

Every Baby Has a Story to Tell. Memory Crying and Baby Body Language as an Expression of Experience in Babies.

The Emerging Field of Pre and Perinatal Psychology

The general consensus amongst medical practitioners and scientists is that babies do not experience pain at birth and retain no memory of the experience. This is based on an understanding of neurological development and the nature of memory that is becoming quickly outdated. At odds with this prevailing understanding is the experience of practitioners in a number of different therapeutic disciplines, who have encountered birth and prenatal memories in their work with clients. This includes dream recall and associated imagery in psychoanalysis (Rank 1929; Fodor, 1949; Share, 1994), the medical use of LSD (Lake, 1966; Grof 1976), breathing techniques (Grof, 2010), hypnosis (Gabriel, 1995; Chamberlain, 2013), spontaneous regressions during bodywork (Upledger 1995) and specific embodied birth and prenatal simulation techniques (Emerson, 2000). Over the past fifty years or so many thousands of people have participated in workshops which have facilitated prenatal and birth regression processes. Drawing from this experience researchers have mapped out how various prenatal and birth events are embodied and how these are accompanied with specific body language. For example, the psychiatrist R.D. Laing recounts a female client talking about her husband wanting a divorce. “It was a body blow right here (pointing to the navel)” (Laing, 1976, p. 73) .This ‘body-memory’ of the earlier trauma of the premature cutting of the umbilical cord and separation from the mother is stimulated by the present moment trauma of her husband’s intention to separate.

William Emerson, a pioneer in the emerging field of Pre and Perinatal Psychology delineated four stages of birth from the babies perspective, constellating around existential and psychological themes, with associated physiological consequences. (Emerson (1), 2004). In brief, Stage 1 corresponds to the baby descending into the pelvic inlet and meeting the closed cervix. The themes of ‘beginnings’ and ‘no-exit’ are associated with this stage. Stage 2 relates to the rotation of the baby’s head in the mid-pelvis. Themes associated with this stage are ‘trust’ and ‘orientation’. Stage 3 is about moving through the pelvic outlet. ‘Exhaustion’ and ‘being seen’ are the major themes. Stage 4 begins with the birth of

the head and body, through to the time that a family settles without any external interference from medical staff. The themes of 'exposure', 'separation' and 'invasion' belong to this stage. Unresolved trauma from any of these stages often shows up in later life, usually at times of transition, such as going to school for the first time, moving home, coming in and out of relationship, even leaving the house.

When any of these stages becomes activated in the present moment, either through regression in a therapeutic setting or by a present moment event that stimulates the 'body memory', specific body language associated with that stage is unconsciously activated. Each of these stages has 'conjunct sites' and 'conjunct pathways' associated with them. A conjunct site is an area of the body, usually the cranium, that was compressed by a maternal pelvic bone during the birth process. A conjunct pathway is a pathway of compression left from being pushed over a maternal pelvic bone by labour contractions. When the old birth trauma is activated the hands unconsciously touch these conjunct sites and move along the conjunct pathways. An example of this would be if a Stage 3 trauma was being activated; the hands draw down over the face from the forehead, mimicking the movement of the foetal face passing along the curve of the sacrum. This might be accompanied by feelings of exhaustion and statements like 'I just can't go on' or 'I just keep hitting this brick wall'. If the umbilical cord was compressed by contractions during this stage there may be accompanying feelings of panic and the sense that 'I can't breathe'.

In an article entitled 'Universal Body Movements in Cellular Consciousness and What They Mean' by Terry Larimore and Graham Farrant (Larimore & Farrant, 1995) seven body movements associated with the early cellular processes of sperm, ovum and the implantation of the blastocyst were described. Further mapping out of these very early territories and the associated body language were developed by other researchers, in particular William Emerson and Karlton Terry (Emerson, 2004(2), Terry, 2005). That these early cellular experiences could have a resonance within our psyches and that specific cellular movements might be expressed at the level of the adult organism evokes incredulity from many people. The basis for this claim is the consistent revelation of these deeply human formative processes in therapy sessions and workshops, in the form of unconscious body language and associated imagery and emotions. These are images and body movements that would be hard to identify without a deep knowledge of human embryology and the emotions echo existential and psychological themes that repeatedly show up in relation to

specific embryological stages. They therefore represent a profoundly important stage of human experience that is not recognised by Western psychology or medicine and is not honoured within Western culture as significant.¹ The science that supports these therapeutic insights is slowly beginning to emerge. Evidence that consciousness is not simply an epiphenomenon of the brain, but resides at a cellular level, in the tissues and even as a field phenomenon is amassing at the borders of the prevailing mechanistic paradigm (Chamberlain, 2013)

