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When the Breast Says No
The Missing Link: A Case Study

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Abstract: This paper addresses the important questions about the impact of deep emotional issues rooted in the mother's early childhood on her pregnancy, breastfeeding, bonding with her baby and the baby's development. Drawing on a study case described in the author's book, *Working with Parents and Infants: A mind-Body Integration Approach* (2007), it explores the mind-body disconnection in conditions such as mastitis, highlighting aspects of breastfeeding never addressed before. Whilst the body's wisdom is largely an uncharted resource in healthcare practitioners' work with mothers, counseling, and psychotherapy, the story told by the "somatic narrative"—gesture, posture, prosody (patterns of stress and intonation in language), sound, and movement—is arguably more significant than the story told by the words. The language of the body reveals *implicit processes* and their links with early trauma and dynamics with attachment figures. A mind-body, mother-baby relationship-focused approach, utilizing mindfulness abilities, provides mothers with a vital avenue of self-knowledge and change. It also mitigates the intergenerational transmission of developmental trauma and prevents breastfeeding difficulties.

Keywords: breastfeeding, bonding, human development

The physical sensations and experiences of a baby are seen as part of a unified continuum of physical and mental states. The significance for observers of a baby's sense of physical togetherness, or panic, or attachment through sucking (or biting) to the mother, is that it is expressive of a baby's whole state of mind/body, not a physical action alone.

(Rustin 1989, p.62)

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Here is a body, and the psyche and the soma are not to be distinguished except according to the direction from which one is looking. One can look at the developing body or the developing psyche. I suppose the word psyche here means the imaginative elaboration of somatic parts, feelings and functions, that is, of physical aliveness.

(Winnicott, 1949, p.244)

The following study-case is a vivid description of how a mother's experienced emotional neglect in early life may lead to her intolerance of physical contact with her baby and how this can manifest through her body narrative and breastfeeding difficulties. Mastitis, a breast inflammation that may prevent a mother from breastfeeding, is seen here as a symptom of a psychosomatic dysfunction. It represents the tip of an iceberg that may be the conflict between the mother's will to breastfeed and her inability to cope with the overwhelming feelings aroused by it. Even if the trauma is a thing of the past, the emotional brain (the amygdala) keeps generating sensations that make the sufferer feel scared and helpless (van der Kolk, 2015).

The mind-body oriented intervention the author proposed in a 2007 book (Sansone, 2007) is now resonating with the more recent pioneering work of Pat Odgen (Ogden & Fisher, 2015), Bessel van der Kolk (2015), Stephen Porges (2011), Peter Levine (2015), Allan Schore (2012), and Daniel Siegel (2007), to cite a few. This intervention integrates body-oriented psychotherapy into the treatment of trauma and attachment issues. These authors insightfully decode the crucial role that the body plays in regulating physiological, behavioral, and mental states, highlighting the wisdom of the body's ability to adapt to environmental conditions. They also address implicit memory and its significance in resolving trauma and attachment failure, as well as how early trauma (including neglect) and how developmental and attachment dynamics affect posture and the body narrative. A mind-body integrative approach includes the body as central in the therapeutic field of awareness, sowing observational and mindful skills and theories. These interventions are not usually practiced in psychodynamic psychotherapy.

This paper explores the relevance of implicit memory to the mother-baby prenatal relationship, birth outcome, bonding, and infant development. It values the body wisdom to access deep emotion and cognitive distortions and the role of the mother-practitioner relationship and compassion in the healing process.

The Prosody of Labor and Birth

My involvement in Andrea's case (names have been changed) began during my research/observational work on the birth unit of a hospital in

London, when my attention was drawn to sounds emerging from a labor room. The sounds were sharp and high, in an upward direction and away from the woman's body. In my experience to that point, labor sounds tended to be deep, primitive, and downward-directed, towards the area that is more involved in the process, emitted in tune with breathing and contractions as the baby descends through the pelvic canal. A fulfilling outcome of labor seems to reside in a harmonious interaction of the mother's mind and body. Since it was the early stage of labor, when the contractions are not so powerful as to induce intense physiological pain, Andrea's sounds seemed closer to screams of fright. A midwife who had just left the labor room conveyed to me that the laboring lady had been behaving that way for a few hours, though she had not yet entered physiological labor.

