, and on the other it becomes a simple method of improving their presence and availability.

From the point of view of the polyvagal theory it is still not clear why the process of relaxation and centering initiated by the breathing results in a direct improvement of the parents` prosocial activity. One conceivable explanation could be, that through the focus on the abdomen during the breathing there is an afferent flow of information from the viscera to the higher areas of the brain. The awareness of pleasant sensations in the abdomen would then lead to direct activation of the ventral vagus function. Stephen Porges formulates this as follows: “The afferent feedback of the viscera serves as a main facilitator in accessing the prosocial circuits, which are connected to the behavioral modes of social engagement”. (Levine, 2010). This would explain what we experience in practice:

parents concentrate the breathing in the belly and develop spontaneously (often within a few seconds) an emotional experience of security and through this process they become more open and available for the behavioral signals and the body language of the child.

Strengthening the Attachment of Co-regulators Suffering from Traumatic Stress

Attachment oriented breathing work is only useful when parents are sufficiently capable of self-awareness. If the adult carers are themselves suffering from traumatic stress, then the baby`s screaming can often trigger a flood of overwhelming feelings of stress. Consequently this can lead to the total breakdown of the parents` capacity for resonance, attachment and self-awareness. In cases like these, where the caregivers are overwhelmed by their own traumatic experiences, they can only very rarely find their way back to a state of openness and receptivity. These parents need a professional therapist, who can help re-establish their regulatory capacity by assuming the role of an auxiliary ego.

The following method, the “umbilical cord connection”, is a specific touch intervention which is used when parents are in danger of losing themselves in a maelstrom of dissociation and entanglement. Together with the parents we look for a place on the body, which when we touch and hold it, makes the person concerned feel as safe as possible. Holding this so-called “safety station” while the parent holds the baby, directly activates the parasympathetic division of the ANS (similar to what was described with the abdominal breathing). One result of this vagal reaction to the establishment of a safety station is the increased flow of blood and warmth to the skin surface. This increase in warmth and the build-up of contact on the skin surface can be felt and named by both therapist and client.

The quality and intensity of the connection at the safety station varies depending on the regulatory state of the client. When both are in a state of openness and relaxation the contact can be felt very intensely. But if the stress and alarm mode is in the ascendant then the contact thread becomes thinner and is lost completely when the parent moves into a dissociative state. The continuum of the parents` regulatory and attachment states is reproduced in the therapists experience of the umbilical cord connection. To express it in another way: the quality of the umbilical cord connection between therapist and client becomes itself an equivalent of the current status of the attachment between the baby and its carer.

In phases of trauma reactivation the self-connection and regulatory capacity of the affected person completely disappear, so that the co-regulatory function of a professional helper is necessary to sustain the bonding process with the child. The therapist can quite concretely feel and name in a preventative way the overwhelming feelings that threaten the client. Thus the therapist has the task to communicate to the client his/her perception of the weakening or breaking down of the umbilical cord connection as a kind of urgent flood warning. (“Now I can feel how the contact thread in my hand is getting thinner. What`s happening in your body at the moment? What are you feeling just now?). Often just pointing out that the connection is about to be lost is enough to reestablish the parents` presence and contact readiness, but it`s better when the exact process of emotional and physical regulation is then explored. Then the thoughts, feelings and physical states, which the clients have until now not been aware of or identified, can be integrated. Ideally the result will be that the parents experience a return of their feeling of security and that emotional access to the child is again possible.

Step 4: Strengthening the Attachment and Recapitulating the Traumatic Experience

So far I have only explained the possibilities of body psychotherapy support for parental sensitivity and emotional regulation. In the practice of parent-infant body psychotherapy the focus alternates constantly between working with the parents and working with the child. For lack of space I can`t go more deeply into the many aspects of body psychotherapy with babies, but I would like to describe in the following how infants react when the parents` relational skills have improved through therapy. We can observe how babies react to the increase in the parents` availability with two basic reaction patterns. In the first “quiet” reaction mode the baby responds to the increased contact readiness of the

parents by becoming relaxed and open. The child can allow itself to turn its attention inward, away from the environment, because it senses the availability of its most important attachment figure.