Baby Body Language

The body language associated with prenatal and birth experience is known simply as 'Baby Body Language' (BBL) (Terry, 2009) Whilst it is present throughout life BBL tends to be diminished by an educational focus on cognitive, rather than expressive concerns, along with punitive or inappropriate environmental responses to what is being expressed. Babies are as yet free of such inhibitions and so 'tell their stories' through their BBL in a very expressive and articulate manner. However, it is generally not recognised as such and so not responded to with the awareness and empathy that enable the story to be 'heard'. As such, we may say, that babies are left with their 'stories' trapped in their bodies and psyches and are alone in that experience. This is extremely distressing for babies, which they express through inconsolable crying, fractious behaviour and disturbed sleep. Later in childhood these unheard stories turn up in nightmares and are played out in games. They give rise to anxieties, phobias, compulsive behaviour and violent outbursts (Share, 1994).

With the knowledge gathered through decades of regressive work with adults, a few practitioners began working directly with babies (Emerson, 2000; Terry, 2009). BBL is universal and every baby to a lesser or greater degree tells the story of their journey to be here through these movements. Karlton Terry, a pioneer in the understanding of BBL, describes these movements as being 'non-volition, non-random movements'. (Terry, 2009) They are non-volitional in the sense that they spontaneous arise out of body sensation, rather than as acts of conscious intention. For example, if I am thirsty the conscious intention arises

¹ This is not the case in many indigenous cultures, where conception, prenatal life and birth are seen as fundamental in the shaping of the individual psyche and wellbeing of society as a whole.

within me to pour water into a glass and drink from it. If I touch an area of my head because a birth memory is being stimulated, it is a spontaneous gesture arising out of my unconscious. I may not even be aware that I am doing it. Yet it communicates something of my experience. In the same way babies are not motivated by a conscious intention to convey their experience. Yet they do so from their experience of what is happening in their bodies. In this regard the BBL is 'non-random'. It conveys meaning even though it is not motivated by the conscious intention to do so.

BBL can be differentiated from other spontaneous movements, such as those by which babies slowly develop their capacity to coordinate. There is usually an emotional component to BBL. Babies express distress or frustration as they touch various conjunct sites and pathways or enact early prenatal themes. There is an intensity and frequency to BBL that is quite distinct from the other movements. Parents, especially mothers, will often *feel* that their babies are trying to communicate something that they are not 'getting'. Perhaps one of the greatest obstacles to acknowledging the presence of BBL, as a meaningful communication of experience, *is that it is so obvious!* How can a form of human expression that is so universal have not been recognised before now? It is like the fable of 'The Emperor's New Clothes' but in reverse. Instead of the exclaiming there is nothing there, when everyone is agreeing there is, we are saying there is something there, when the general consensus is there is not. Students, who train in working with BBL, often say 'how could I not have seen this before?' It is a revelation even to midwives, paediatricians, craniosacral therapists or osteopaths, who work regularly with babies. Perhaps the deeper question is how can a theory (i.e. babies are insensible to their prenatal and birth experience) be so powerful that it blinds us to what is right before our eyes?

The non-volitional, non-random movements are the more active component of BBL. The conjunct sites and pathways are the 'fixed' components. These compressive forces and stress patterns become held in the connective tissues of the body (Upledger, 1990). Indentations from maternal pelvic bones or the pressure of the cervix can often be clearly seen. The most obvious fixed BBL is the 'birth lie-side' (Terry, 2009). This is the side of the baby that was against the mother's spine during the last few weeks of pregnancy and during the labour. Although there are variations on the theme most babies are in a transverse position in relation to the maternal pelvis during the last few weeks of the pregnancy. The head leads the descent into the pelvis (cephalic presentation) and as the baby descends

the neck flexes so that baby's crown comes into contact with the cervix. During the descent the baby's head turns about 45 degrees so that it is now in an oblique position, usually with the baby's occiput facing either to the left or right anterior aspect of the maternal pelvis. In obstetrical terminology these are known respectively as 'left occiput anterior' (LOA) and 'right-occiput anterior' (ROA). The most common and effective presentation for moving through the average maternal pelvis is LOA. Other presentations include occiput posterior (OP) and breech.