Screaming involves the neck, jaw, and chest and can enhance muscle tension and shallow breathing, as it tends to prevent deep breathing that involves the abdomen. Screaming produces vibrations traveling away from the body, rather than reaching the baby and facilitating his/her descent. Fear increases muscle tension throughout the body and inhibits the labor process. The result is a distorted perception of one's body and consequently of the birth process (Sansone, 2002). The adrenalin produced by fear inhibits oxytocin secretion and activity of the deep primal brain necessary for the normal unfolding of labor (Odent, 2015). It was later revealed that, for Andrea, an idealized representation of birth, associated with high expectations, had induced fears of an unpredictable labor outcome and, more generally, a fear of the unknown.

When the mother lets go rather than resisting labor and birth, breathing unfolds rhythmically and becomes a great resource for connecting with the birthing baby. A warm and softly pulsating uterus or pelvis is shaped by the mother's feelings; acting as an emotional container, it provides the best birth environment for the fetus (Piontelli, 1992).

The human voice expresses emotion through tempo, timbre, or voice quality (Sansone, 2004). Vocal communication of emotion is biologically adaptive for socially living species. Human affect bursts or interjections can be considered close to animal affect vocalizations. The development of speech, unique to human species, has relied on the voice as a carrier signal, and thus emotional effects on the voice become audible during speech (Scherer, 1995; 2003). A practitioner's ability to listen deeply, thus accurately identifying a client's emotion from voice cues, is crucial. Voice can give us information about the level of stress, muscular tension or relaxation, or embodied mindfulness, and sense of presence. In fact, tension in the mother's throat, where her sounds originate, often manifests in the way she holds her baby.

My research and observational study of mothers and infants from pregnancy and beyond led to the finding that the woman's bodyself awareness during pregnancy, labor, and birth will not only shape the

quality of her holding and interactions, but also of how she talks to her baby (Sansone, 2004). Through the voice vibrations the baby connects with the mother's internal world and senses the quality of her emotions. This embodied process begins during intrauterine life. Prosody, the patterns of stress and intonation in a language, is a significant aspect of the body narrative. Other elements—movements, posture, gestures, eye contact—are all intrinsically linked to our mental and emotional reality. For instance, a depressive state manifests itself through slow motions, a flat, low-pitched voice, and reduced eye contact.

Meanwhile, for Andrea, labor was becoming complicated and a midwife indicated that she needed an epidural. Contractions had significantly slowed and become sporadic. Several hours later, there was no change in the dilation of the cervical opening. It has been noted that laboring women may request an epidural either because they find the pain unbearable or because the fear of not being able to manage the unknown is too overwhelming. Despite the anesthetic effect of the epidural, Andrea continued emitting acute screams from time to time. Silence occasionally intervened, probably between two contractions.

The active-birth-oriented obstetrician advised Andrea of some more suitable positions to facilitate the baby's descent. It is quite unusual for a mother giving birth at the Birth Unit, where privacy is one of the guiding principle, to be surrounded by numerous staff. Although this seemed to be Andrea's choice, it may have contributed to interventions, such as forceps, being needed. During labor, breathing, contractions, and gravity need to work in synchrony. Fear is associated with altered breathing and loss of a sense of grounding. To allow her body to be guided by the process of labor, a woman needs to feel and balance gravity effectively. Although this is an implicit process, the dynamics of which may be rooted in early trust experiences with caregivers, the conscious body-perception enables a laboring woman to be led by gravity, movement, and her breathing, almost like by sea current. However, resistance to the flow of gravity prevents the uterine muscles from stretching, relaxing, and contracting alternatively, and the pelvis from dilating in rhythm with the breathing and the baby's movements (Sansone, 2004). In addition, the adrenalin produced by feeling unsafe interferes with oxytocin, which facilitates the flow of labor (Odent, 2015).

