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## Body Psychotherapy with Parents, Babies, and Infants

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Since 1997, he has been directing a therapeutic and educational center in Bremen, the Zentrum für Primäre Prävention (ZePP) [Center for Primary Prevention]. He is also the editor of the book *Auf die Welt gekommen: Die neuen Babytherapien* [Coming into the World: The New Baby Therapies]. His second book on this topic was published in 2008: *Emotionelle Erste Hilfe: Bindungsförderung, Krisenintervention, Eltern-Baby-Therapie* [Emotional First Aid: Attachment Aid, Crisis Intervention, Parent-Baby Therapy].

Research on newborn babies and their early relationships has gradually moved into the focus of attention since the middle of the twentieth century. The results of contemporary infant, attachment, and brain research clearly substantiate the view that the psychic and bodily health of the growing child is fundamentally determined by the quality of its first attachment experiences. The increasing helplessness

and bafflement of many parents in coping with their babies has meanwhile found its way into general awareness. Issues such as crises with screaming babies, the ever-rising rate of cesarean sections worldwide, and news of cruel child murders have come to center stage for public discussion. The twenty-first-century boom in modern baby research and the radically changed attitude toward accepting the concept of a “competent infant” (Dornes, 2011) have led to an intensified discussion as to how the essential tools of modern psychotherapy (and especially Body-Oriented Psychotherapy) could be deployed in the field of prevention, crisis intervention, and trauma therapy with parents and children (Cierpka and Windaus, 2007; Harms, 2000). It is the intention here to outline some of the practical possibilities offered by the Body Psychotherapeutic approach in building up and supporting stable attachment relationships between parents and child.

### History of Parent-Child Body Psychotherapy

The beginnings of parent-child Body Psychotherapy are closely interwoven with the history of modern Body Psychotherapy. Despite having barely been acknowledged by contemporary infant research, there was significant pioneering work done on parent-child dynamics in the research on psychosomatic problems and their prevention by the physician and natural scientist Wilhelm Reich (1897–1957).

At a time when René Spitz, John Bowlby, and other psychoanalytic researchers were beginning to study the momentous impact on children’s personality development when deprived of maternal care, Reich was already con-

cerned with the basic preconditions of what constitutes that maternal love: good emotional and body contact and the ability of the mother to empathize with the needs of the child (Boadella, 2008; Bowlby, 2010). Having already made a major contribution to the development of a Body-Oriented Psychotherapy in the 1930s and 1940s (Reich, 2010), from the mid-1940s on—triggered by the birth of his son Peter—Reich became increasingly interested in the study of the natural expressions of babies, the preconditions for the development of emotional armoring, even in the nursing phase, as well as the possibility of employing vegetotherapeutic techniques on babies, infants, and their parents. In December 1949, together with forty colleagues from the specialist fields of medicine, obstetrics, and social work, Reich founded the interdisciplinary research project “Children of the Future,” with the goal of conducting a long-term study of the self-regulatory processes of and the conditions for the preservation of basic emotional health in babies and in older children. This comprehensive research project focused on the following four main themes (Reich, 1987):

1. Prenatal counseling and preventive Body Psychotherapy for pregnant women and parents-to-be
2. Attentive monitoring and supervision at the birth and during the first days of life of the newborn baby
3. Prophylaxis of early armoring in the first five to six years of life
4. Long-term study and further observation of the children until the end of puberty

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

Our infant was pale, its upper chest was “quiet.” The breathing was noisy, and the chest did not seem to move properly with respiration. The expiration was shallow. Bronchial noises could be heard on auscul-

tation. Generally the infant appeared uncomfortable. Instead of crying loudly, it whimpered. It moved little and looked ill. . . . On examination of the chest, the intercostal muscles felt hard. The child seemed oversensitive to touch in this region. The chest as a whole had not hardened, but it was held in inspiration with the upper part bulging forward. . . . Upon slight stimulation of the intercostal muscles, the chest softened, but did not yield fully when pressed down. The infant immediately started to move vigorously. The breathing cleared up appreciably, and the child began to sneeze (bursts of sudden expiration), smiled, then coughed several times vigorously, and finally urinated. The relaxation increased visibly; the back, formerly arched, curved forward and the cheeks reddened. The noisy breathing stopped. (Ibid., pp. 106–107)

In this first practical example of bioenergetically-based baby therapy, alongside the reflection about the child’s “affect,” expression, and body language, Reich utilized mainly gentle bodily touch in a playful way to release the tense muscles and tissue blocks and to open up the original expressivity of the child. In this first case study, it is the reestablishing of the child’s natural pulsation and its ability to relate that is the benchmark of the therapeutic intervention (Reich, 1985).