As babies descend into the pelvis and especially with the onset of labour contractions, the lie side of the cranium is compressed against a large mass of bone known as the 'lumbosacral promontory (LSP). The consists of the lower lumbar vertebrae and the superior aspect of the sacrum. As the labour proceeds the baby's head and shoulders are pushed over the LSP. There will already be some compression in the lie side from the tight squeeze within the womb during the last few weeks of the pregnancy. This is exacerbated during the birth as the foetal skull distorts to accommodate the pressure from the LSP. Although the neonate skull has the capacity to remould after birth, the stronger compressive forces remain held in the tissues. The lie side can be identified by a number of different indicators. The cranium is generally more compressed on this side, with the eye closer to the midline and slightly inferior to the eye on the other side. This is due to the dragging forces exerted on the cranium as contractions push the baby over the LSP. As most babies rotate into the lie-side during the rotational stage of birth, the nose deviates away from the lie-side, due to pressure from the sacrum exerted on the nose as the baby turns into it. The shoulder on the lie-side is usually more contracted and the baby may tend towards a 'banana' shape, with the convex curve along the right side mirroring the curve of the mother's lumbar spine.

As such we can say that the lie-side tends to hold the most intense aspects of the birth story. This is especially true of the connective tissues, which adapt to stress and hold the memory of any intense or traumatic experience (Upledger, 2009). Gentle stimulation of conjunct sites and pathways usually elicit an emotional response and babies will spontaneously re-enact aspects of their birth experience, especially the places where they became stuck (Peirsman, 2006; Agustoni, 2013). There tends to be more active BBL on the lie side, with babies repeatedly touching the most prominent conjunct sites and pathways.

Movements on the lie side tend to be more jerky, as peripheral nerves may be compressed and more 'shock' is held on this side of the body. The emotional expression in the lie-side eye is often different than the non-lie side eye. It may be less present or hold more fear or anger.

Memory Crying

BBL is often accompanied by memory crying. This can be differentiated from a 'present moment needs cry'. A present moment needs cry is crying elicited by a present moment issue that needs attending to, such as hunger, dehydration, discomfort due to heat, cold, boredom, tiredness, overstimulation or a soiled nappy. Most people are familiar with these forms of crying and are able to attend to them. Memory crying occurs when the memory of an earlier traumatic event surfaces. There are various theories of how memory becomes holographically imprinted at a cellular and tissue level (Pearshall, 1988; Ho, 1996; Oschmann, 2003; Barrett; 2013; Verny 2014). In adults birth and prenatal memories may surface as if they were holographically unfolding in the present. Images and emotions associated with the earlier event are experienced as a gestalt. Being able to experience the intensity of the event, whilst retaining a conscious witness to it enables an integration of the event at a higher level of consciousness, rather than have it operate unconsciously at the level of a threat to survival.

The memory crying of babies is clearly experienced as present moment lived experience. BBL becomes more frequent, sometimes even frantic. The emotional expression which can be seen in the eyes and heard in the tone of crying alerts us to the existential theme that the baby is in contact with. Memory crying conveys one of three essential emotions; anger/rage, sadness/grief or anxiety/terror. Babies may look lost, alone, confused, pressured, withdrawn. These nuances interface with one or more of these three essential emotional qualities giving us more clues as to what the crying conveys of their experience.

In so far as memory crying is recognised for what it is and responded to appropriately it can lead to a release of tension. If it is mistaken for a present moment needs cry and is responded to with attempts to feed or pacify, either by 'shushing' or the use of a pacifier, it only leads to greater tension and distress. This can lead to cycles of ongoing distress for

both the baby and the parents. From the parents perspective they are trying to do everything they can to soothe their baby, but nothing works. This, in turn, leads to a loss of confidence, increased stress and frustration, often accompanied by exhaustion due to loss of sleep and tension between parents, as they both struggle with their own tension and tiredness. For the baby, who feels acutely the stress level of the parents, this increases distress and tension, so that both baby and parents become trapped in a vicious circle of negative feedback, in which everyone feels isolated within their own sense of helplessness.

