

Working with Babies

Enhancing the future through resolving the past

Working with babies provides a unique opportunity to resolve many of the difficulties that can become imprinted early in life and can go on to affect our full development and potential as we mature.

One of the most formative experiences that we all undergo is the experience of birth. It is becoming increasingly recognised that the quality of our prenatal life and the nature of our arrival into the world is fundamental to, and may have significant impact upon, our future development.

In the United Kingdom in the middle part of the twentieth century, as the hospitalisation of birth was encouraged, birthing women were organised from the viewpoint of obstetricians and other medical practitioners. This led to the development of birthing practises that favoured the medical professionals but actually made the birth more difficult for both mother and baby.

Later on, the active birth movement led the way for the de-medicalisation of birth and focussed on how the mother could empower herself during her pregnancy and while she gave birth. In recent years, health professionals in various fields of research have been considering the birth process from the baby's point of view.

This has been very challenging, especially since, as recently as 1995, most parents and health care professionals believed babies to be too small and undeveloped to be affected by their prenatal life or birth.

A number of pioneers in this field have developed unique approaches to working with babies, children and their families in order to help resolve those issues that have their origins in prenatal life and the birth process.

These issues within a baby can, over time, affect the dynamic of the whole family. It is therefore important to work with the baby within the context of their family system.

In developing these approaches, practitioners and teachers have drawn from a wide range of modalities including Craniosacral Therapy, Polarity Therapy, Psychotherapy, Trauma Resolution work, and birth simulation work. Combining this with a detailed study of midwifery and obstetrical practises, embryology and neurology, a powerful method of working with babies and their families has emerged.

These revolutionary approaches look at the affect upon the baby of its prenatal life, the birth process and current birthing practises and how these affects may be resolved to ensure good health and optimum potential.

One of the challenges that is often faced in working with babies is what I call the inside-outside dilemma. The baby is on the inside and has its own unique experiences of its life in the womb and the nature of its arrival into the world.

The baby's parents, other family, doctors, midwives etc. are on the outside, and they also will have their own experience of these times. In many cases, the experiences of the baby and the parents are not the same.

I have worked with a number of mothers who have stated that, to them, the birth was wonderful. However, when we start working with babies it becomes clear that they may still be holding some left over issues around their arrival into the world.

CASE HISTORY - Emily

Sally brought her baby Emily to see me for a check-up following the birth. Sally was a week overdue and the doctors informed her that she had two options regarding the delivery of her baby.

One of these choices was induction, the other was elective caesarean section. After weighing up the pro's and con's of each option, Sally chose to have a section, in the belief that it would be the safest alternative of the two.

When she brought Emily to see me, she stated that she was completely satisfied with the way the birth had gone, although she did have a little regret about it not starting "on time".

As I began to work with Emily, she started to express a lot of anger and upset that was directed towards her mother. At the same time, she initiated pushing movements with her legs, in the same way that a birthing baby would push against the back of its mother's womb.

As we worked over a number of sessions, it became clear that Emily (although only 3 months old) blamed her mother for not allowing her to have a "normal" birth. As we made clear to Emily that mum made what she thought was the best choice in the circumstances, and we supported her to express her strong feelings, she eventually began to soften and settle.

Having undergone this course of treatment, Sally reported that the degree of bonding between her and Emily and greatly improved and she was a much more content baby.

Our early life

Every parent must surely be aware that the conception, gestation and birth of a child are miraculous events. One needs only to look into the eyes of a newborn baby to be wonder-struck by the miracle of life.

Today, many prospective parents are taking the time prior to conceiving their child to take steps to resolve any issues in their physical and emotional well-being as well as in their relationship with each other.

They are consciously taking this time in the understanding that the more they resolve, the healthier will be their sperm and egg and the new life that results from their union.

It is becoming clear that this type of conscious conception, as well as active parental responsibility during gestation, can contribute to easier birthing and bonding.

Impaired bonding of the infant to its parents has been shown to be one of the major factors in the development of aggressive and violent behaviour as well as relationship difficulties later in life (see references:1).

Contrary to many beliefs, bonding can, and ideally should, take place while the child is still in the womb.

In contrast to the ideal scenario, most parents do not undertake any preconceptual healthcare nor do they consciously conceive their child. The effects of this may adversely impact the baby while it is developing in the womb.

Table One lists a number of potentially disturbing events that may imprint the pre-nate while it is still in the womb. This, and the information in Table Two, is derived from the work of Dr. William Emerson (see references:2).

TABLE ONE

- Unwanted pregnancy

- Conception by force, manipulation or rape
- Conception under the influence of alcohol, cigarettes or drugs (recreational/pharmaceutical)
- Thinking about, planning or attempting abortion
- Intrauterine toxicity (from alcohol, cigarettes, drugs, medications and strong negative emotions)
- Prenatal twin loss (research has shown that up to 70% of all pregnancies begin as multiple conceptions) (see references:3)
- Foetal surgery, invasive antenatal testing and ART
- Adoption · Accident, illness or injury during pregnancy
- Divorce or separation of parents
- Death of a loved one

The Birth Process

For the first nine months of its life, a baby has been growing and developing within the relative safety of its mother's womb. As this time draws to a close, both mother and baby release certain hormones that initiate the contractions of labour. The baby, therefore, possesses an inherent wisdom as to when it is ready to birth itself.