His daughter, the pediatrician and obstetrician Eva Reich (1924–2008), continued the tradition of her father’s bioenergetic baby and infant research (Reich and Zornansky, 1993; Overly, 2005). In the “butterfly touch” baby massage that she developed, important elements of the vegetotherapeutic work were systematized into a specific treatment sequence; she also introduced the concept of neurosis prevention into the work with expectant women, parents, and newborns (Reich and Zornansky, 1993; Deyringer et al., 2008).

In Scandinavia, a Norwegian student of Reich, Nic Waal, had developed and popularized Reich’s concept of a form of Somatic Psychotherapy in the field of child and adolescent psychotherapy, particularly for the treatment of autistic children (Waal, 1970).

From the beginning of the 1980s on, influenced by recent infant and attachment research, the first integrative models of parent-child psychotherapy were being developed that combined the approaches of attachment theory, Prenatal Psychology, Depth Psychology, and mindfulness-based psychotherapy with concepts of Body-Oriented Psychotherapy (Brisch, 2013; Brisch and Hellbrügge, 2008; Diederichs and Jungclaussen, 2009; Downing, 2003; Harms, 2008; Terry, 2006; Thielen, 2009, 2013; Trautmann-Voigt and Moll, 2010; Ventling, 2001).

### Body and Attachment

Most modern approaches to parent-child psychotherapy are in agreement about the need to improve the regulatory and attachment capacity of parents and babies; the various ways of achieving this are, however, very different. A distinctive feature of the Body Psychotherapeutic approach to this work is the consideration of the neurovegetative basis of early relational and attachment processes between babies and parents. Wilhelm Reich had already seen that the ability of the infant and parents to communicate was firmly rooted in the regulation of the autonomic nervous system (ANS) (Reich, 2010). The two fundamental branches of the ANS, the parasympathetic and the sympathetic, can be divided into basic behavioral strategies. The stress and alarm mode of a young, insecure mother expresses itself in hyperexcitation, motor agitation, pronounced hypervigilance (constant scanning of the environment for danger), and a permanent concentration of her attention on the child. Feelings of distress and harassment while in contact with the child are other phenomena of the stress and alarm division of the ANS. In contrast, a secure attachment between parents and child presents itself predominately in a relaxed body, an enhanced awareness and sensitivity, as well as an increased receptiveness and willingness to be in contact with the child. One essential focus of parent-child Body Psychotherapy consists of utilizing the body to access and to directly influence the vegetative response of both parents and child and the natural disposition to open up that is connected with it (Harms, 2013).

The American psycho-physiologist Stephen Porges shows in his recent research that the classical perspective of a two-branched ANS needs to be comprehensively reexamined (Porges, 2010). In his polyvagal theory, he differentiates *three* neural circuits involved in regulating stress and safeguarding the survival of the human organism; these neural circuits come into operation in a hierarchical sequence.

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

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

In Body Psychotherapeutic work with parents and children, we utilize an exact diagnosis of the body and behavior of both parents and child; this enables us to track and to evaluate continually the vegetative regulatory states in the course of the therapeutic process (Ogden, Minton, and Pain, 2010). By determining the regulatory mode of the body within the parent-child relationship in a situation where a parent is holding the screaming child, we can, for example, determine more specifically when the small win-

dow of tolerance that the parents have for contact with the child in this state is going to collapse and also what must be done to maintain the parents as adequate co-regulators of the baby.

### Three Levels of Parent-Child Body Psychotherapy

The form of Body Psychotherapeutic work done in Germany with parents and children is based on three fundamental principles:

1. Observing behavior
2. Focusing on mindfulness
3. Touching the body

The **first level** of therapeutic work with babies and parents consists of the nonjudgmental observation of the body language and expressive language of the relevant partner(s) in the interaction. In the context of “reading the baby,” the work focuses mainly on ascertaining the behavioral and regulatory condition of the child. When does the baby refuse eye contact? How does it react to being touched in specific zones, areas, and segments of the body? Which activities trigger stress (e.g., when the baby is picked up abruptly and without warning; when the caregiver comes too close, too fast; etc.)? Is the baby capable of returning to a state of bodily relaxation after a few moments of stress? There is an art to reading the bodily signals of the baby, and it becomes an important source of information in determining whether the child is in a more receptive, open state, or in a more withdrawn, closed state.