Parents may see that their child seems to be in pain and that it is not simply a question of a present moment need, but not know what to do. The nature of body memory is that it is not static, but may be more or less dormant or active depending on external stimuli. A common example of this is when clothing is pulled over a baby's head, activating the memory of passing through the cervix. When babies are tired body memories are also more likely to be activated. This may resonate with the theme of exhaustion in Stage 3 of the birth process or it may simply be that as the baby becomes more aware of their internal body state and less distracted by interesting objects in the environment. We probably all have the experience of beginning to drift into sleep at the end of the day and as we do so, beginning to notice aches or pains that we have not been aware of in the day or suddenly jerking awake as some anxiety left over from the day reasserts itself. Babies are no different and may suddenly startle awake just as they are beginning to drift off.

As well as the emotional content of body memories and their activation, compressed cranial bones and tense connective tissue may be the source of present moment physical pain. Until recently it was believed that babies did not experience pain as adults do. This led to babies being operated on without the use of anaesthesia as recently as the 1980's (Chamberlain, 1998, pp. 200-201). Even now babies are subject to many invasive and painful interventions during and after birth as if they were insensible to the pain. However, a recent study from Oxford University, shows that newborns are actually more sensitive to pain than adults (Goksan et al, 2015). Using functional magnetic resonance imaging (fMRI) to monitor the brains of babies and adults, they observed the centres of the brain associated with pain that were activated by poking the feet with a pencil. The babies' pain centres responded to pokes that were four times weaker than those that stimulated the same response in adults. This supports what is clearly observable in clinical practice, which is

that babies experience pain at birth and also afterwards, as the result of painful and stressful medical interventions.

Emotional and physical pain are tolerable for only so long. If there is no relief from suffering it can lead to resignation and dissociation. If babies are met with inappropriate responses to their crying (i.e. memory crying is continually responded to as if were a hunger cry) or they are left to cry on their own, not only is the original trauma unacknowledged, but is overlaid with the frustration of not being understood. The use of controlled crying, in which babies are left for short periods to cry on their own, with ongoing gradual incremental extensions, is promoted by some 'experts' as helping babies to find 'contentment' (Ford, 2006). Whilst there may be some short term benefits from this practice, as parents get a break from the cycles of distress they have been trying unsuccessfully to manage, babies' experience is more often that of being abandoned in their pain. Babies become quiet not because they are now content, but because they have dissociated from their unbearable experience. This is known as 'Good Baby Syndrome' (Appleton (1), 2013) and shows up in regressive sessions with adults as a source of poor self-esteem, existential anxiety, low energy states, such as chronic fatigue and the underlying belief 'I can never get my needs met', which may get acted out in unhealthy relationship dynamics.

Integrative Baby Therapy

Parents bring their babies for treatment for a number of different reasons. These include inconsolable crying, so-called 'colic', sleep problems, fractious behaviour, or simply because they would like to know if their baby has been left with any after-effects from the birth. For most parents the understanding that babies have experience in the womb or at birth, which may impact on them and be the source of their distress is new. As such it needs to be addressed sensitively, without putting pressure on the parent's belief systems or evoking parental guilt (i.e. 'I hurt my baby', 'I was not able to protect my baby'). The initial focus therefore is not specifically on the baby, but to build trust and foster a therapeutic alliance with the parents. This involves making them comfortable, both physically and emotionally, getting clear about what they would like from the session and what the therapy can offer. There is no particular sequence in which this unfolds. Rather, the therapist needs to sense what needs attention so as to create ease and openness between the parents and the therapist.

After these preliminaries the therapeutic intention is to open up 'potential space'. This term was originally used by the child analyst D.W. Winnicott (Winnicott 1971, p. 107) to describe the space between the mother and baby whereby the baby's sense of self develops out of the reciprocity of the relationship. Here it is used to indicate the space in which the parents and the baby are able to bring their experience. The parents are invited to tell in their own words the stories of what the birth and pregnancy was like for them. For many parents, even though they may have talked for many hours prior to the birth about their hopes and intentions, it is often the first time following the birth that they actually get to hear each other's experience. With all the busyness of adapting to the needs of the baby, this often does not get the time that it deserves. Strong emotions may emerge as the stories are told. The parents are supported to allow the feelings to be part of the therapeutic process. Sometimes as stories are recounted the baby will, at a specific point, begin to memory cry. The parents are then supported to listen to the baby's story.