During a normal delivery, the baby finds itself descending head first, through the mothers pelvis and down the birth canal.

In order for the baby to pass through its mothers pelvis, certain physiological changes need to occur. The widest part of the baby is its head. Fortunately, for both mother and baby, the head is able to mould in order to facilitate its passage through the pelvis. This moulding is able to take place because the bones of the skull have not yet "fused" together. They are like large plates that are floating on the membranous surface of a water-filled balloon.

As the baby begins its passage through the pelvis, the various bones of the skull naturally move and distort in particular ways, in order to facilitate the descent. This may include one or more bones overlapping each other. The overall effect of the birth process upon the baby, and particularly upon its head, is one of compression. New parents are often alarmed by the degree of moulding that is present in their baby's head.

Medical professionals often state that this is nothing to worry about as moulding is a natural process that will fully resolve itself in a matter of days.

It is true that moulding is a natural process and that a certain degree of resolution occurs quite quickly. However, it is often the case that due to the strong compressive forces that the baby experiences during its birth, the bones of the skull may not fully release and return to their natural position. If these bones remain locked together they can interfere with the natural growth and development of the skull and the brain.

The compressive forces of the birth process are often fed into the spine and pelvis resulting in a greater degree of tension and less freedom of movement in certain joints and in particular areas of the body.

These effects may have body-wide repercussions and potential long-term consequences on the health and well-being of the developing child.

Many conditions that we are used to seeing described as "normal" during infancy may have their origins in the rigours of the birth process.

In fact, it would be more appropriate to describe these conditions as common, reflecting the commonality of the experience that we have all gone through, rather than normal.

To suggest that something is normal implies that it is something necessary for the baby to experience and is indicative of good health.

Typical examples of common conditions related to unresolved cranial moulding are difficulties with feeding and sleeping, constant crying, colic, ear problems, squint and other visual disturbances.

Other conditions, that may not manifest until later in life, include asthma, autism, behavioural and emotional problems, dyslexia, epilepsy, hyperactivity etc.

CASE STUDY - Sarah

Sarah, a 4 week old baby, was brought to see me suffering with severe colic. Her parents were concerned by the fact that she would scream inconsolably for several hours in the evenings, pulling her legs up into her body as she did so. Although she was breast-feeding, Sarah was unable to digest the milk when her mother ate fruit, vegetables and other foods, and was also suffering from smelly green stools. Consequently, her mother was living on a diet of dairy products and chocolate as these seemed to provide the least distress to Sarah. Sarah's mother stated that her labour was very quick and had been induced for the convenience of the consulting obstetricians. Consequently, she felt very angry at what she considered to be the mismanagement of her labour.

Induction's generally have the result of creating more intense uterine contractions and have the potential to produce more pronounced shock and cranial moulding patterns.

This was certainly the case with Sarah. Just looking at her, I was struck by the strong asymmetry that was present, particularly in her face. By taking a light contact onto the back of her head I became aware of the strong degree of compression that was present throughout her body. Some of her cranial bones were compressed and misaligned in relation to their neighbours.

From just the very first session, I could feel some of the tension in her body begin to relax. Her occiput softened and there was a lengthening throughout her body as the tight soft tissues released their tension.

Sarah's parents noted that the day after the treatment she had continuous bowel movements that gradually became less green and smelly. By the next time I saw her, Sarah was obviously a different baby. She seemed much more at ease and relaxed, and the powerful screaming, that was the initial cause for concern, had stopped. These improvements continued over the few more sessions that Sarah and I had together.

Assisted delivery

In many cases, interventions are used that are intended to make the birth process easier for both mother and doctor. Often, such interventions are necessary for the safety of both the mother and baby.

However, such interventions can potentially have long-term side-effects. The use of such tools as forceps and ventouse, for example, can often create more extreme moulding patterns, body tension and shock in the baby. In these cases, it can often take longer to get a resolution of the underlying problem.

The use of pain-relief medication can also create long-term side-effects. Dr. Lennart Righard, of the University of Lund, Sweden, produced a study showing that babies born from a medicated birth were often unable to attach to their mother's breasts and begin feeding (see references:4). This may then set up an early pattern for bonding and relationship difficulties.

More recent studies, from the University of Gothenberg, have linked high doses of opiates and barbiturates, used as painkillers in labour, with increased likelihood of substance abuse later in life.

Caesarean Sections

It has often been reported that baby's born by caesarean section have an easier time and suffer less as a consequence than those born vaginally, primarily because they don't experience the cranial moulding from the birth canal.

Indeed, many parents (especially in the USA, and increasingly so in the UK) are now opting for elective caesareans as a way of avoiding the pain and discomfort of the birth process.

Research has estimated that a caesarean section rate of only 6-8% is medically justified. This is in comparison to the UK national rate of up to 20% (up to 50% in some parts of the USA) (see references:5).