When working with the parents during the initial phase of the therapeutic process, we explore the spectrum of their behavior in contact with their child. The focus of this behavior-oriented perspective is on the degree of sensitivity that the parents show in their responses to the child’s body and behavioral reactions. Do the parents show a direct, or a delayed, response to signs of distress in the child? Are their responses appropriate to the respective developmental stage of the baby, or are they in length and intensity, over-

whelming or indifferent and inappropriate for the welfare of the child?

When exploring the behavior of the parents, we concentrate on those critical moments in contact with the baby, especially when they reach the limits of their coping strategies. For example, how does a young mother react when continuously offering the breast is no longer enough to calm the agitation and crying of her three-week-old baby? What does she do exactly when the baby’s screaming gets worse and her own experience of stress and disorientation increases? By observing the behavior of these parents—their breathing patterns, the way they use eye contact, and other forms of emotional expression—we can make initial assumptions about their characteristic stress and attachment patterns and therefore begin to develop suitable therapeutic procedures.

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

The **third level** of parent-infant Body Psychotherapy includes the application of various forms of bodily touch that we use to improve the capacity for contact and attachment of both parents and child. We can differentiate between two areas of bodywork here: on the one hand, the classical methods of skin and body stimulation (e.g., the “butterfly touch” massage of Eva Reich; see Wendelstadt, 2000), and the Biodynamic Massage of Gerda Boyesen

(see Claussen, 2000), etc., that essentially focus on developing the ability of both parents and child to relax. These approaches use touching techniques on the child's body primarily as techniques to strengthen the parasympathetic, releasing function of the ANS in both parents and child, which also generate oxytocin in the parent (Unvas-Moberg, 2003). By supporting the relaxation and regulatory quality of the body, we can improve the capacity of the parents and the child for opening up and relating.

On the other hand, in the contemporary approach of parent-infant Body Psychotherapy, touch is also used as a medium to establish a state of secure and safe attachment (Harms, 2013; Renggli, 2013). Especially in working with the parents, touch is used to open up an inner state that makes intuitive contact with their baby easier. In this method, the use of touch to foster attachment is always combined with mindfulness techniques. The goal is not to achieve an externally induced relaxation, but rather to encourage a subjective awareness of the altered state of openness and capacity for relating that have been activated in the course of the attachment-facilitating bodywork.

### Parent Focus versus Infant Focus in Body Psychotherapy with Parents and Infants

We can differentiate modern concepts of integrative parent-infant Body Psychotherapy according to their focus in the work with parents and children. In the prenatal and perinatal baby therapies (Emerson, 1996, 2000; Schindler, 2011; Terry, 2006), direct bodywork and relational work with the baby play a major role. In a safe relational situation, babies are invited to recapitulate any of their unfinished pregnancy and birth experiences and express them through body language. In this baby-centered approach, the child sets the pace, and chooses and processes the various themes in therapy. The accompanying work with the parents cognitively integrates the developmental origin of the body and the expressive processes of the baby. The goal of this method is to enable the adult caregivers to reevaluate the child's expressive language with empathy (e.g., "*Now I can see how distressed my daughter was, as she was stuck*

*in the last stage of birth. I see her desperate screaming fits in another light now*").

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

However, we find the strongest focus on the parents in those Body Psychotherapeutic approaches that combine body-based techniques of psychotherapy with specific video-analytical methods (Downing, 2003, 2006; Trautmann-Voigt and Moll, 2010). Here, microanalyses of video sequences are used to study how well the parents interactively match (or miss) the child's signals and the internal, psychosomatic, and experiential content that these interactions produce (Ruegg, 2007).