This interplay of forces sustaining labor unfolds in connection with self-trust (and trust in the other) and takes shape during our early experiences. The special attachment that develops between mother and child is the first experience of being entirely loved and trusting another human being. This unique relationship builds the foundation of the child's capacity to trust his/her own bodyself and the way he/she will relate to others. While acknowledging the importance of the birth environment and appropriate emotional support for the laboring woman, self-trust, self-holding, and grounding are essential and are built through a fulfilling

experience of being held by and trusting our caregivers in early life. We can clearly see in this case study the continuum from childhood experiences through pregnancy, birth, and beyond.

After birth, the baby was immediately whisked away to just outside the labor room and placed into a cot to be helped with breathing through an oxygen machine. This triggered a call to a neonatologist to check the baby. The infant did not seem to show particular signs of distress due to the difficult birth, although she seemed to be lacking vitality, which might have been due to resting comfortably wrapped in a towel. Meanwhile, I had recognized Andrea's voice as someone who attended my prenatal classes. Let us step back for a moment to examine that earlier experience.

Prenatal: The Virtual Body in a Shell

The portrait of Andrea during prenatal classes came to my mind clearly and strikingly. The first time I saw her, at nearly four months pregnant in a prenatal class, she showed pride in her posture and movements, and an ecstatic enjoyment about her pregnancy, an attitude she maintained throughout subsequent classes. In late pregnancy, she showed no signs in her posture or facial expressions of the tiredness or discomfort that women commonly experience at this time. Instead, she proudly assumed some flexible ballerina poses, (later on I would learn she had studied ballet as a child). Andrea used to come to the class and chat with other women, then sit on the cushion, open her legs wide, and stretch her chest forward. Observing her posture and body language gave me the impression that she was wearing her body like a beautiful dress to exhibit. Once, while talking to the group, she commented that her pregnancy had been as wonderful and perfect as she had always expected.

Andrea's attention seemed to be directed mostly outwards (to the other group participants), creating the impression that there might be difficulties in her psychosomatic integration as well as connecting with her unborn baby. Donald Winnicott (1958) beautifully described the mother's reverie as a state in which she appears absent from the world around her. Her reverie emerges from contemplating her baby during pregnancy, which helps her identify with her baby's needs after birth. A reduction in late pregnancy of the woman's need for social interactions that are not related to her "primary maternal preoccupation" has long been noted. This term, coined by Winnicott (1958), refers to a process that has survival value, as the mother starts to become more aware of and concerned about her baby (Winnicott, 1958).

Andrea tended toward speaking rapidly while avoiding eye contact. During a prenatal class run by a midwife and family therapist, during which the participants were invited to talk about their feelings and communications with the baby (topic of the session), Andrea jumped from that subject to talking about her husband or anything else but the topic at

hand. She tended to describe anything concerning pregnancy and birth as perfect and idyllic, without ever mentioning her "felt" experience. Her idealization of pregnancy and high expectation of birth appeared as a sign of a possible lack of connection with the present moment and the real baby; a trait I've noted in many modern pregnant mothers but not in African indigenous mothers, probably because they are unexposed to the stress, anxiety, and developmental trauma of Western society. My research and work with these indigenous pregnant mothers has revealed that their ability to attune with their body allows them to nurture a mental representation and expectations of the baby that are closer to the real baby.

Andrea's virtual confidence turned out to be the thick shell of an idyllic pregnancy, which she likely needed to develop to compensate for a missing experience in her early life. I would learn later, during our sessions, how such a defense mechanism is used to deny unbearable emotions related to early experiences (Freud, 1953/1974). At that stage, when I was just observing her during the prenatal classes for my research project, I did not have a clear understanding that her apparent confidence was a sign of defense and disconnection with her emotional life and developing baby. I did have an intuition of it though, guided by her somatic narrative, which is today the focus of a new kind of treatment called Sensorimotor Psychotherapy (Odgen, 2015).

Perinatal: The Birth Story

The day after Andrea gave birth, I visited her and was welcomed in a friendly manner, remembering our earlier connection during the prenatal classes. Her baby, Rosy, was lying awake in her nearby cot. Walking first to Rosy's cot to welcome her, I had not yet taken a seat when Andrea began relating her birth story. This is a need many new mothers tend to manifest a day or two after birth. "I had some problems due to the baby's position, but everything went well in the end. In the labor room there were the people I expected; Raphael (the consultant obstetrician), Clare (the midwife manager), and Helen (the midwife on duty), whose strong and alive personality I like very much," Andrea related.