Caesarean born babies have a different experience to vaginally-born babies. They undergo many physiological and psychological changes, over a very short space of time, as they transition from life in the womb to the outside world. They also experience a sudden pressure change as the uterus is surgically opened.

These factors can actually imprint a significant amount of distress into the baby's system albeit, in certain circumstances, without any cranial moulding.

CASE STUDY - Hayley

Michael and Amanda had been trying to conceive a child for 11 years. Having given up hope of having a child of their own, they decided to adopt a little boy, Simon. As the adoption process reached its final, critical stage, Amanda fell pregnant.

This was a very stressful time for everyone. Amanda was very sick for the whole 9 months of her pregnancy. The stress of the adoption process, the stress of wondering whether the adoption agency would take Simon away and finally the stress of finding out that the baby was in a breech position, with her head wedged under Amanda's ribcage, and she would need to have a caesarean section.

Amanda brought Hayley to see me when she was 22 months old because she had been very sick as a baby and now has extreme temper tantrums.

As I started working with Hayley, she always seemed to settle into her Mum's lap in exactly the position she had been stuck in the womb, with her head tightly pressed into Amanda's ribs.

Over time, by allowing Hayley to express the feelings she had about being stuck and having to be born surgically, she was able to move from her stuck place, turn around, and go through a symbolic birth process, head first.

By empowering Hayley to move from her stuck place she was able to re-pattern the shock that had become imprinted at the time of her birth. She was also able to let go of the emotional charge that had built up as well. Today, Hayley is a much happier little girl and no longer has the violent temper tantrums that plagued her early life.

Table Two gives a list of interventions and other conditions that can potentially give rise to shock and trauma during the birth process. However, it must be reiterated that many of these interventions are often necessary and can even be life-saving.

TABLE TWO

- Obstetrical interventions i.e. forceps, ventouse, labour induction, premature rupturing of membranes
- Obstetrical anaesthesia and analgesia e.g. gas and air, pethidine, epidurals, general anaesthesia
- Caesarean section
- Birth complications e.g. placenta previa, cord compaction and oxygen deprivation, nuchal cord, foetal distress, cephalo-pelvic disproportion, breech presentation
- Prematurity
- Separation from mother for cleaning, weighing, suctioning etc.
- Post-natal testing
- Early cutting of umbilical cord

Shock

It has been estimated that approximately 95% of all babies experience some degree of shock, whether mild or severe, at some stage during their prenatal life or their birth process (see references:6).

In my experience, a significant number of parents also suffer some shock during this time, and often have unresolved emotions concerning the management of their labour.

If the shock naturally works its way out of our system, then no lasting damage is done. However, oftentimes the complete discharge of this shock is hindered by external pressures and social "norms".

Unresolved shock and trauma accounts for a great deal of physical, psycho-emotional and social problems.

To a birthing baby, the physical rigours of the birth process may be a direct contrast to its time in the womb. It may feel threatened by the whole process, and so it is not uncommon for newborn babies to have their muscles clenched, as if to protect themselves.

At the same time, the baby may enter a state of hyperarousal, even panic. It is, therefore, also common for newborn babies to be incredibly angry, frustrated or even frightened following their birth.

Another effect of shock imprinting at the time of birth, is for the baby to go into a state of hypoarousal. In this case, the baby would withdraw into itself and appear to sleep a lot. Many

parents have commented that they have really good babies who seem to sleep all the time, when actually they are suffering the effects of shock.

Later on in life, as the child grows and matures, these stress responses may become habitual. This may mean that the child habitually responds to difficult and stressful situations with the same degree of overwhelm as they did at birth.

In other words, stressful situations can take us back to responses that had their origins in prenatal and birth-related trauma.

Whilst these responses were appropriate at the time, today they may cause us to react out of proportion to the situation at hand. At the same time, they may cause further agitation to the tissues of the body and a possible entrenching of the original trauma.

Hence, many physical and psycho-emotional disorders that we suffer from as both children and adults may have their origin in prenatal life or the rigours of the birth process.

It is therefore a primary responsibility for the therapist to help the baby to negotiate safely the complete release of any imprinted shock from its early experience.

Treatment Process

Fortunately, these imprinted shocks are not locked away, never to be accessed. If we can learn to observe babies and children in a new way, we will see that they are constantly showing us how it was for them in their early life.

Obviously, babies and children are not telling us a verbal story of their history but express themselves through their body and eye movements, their expressions as well as through their play.

The practitioner works by monitoring the subtle energetic and physical cues that the baby presents and responds appropriately. With older children, some of the work may involve play with toys or some re-enactment of the birth process using balls, tunnels or other games.

It is also important that the parents recognise these cues and learn how to modulate their responses to the newborn at home, thus providing self-help and care directly within the family environment.

I truly believe that through helping babies and children to resolve some, or all, of their early patterning we can help to create a more positive future for them where they can begin to realise their full human potential and sow the seeds for a more loving and caring generation.

References

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Graham Kennedy