The potential space allows the 'inherent treatment plan' to emerge (Becker, 1997). This term was coined by cranial osteopath Rollin Becker to describe the capacity for the body to move towards its own solution to a symptom, which the physician needed only to support. The same principle is at work in the 'relational field' that is created by the family and the therapist through the process of deep empathic listening. The therapist does not take on the role of the expert who has answers, but, to use another osteopathic term, becomes the 'fulcrum', the 'still point', around which the inherent treatment plan can unfold. This requires the therapist to be fully present and tracking what is happening in the relational field to see what needs attention from moment to moment. This is done with the awareness that something very 'intelligent' is trying to happen within the relational field, that will only emerge in its own time. The therapist must resist the temptation to intervene too soon. Only then can the 'prominent presenter' emerge. Karlton Terry describes the 'prominent presenter' as 'the affect most convincingly and repeatedly given by the baby's body language, requesting that the therapy be guided and oriented by the most prominent and persistent theme that is expressed by the baby' (Terry, 2009, p. 19) Here the term is expanded to include the parents. Often babies need a parent to deregulate their own stress level to create the potential space in which the baby feels it is safe enough to deepen into his or her own 'story'. So the unresolved trauma of a parent may become the prominent presenter.

It is indicative of the sensitivity of babies to the relational field that they may wait until a parent has worked through a traumatic issue before beginning to express BBL. Babies may also respond to a parent talking about a specific stage in the birth, or prenatal event by expressing the BBL associated with stage. The baby is clearly resonating with what the parent is saying and feeling. This is a cue to pay attention to the baby and see what the baby has to show us about the experience. All work in Integrative Baby Therapy is based on permission. So the therapist might ask the parents 'would it be ok if we paid attention to your baby now?' This both reassures the parents that nothing will be done to their baby without their permission, whilst also inviting the parents to become curious about what their baby is expressing.

Knowing the terrain of the birth and prenatal stages helps to focus this curiosity. For example, if we can see that the baby is touching a specific conjunct site on the lie-side, we can determine exactly where the baby became stuck in the birth process. But, rather than give a lot of information to the parents, the therapist can use this to evoke the interest of the parent by saying something such as 'I notice little Jonny keeps touching the same spot on the left side of the cranium. I wonder if he's feeling something there?' By drawing the parents into the process the therapist is inviting a deeper empathy on their part, whilst opening the way to suggest possible ways of deepening the exploration of what is happening. This might involve asking permission to palpate the conjunct site. This is done by moving hand over the conjunct site just off of the body. Babies are incredibly open and sensitive. They often respond to even the subtlest palpation. It may be that each time the therapist's hand passes over the conjunct site the BBL becomes more intense or the baby begins to memory cry. This enables the parents to see that the baby is responding to something that is clearly not a present moment need. Only later or at the end of the session might it be helpful to share a more detailed description of lie-side theory or of the specific birth/prenatal stage that the BBL was indicating.

Once the prominent presenter has clarified the parents are encouraged to identify the emotional tone. This evokes a more accurate empathy on their part, which the baby feels. Rather than feeling powerless to help a baby who seems to be crying for no particular reason, parents are now able to identify 'when my baby touches that particular place on the

head she cries and looks angry'. The anger is now identified with a specific historic experience, which makes sense to the parents. Parents are then supported to empathically mirror the emotion. This is usually modelled first by the therapist, who speaks directly to the baby. 'I can see you are really angry.' This may be expanded to include a reference to what the BBL is telling us, such as 'That was really painful when you got stuck there' or 'That really frightened you when the medication came through your [umbilical] cord.'