Andrea's friendly feelings towards me made me think of the transference that she had begun to form earlier, during the antenatal classes. I was struck by her way of viewing her experience of giving birth with extreme optimism and control. Her language had a 'faraway' quality, and she did not turn her face toward her baby while talking. Again, her prosody and use of her body were a rich source of information about her state of mind. Then she began talking about the obstetrician, "Raphael has a strong personality, like me. Sometimes he is hard, but he can also be soft and nice." She then mentioned their frequent arguments during her prenatal check-ups, in particular the one concerning nutrition. As a consequence of that interaction, she did not want to see him for some time.

"But I like him. I needed him to be present during my labor but under the condition that he would be really interested, not because he was on duty." Her transference mechanism was clearly playing out, making me wonder about her desperate need for being noticed and "felt," something, as later revealed, she had seldom, if ever, experienced in her childhood. Transference can be an important source for inference about one's state of mind and early attachment figures.

While talking, Andrea did not make eye contact. I had noticed this during the prenatal classes, when she always looked away from the group leader. Her eyes, now rolling, then up and down, wide open, moved around quickly, while she went on saying that things in her life had always gone right. She said that she usually found the right people in the right place, and that on that day, for example, the midwife who helped her deliver was the one she liked most. Again, the movements of her eyes did not show any signs of reflective moments, which women commonly show while telling their birth story. She hadn't mention about her feelings and body experience during labor at all, such as breathing or contractions, pain, worry, or any aspect of her baby's behavior while coming into the world. Again, her language had a faraway quality and felt quite distancing. This indicated a possible denial of reality expressing itself through a tendency to over control and idealize. Idealization could be seen here as a mental process to protect Andrea and lead her away from her body sensations (van der Kolk, 2015).

Earliest Breastfeeding

At one point, Andrea asked me to pick up her baby, saying, "Rosy likes you, she remembers you very well," alluding to when I had held her a few hours after birth. Then she got out of bed, sat on the rocking chair next to me and prepared for breastfeeding. I held Rosy out to her, and then she lifted her top and adjusted the baby to her breast. She displayed an imposing, rigid, upright posture, lacking the slightest soft rounding of the chest that would have been a sign of *holding* of the feeding baby. The arm holding the baby looked contracted and fairly geometrical. Her fingers, spread out apart to hold the tiny head, revealed some tension. This, together with her tight shoulders and chest, formed the picture of a ballerina pose. At the same time, I did not see any sign of discomfort nor change in her facial expression or immobile shoulders, as is often seen in women the very first days they breastfeed, due to either early milk expulsion or unfamiliar breastfeeding positions. From time to time she repeated, "Sweetie! Sweetie! Sweetie," without making any eye contact with the baby. Dr Stephen Porges (2011) has documented the lack of expression in traumatized people and hypothesized that this reflects an inability to establish relational engagement.

The importance of the mother's soft attuned facial expressions and voice intonations to facilitate the communication and connection with the baby cannot be over-emphasized, something hindered in parents who experienced developmental trauma or attachment disorders. The attuned dance between mother and baby is meant to meet the baby's needs by picking up her cues and pace, in short, by being *receptive.* The mother's vocal tones and facial expressions resonate and amplify the intensity and duration of the affective states in both members of the dyad. The mother's eye-contact is a source of safety, feeling felt, pleasure, and vitality. The mother's breathing and chest expands, her open posture gives the loving message to the baby, "I am holding you safely." This *dancing together* allows for physiological co-regulation in both mother and baby through a good functioning of the vagal nerve, as according to the polyvagal theory (Porges, 2011). This co-regulation is essential for the unfolding of breastfeeding.

Murray and Trevarthen (1985) pioneered experiments with "still-face" and "double-video." First, mother and baby communicated happy moments with vivid expressions and the baby produced many different expressions in response to the mother and looked very happy. This was recorded in a one-minute video. The recording was a perfect copy, but when viewed later, produced only a depressive state in the baby, who looked confused and distracted. The baby seeks real conversation and coordinated and expressive bodily responses that require equally rich and expressive responses from the mother.