### Instruments of Parent-Infant Body Psychotherapy

#### 1. Bodily Awareness and Stress Exploration

As mentioned, mindful bodily awareness is utilized in parent-infant Body Psychotherapy to explore the bodily and emotional experiences of the parents during specific attachment and regulation difficulties. By targeting particular body perceptions, the objective behavioral processes of the caregivers (e.g., hectically rocking the baby in their arms) can be connected to inner emotional and bodily states (Harms, 2008; Levine, 2010). We can show an insecure mother how, in contact with her baby, to concentrate on her inner bodily and organic sensations instead of on the mesmerized, questioning gaze of the child. We thereby connect the parents' specific coping strategies ("holding and rocking the baby") with inner bodily states ("tightness

in the chest”) and with affective aspects of their attachment experience with the child (“feelings of helplessness and estrangement”).

In contrast to classical Neo-Reichian therapy, with its emphasis on the expression of repressed affective states, the attachment-based approaches of modern Body Psychotherapy focus on the perception and integration of unconscious and preconscious experiential content. As the parents learn to “somatically mark” and localize (Damasio, 2006) both positive and negative states of being with their child, they are then able to recognize much earlier when they are on the verge of losing the attachment, or the contact, and can work systematically to prevent this from happening.

Body perception, in itself, is also used as a tool to help develop a state of inner calmness and dual awareness on the parents. In the course of the therapeutic work, parents are trained to use guided attention to perceive their bodies as a source of inner information, and thus to care for and modulate the current contact between them and with their child. Together with behavior observation and the reading of the body, this internal “body scan” is one of the most important tools for the parents in reestablishing sensitivity and their capacity to relate with the child.

## 2. Respiration and Strengthening

### Attachment Bonds

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

#### 2a. Encouraging the Ability of the Body to Relax

Parents are trained to shift their attention during the inspiratory phase to their abdomen while in contact with the baby. Modulating the breath in this way strengthens the parasympathetic division of the autonomic nervous system. Bodily relaxation—a general slowing down of external activity and an improved capacity for reso-

nance and contact in the parents—is a direct result of this method. Respiration functions here as a means of influencing the deeper vegetative regulation of the body, so that the intuitive competence of the parents is more able to assert itself.

In his attachment-oriented concept, Harms (2000, 2008) emphasizes abdominal breathing, whereas other clinicians and authors (Diederichs and Jungclaussen, 2009; Wendelstadt, 2000) focus more on supporting the expiratory phase. Ultimately, both methods seem to function fairly well. Unlike expression-oriented methods of Body Psychotherapy, this work is less concerned with releasing repressed emotions and more about developing an inner frame of mind that facilitates parental contact with the child.

#### 2b. Respiration as a Means of Guiding Attention

Breathing can also be used to guide the attention, mainly toward the inner life. The parents are trained to align the breathing with direct body perception. With the baby lying on the mother’s belly, she tries to sense **from the inside** how, when she breathes in, her belly snuggles up to the child’s body. The breathing helps the mother to focus her attention on the interior of her body. Even after only a few breaths, the mother who earlier was feeling very insecure has a softer face, her shoulders relax, and her respiratory movements are more flowing and connected. She is amazed and says, “*I suddenly notice how my belly is full of warmth, just as if a warm liquid was flowing through me. Now I feel intimate and close to my baby. It’s as if the outer borders weren’t there anymore.*” The vagotonic effect of the respiration facilitates the inner perception of the body. It becomes easier for the client to identify and describe inner bodily and affective states.

#### 2c. Respiration as an Early Warning System

When the parents have learned to observe their breathing continuously from the inside, it becomes somewhat of an early warning system for the imminent breakdown of their relational capacity. For Harms (2008, 2013), the inner connection to abdominal breathing is a parameter

for the existence of an adequate receptivity and capacity for contact on the part of the child's caregivers. Losing the connective thread to breathing is a signal that the stress and alarm system of the organism is beginning to take over. So, when the parents are coping with their agitated and frantically screaming child, they can also ensure that they stay available as co-regulators for the baby, through repeatedly making contact with their own abdominal breathing.

One mother described it during a session in the cry-baby clinic: *"When my baby's crying gets so strident and shrill, after a certain point I only function automatically. I rush around the room, sit on the gymnastic ball, moving around all the time. In this phase, I cease to exist, I'm not myself anymore. When I then concentrate on the breathing, I can get myself back down. I have a focus where I can concentrate in all this craziness with my baby. Through the breathing, I find a certain kind of safety and I start to sense myself again. Even if my child goes on crying, I don't feel so alone with it all."* For many parents, two things are important: on the one hand, they can integrate the abdominal breathing technique into their everyday life; on the other, they can do something in those difficult phases, they can experience self-efficacy, and they are in a position to influence their own relational capacity constructively.