Often the crying will initially intensify when we mirror the baby's experience. We have probably all had the experience of telling a friend of something that has been bothering us and in the telling, *if the listener is really present without trying to find solutions*, we deepen into the story, feeling it more as we tell it. When we have finished there is a sense of relief. It is the same for babies. Supporting parents to be able to tolerate the crying in the session becomes the therapists primary task at this stage. If the parents tolerance threshold is dropping the therapist may look at ways to support them, including various breathing or body awareness techniques, offering support through physical contact, verbal assurances or taking a break from the process. Staying in empathic resonance with the baby as the crying intensifies is usually the most challenging part of the session for the parents. This is partly because the parent naturally wants to soothe the baby and partly because the parents' own unresolved pre and perinatal trauma may be stimulated. Once the baby has passed through the apex of the crying, it begins to quieten and the baby settles. Parents usually report that their babies cry much less after a session and that it is then more often related to present moment needs, rather than a body memory. The BBL associated with the memory is also reduced in its intensity or disappears completely. Insofar as memory crying and BBL continues parents and parents are able to respond with the appropriate empathy so that the baby is more able to move through the experience and settle again. This increases parental confidence and enables a deeper bonding to happen than when both parents and baby are permanently stressed and exhausted.

Empathic mirroring and the capacity to hear the baby's 'story' is at the core of Integrative Baby Therapy. Other therapeutic interventions may also be employed to support babies to complete processes that they were not able to do at the time due to overwhelming pain and distress, which caused them to dissociate, or the effects of medication given in the birth, such as induction, augmentation or pain-relieving drugs. Babies will often spontaneously re-enact their birth during a session moving into the position where they became

stuck or overwhelmed. Supporting them to find their own internal impulse to move through this stage, but this time with the conscious support and empathy of the therapist and parents, enables the baby to move through this 'scary place' in an empowered way. As such, it changes the experience. What was initially experienced as overwhelming and fearful is now experienced as a challenge that can be overcome. Supporting the baby's feet to help them build the internal impulse to push forward, whilst empathically tracking and reflecting back their experience is one such way of doing this. There are numerous other empowering interventions that may be offered in response to the specific BBL and emotional tone that is being expressed.

Case Study

N. was six months old when his parents brought him for treatment. They were concerned that he did not seem comfortable in his body, as if he was "straining against something". He also went through bouts of high-pitched crying that would only cease when he had exhausted himself. Both parents were present in the sessions. They were both aware that N. was trying to communicate something that they were "not getting". The father was a little dissociated during the sessions, whilst the mother was very stressed with a strong tendency to self-criticism, which extended to her mothering skills. Both were very eager to do their best to understand and support N.. (Both parents also had individual therapy sessions at different stages over the next couple of years to work with these issues).

They had both very much wanted a baby and were overjoyed to discover they had conceived after years of trying. They had hoped for a water birth at home, but as N. was late in terms of the due-date, they were persuaded to go into hospital, where induction drugs were given. Pethidine was then given to relieve the labour pains. After this the birth proceeded very quickly, but with N. becoming stuck whilst crowning. His mother felt shocked by the speed and intensity of the birth. It seemed to her that N. was still very "doped up" by the pethidine after the birth and that the hospital staff tried to force him to latch on when neither of them were ready to breastfeed. After this there were a number of feeding problems and he needed to be fed initially with a syringe. However they were later able to establish breastfeeding.

During the first session N. took my hand a number of times, pressed my fingers hard into his umbilical area and then pushed my hand away. Each time he did this he held his breath, arching his back and straining, as if he was trying to push something out through his abdomen. As the parents were very open to the possibility that N. was showing us something that he had experienced during the birth, I felt able to relate to them that what I was seeing was that he was telling us something about how he had experienced what had come through the umbilical cord. As he also began to rotate to his right, which was his lie-side, it suggested that that this was associated with his birth experience. The particular intensity and rhythm of his expressions were also congruent with the nature of induction drugs, which instigate much stronger and longer contractions than natural physiological contractions. This particular intensity and rhythm can be seen in many babies whose births have been induced or augmented. As he moved into the rotational phase of birth N. expressed anger, both with his eyes and in his crying. There was also a quality of ambivalence about moving forward, *as if* he was being pushed before he was ready. Many children and adults whose births were augmented or induced are very sensitive to having their own pacing over-ridden later in life and may experience even the most gentle encouragement as a forceful manipulation (Emerson, 1996, p.76).