In the second, “cathartic” reaction mode as a response to the increased attachment capacity of the parents the baby goes through a dynamic screaming cycle, in which it recapitulates the experiences which lead originally to its withdrawal. By experiencing a more secure attachment to the parents, the baby can allow itself to revive the painful birth and separation experiences, which are stored in its implicit memory.

From an attachment oriented perspective this recapitulation also carries the risk that the parents get caught up in the intensity of the baby`s traumatic feelings. Especially when they suffer from posttraumatic stress themselves, there is a danger that this will be reactivated. In these cases it can be helpful to use the umbilical cord technique to avoid them becoming overwhelmed and dissociating. While the baby goes through the various stages of its crying and screaming cycle, the therapist can use the umbilical cord connection as an important source of information about the bonding status of the adult carer.

In practice we would break off the trauma recapitulation work when the capacity of the parents for holding and relating is breaking down as they move into the dorsal vagus mode. Here the danger is that through the withdrawal of the co-regulators the baby experiences the recapitulation of the original stress situation as a retraumatization. To avoid this we tell the parents to use the calming and coping strategies they had previously used (walking hectically about, offering toys or pacifiers etc.), when they are on the edge of being overwhelmed. Although these behaviors rarely help either parents or child to calm down, they still convey some support and stability for the parents. In phases where they are really stressed it can be helpful to fall back on these compensatory strategies so that they at least have a minimum of security.

Trauma or Attachment

What I have dealt with up until now shows that the focus of the therapy I`m presenting here is concentrated on recreating the parental function as co-regulator. In practice we see that the build-up of the self-connection in the parents leads to a direct improvement in the relational situation between parents and child. Through their improved capacity for self-observation and self-awareness it is easier for them to recognize dysfunctional relational and regulatory states and to rectify them themselves. Another practical result of their improved regulatory and relational capacity is that many parents lose their fear of the child`s crying. Especially the abdominal breathing and the ability to observe themselves in a mindful way constitute effective tools with which the parents can directly regulate their own internal stress. They report, often with pride, how they have managed for the first time to really cope with the child`s screaming. The experience of self-efficacy is crucial here – coping with the situation oneself!

We aim at an explicit working through of the trauma in body psychotherapy with parents and infants when the stress level and traumatic symptoms (explosive screaming fits, stereotypical movement patterns, easily startled) persist despite the fact that the sensitivity and relational skills of the parents have significantly improved. In such cases we take a more baby centered approach and concentrate on the pre- peri- and postnatal background of the child`s behavioral difficulties. Together with the parents and the child we recapitulate the experiences which led to the trauma and place them in a larger context (Schindler, 2011). Due to lack of space I can`t go more deeply into this here.

In conclusion I would like to present an image which describes well the relationship of trauma work to attachment work in parent-infant body psychotherapy. Imagine that you are living on the banks of a

great river. Every day you would look out at the water and see how various ships and boats transport people and goods from one place to another. Imagine further that suddenly a group of people have decided to build a dam further upriver, in order to use the water to irrigate their fields. It is easy to envision that this project would have catastrophic consequences on the lower reaches of the river. The water level would sink rapidly and a series of rocks and stones which had until then lain beneath the water would become visible. Because of the low water level, ships would have difficulty negotiating the river and in some places shipping traffic would grind to a halt, because the obstacles prevent them getting through. What possibilities are there to solve this dilemma? One possibility would be to destroy the great rocks one at a time and remove them with cranes. This scheme would be very difficult to carry out and would cost an enormous amount of time and money. It would be much easier to do it another way: all our efforts would be employed in finding a way to restore the original water level. By dismantling the artificial dam we would ensure that the self-regulation of the river was restored. Many problems would solve themselves automatically and normal shipping traffic would again be possible (Harms, 2008).

In the attachment oriented work of parent-infant body psychotherapy we try to do something similar: through specific methods we try to deepen the “water level” of the attachment capacities and to let them flow. Of course we could try to deal with the many “rocks” or wounds which the participants carry – and sometimes this is necessary. For many parents however, who possess sufficient attachment resources, the trauma oriented approach is as a rule not helpful, perhaps even counterproductive. If we succeed in improving the sensitivity and self-connection of the parents, then more closeness and intimacy in the relationship with the child appear spontaneously. The effect is that everyday life becomes filled with positive and successful relational experiences and the traumatic stress and reaction patterns of both parents and child lose their destructive power.