### 3. Bodily Touch and Security

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

Another area where bodily touch can be effectively employed is in Body Psychotherapeutic work with trauma-

burdened parents. Their own traumatized areas are often reactivated by the crying and agitated state of their baby, leading to temporary dissociative states. This intermittent state of panic or freezing interrupts the relational thread between parent and child. In these cases, the body and breathing techniques already discussed are of little practical use.

In this context, Harms (2013) discusses a further method whereby the therapist can utilize the established "safety station" to "log in" to the parental system. In practice, this means that, through contact with the "safety station," the therapist continuously monitors the inner situation of the client. If the contact thread grows "thinner" or "breaks off," this represents the weakening of the bond in two ways: first, it is a sign of the loss of the alignment between therapist and client; and second, it represents the weakening of the "umbilical-cord bond" and an instable connection between the parent and child. By continuously observing, naming, and evaluating the "umbilical-cord bond" in this process of dual awareness, the therapist can help to reveal and resolve any imminent breakdowns in contact with the child. Thus, through bodily touch, the therapist temporarily assumes the regulatory function of the overwrought parent. To put it another way: the professional helper becomes the bodyguard and auxiliary ego of the temporarily overwhelmed caregiver.

### 4. Strengthening the Bond through Imagination

One difficulty in parent-infant psychotherapy is that the problem with the child, as described by the parents, does not directly present itself in the treatment setting. This is especially true of regulatory disturbances in the child's sleeping patterns. It applies similarly to crying fits that occur in the evenings and then overwhelm the parents. It often happens that, while they are describing the stressful crying and sleep situations, the "real" baby is behaving perfectly quietly. In these cases, various approaches of parent-infant psychotherapy utilize imaginative techniques to gain access to those moments when parent and child are well bonded. Here, the visualizing of "successful" relational moments plays an important role. Parents are asked

to imagine a lovely situation with their child and, at the same time, to observe the inner reactions in their bodies. Imagining the early-morning cuddling situation with the newborn baby leads to an “expansive” sensation in the chest, connected to a spreading feeling of happiness and contentment. Those parents who have almost permanently lost their relationship thread to their baby have particular difficulties in carrying out this exercise, even though there may still be “successful” and encouraging moments with their infant. Positive imagination weakens the hold of negative self-judgment and can introduce a more realistic reevaluation of the relationship to the child.

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

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

## **5. The Baby as the Focal Point of Parent-Infant Body Psychotherapy**

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

### **Various Methods of Baby-Oriented Body Psychotherapy**

#### **Strengthening the Bond and Catharsis**

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

In another variation, the baby responds to the improved receptiveness of the parents with strong affective-bodily abreactions and expressive processes. In other words, the return of the parents to a state of enhanced openness is the starting signal for the child—bodily—to express hitherto-repressed experiential material. In clinical work with parent-infant therapy, this often leads to a paradoxical situation: while the parents are feeling better and experiencing an increase in security, the baby is going through an intensive (re-experiencing) process in which the pain, helplessness, and existential distress of the bonding and developmental traumas can now be more easily expressed through its body language.



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

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

### The Recapitulation of Terror

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

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

In baby-oriented process work, the therapist remains in constant dialogue with the child. The therapist "mirrors" the body language of the baby and translates it into a language that enables the parents to see the origin of the respective "problematic" behavior (e.g., the baby's uncontrollable and never-ending crying) from a different perspective and to experience it emotionally in a new way.

Due to space restrictions here, this can be only a brief description of baby-centered work in parent-infant Body Psychotherapy.

### Conclusion

Nowhere can the self-regulation of life be so vividly and directly experienced, and "health" understood so directly, as in psychotherapeutic work with babies and infants. Babies are masters of the present moment, of slowness, and of the essential encounter. Eva Reich, the daughter of Wilhelm Reich and a qualified pediatrician, wanted to make it a condition of training in Body Psychotherapy that all students should work for a while with babies, so as to gain a deep impression of their expressive language. Experiences gained in this sort of therapeutic work with babies create a new perspective on the people that we encounter as adults in psychotherapy. They give us an idea of the wounds that often originate in the earliest phase of human development, but they also provide a vision of the healthy, authentic self that exists in each of us.

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