In this session both the parents and myself were able to empathise with N's. anger. Also in being able to pull my finger into and away from his umbilicus N. was able to regulate his experience of what was coming into this area in a way he had not been able to do during the birth. At the end of the session his body was more relaxed and he was happy to breastfeed. When they arrived for the following session a week later the parents reported that N. had "matured enormously", was "more vocal" and that his head and face had "changed shape". The high-pitched crying had disappeared, as had the sense of straining.

N. presented in the second session as being more relaxed, with less compression held in his cranium along the lie-side. In this session he moved spontaneously into the rotation stage (Stage 2) of his birth, where he became very disoriented and anxious. This seemed more connected with the effects of the pethidine as he moved through the mid-pelvis. The effects of pethidine are that babies feel disconnected from their mothers, leaving them feeling alone, whilst at the same time their own awareness becomes clouded and diminished by the effects of the drug (Emerson, *ibid*, p.48). In therapy sessions as one layer of pre and perinatal experience is worked through, another will often present itself to be

worked through. This is always led by the inherent treatment plan which unfolds as the baby prioritises what needs to be worked with. *It is never dictated by the therapist.* Having resolved the layer of experience connected with the induction drugs, N. now needed to work with the effects of the pethidine and the disorientation of Stage 2. After this session, in which N. was supported to feel reconnected with his mother, the parents reported “huge developmental developments” and the subjective sense that N. was “more embodied”.

We worked together for another nine sessions, at first on a weekly basis, then fortnightly, then monthly. During this time N. continued to show BBL and memory cry, sometimes moving rapidly between a birth stage and a prenatal phase, when there was an experiential theme linking the two. The predominant prenatal theme that he worked with was implantation. This is when the blastocyst implants into the uterus wall and has its first taste of the maternal blood. He showed this through a very specific body gesture that is associated with this phase. This involves a burrowing motion with the forehead, either into a pillow or the mother's body, along with a pulsatory movement that is expressed throughout the whole body. He also threw himself violently at his mother, smashing into her with a particular force and angrily biting her. When these sort of aggressive expressions accompany the implantation BBL they tend to reflect the blastocyst's experience of meeting the uterine tissues. It can seem bizarre at first that such early cellular experiences have an impact that are then carried into later life, but clinical experience confirms this. In this case, even though N's. parents very much wanted a baby, his mother held a lot of historical stress which was exacerbated by the need to be the ‘perfect mother.’ This was held in her tissues and it seemed that N. was telling us something about his encounter with this quality in her.

In the present moment there was also a rather harsh way in which she handled him, that lacked softness. Over a number of sessions we worked with this by encouraging her to protect herself, whilst still allowing N. to express his feelings, and to handle him more gently. She was also able to express to him her feelings of regret that she had not been able to receive him more gently when he first arrived in the womb. These feelings very much arose as an intuitive response to his actions, as opposed to any interpretation by the therapist. The combination of empathy for N., self-care by the mother and change in quality of contact resulted in less aggressive behaviour in N., and a ceasing of the implantation BBL. However, as she tended to be very self-critical and masochistic in regard to how she dealt with these issues, it was suggested that she have some extra support for herself. It was at

this stage that she began a series of craniosacral therapy and psychotherapy sessions, which helped her to soften these tendencies. This enabled her to be more appropriately available for N..

Writing later of the sessions with N. she wrote, "... [they] presented a remarkable opportunity to deepen our understanding and compassion both within and outside of the family. The sessions allowed N. to express at a fundamental and pre-verbal level how he experienced his entry into the world and with guidance we have learnt how to recognise and respond to his 'voice'. He has grown into a child who can and does communicate very clearly and often showing levels of understanding about relationship that is surprising. His communication is accompanied with a confidence of 'being' in the world, and feeling free. It is very clear to us that this stems from the space created by these sessions in which he experienced the world as a place that supports, listens and acknowledges.' (Appleton (2), 2013)

In conclusion: Babies reveal their prenatal and birth experience through BBL and memory cry. These 'stories' mostly go unheard. Clinical experience shows that being able to 'hear' and respond to these stories empathically brings relief to symptoms such as inconsolable crying, fractiousness and sleep disturbances. As well as symptomatic relief it supports deeper contact and bonding between babies and their parents. As indicated in the words of N's. mother above it may also engender greater communication skills, self-confidence and empathy.

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