Reflecting on Andrea's tendency to speak fast and endlessly, even while breastfeeding, seemed to be an attempt to flee her unbearable body sensations. I recall Rosy's eyes being closed. She was dozing at the breast, just giving the occasional suck. Attunement requires conscious, unhurried, and peaceful interactions, slowing down to listen to the baby. Anxious mothers can push these interactions too fast in an effort to connect with or comfort the baby or, alternatively, they, too, can easily give up trying to engage.

Investigations by both Andrea and myself were opened up by our transference and countertransference as well as her body narrative. I began to witness Andrea's defenses, such as her tendency to hand the baby to me, or to speak fast without making eye contact, as information contributing further to understanding of her body-mind state. Over time, as I saw the intimate links between psychoanalytic interpretations and the body narrative (e.g. breastfeeding posture, lack of eye contact, type of intonation and voice rhythm, gestures, quality of holding), I came to understand that the mastitis Andrea developed later on was quintessentially psychosomatic, with an ability to communicate a hidden layer, something of value. Sadly, it is this layer too often missed out by the practitioners. Yet, it deserves sensible investigation.

A Few Days after Birth. The Missing Link

A few days after being discharged, Andrea returned to the Birth Unit crying loudly. The midwife said, "It must be post-natal depression." Later I learned from another midwife that Andrea had developed mastitis and needed to spend a few days at the Birth Unit. The day after Andrea's return to the hospital I was on my way to visit her when I saw her walk towards me holding her baby out while explaining that she needed a shower. She did not look at the baby while doing so. After her shower Andrea walked back and forth down the corridor to reception a few times while holding her sore breasts with both hands, looking as if she was carrying a tray with crystal glasses in the middle of the air.

The next day, while approaching Andrea's room, I saw a midwife who had just visited her showing signs of discomfort and powerlessness. She glanced at me and claimed, "It is a difficult case."

Mastitis, which was hindering Andrea's breastfeeding, was being treated as a medical condition by the midwives and obstetrician. The midwives assisting Andrea seemed to feel they were encroaching on the new mother's territory with their instructions for holding and nursing the baby. Winnicott had strong views about the difficulties of intervening in the parent-infant relationship. He believed that you cannot teach a mother how to hold her baby, but you can talk to her instead of the importance of providing a holding environment to facilitate her capacity to care for the infant (Winnicott, 1988; 1991). Allan Schore (2012) describes the relationship with the client as a source of healing (2012). Gabor Mate (2004) and Bessel van der Kolk (2015) talk about the effects of a compassionate empathic therapist or practitioner in inducing a physiological state in the client that contributes to healing.

As I arrived for another visit, Andrea appeared to be delighted to see me, offering a bright "Hello." The midwife attending her asked in which arm she would like to get the needle. Andrea offered her left arm while saying, "I don't need this drug." Her left arm was tied to the tube delivering medication, which prevented her from holding her baby, who was lying on the bed next to her left side. As I approached to greet Rosy, Andrea brightened and invited me to pick her up. As I prepared my arms to hold the baby, I felt this time that I had to bear the full impact of Rosy's unmet psychophysiological need for affectionate physical contact and intersubjective engagement. The seeds of her primal trauma were only too evident in her lack of aliveness, her slumped posture, and her pallid appearance. Her eyes were open but vacant and unfocused. Rosy seemed to have picked up on feelings of weariness and inadequacy.

This provided a detailed picture of a slumped and resigned body/mind state, which Hopkins (1990) describes as a lack of physical vigor due to inadequate holding and handling. This state had appeared soon after birth, indicating that it might have resulted from missing prenatal

bonding experiences. Numerous studies illustrate the sensitivity of young infants to the quality of their interpersonal engagement. The infant internalizes the mother's mental state and the reciprocal effects on the relationship, which impinges on her/his development (Murray & Stein, 1991; Murray, 1997a; Murray, 1997b). This process is increasingly threatened by our stress-driven, technological, and soul-sucking culture leading becoming parents away from the sense of presence and attentiveness required to engage emotionally and relationally with infants and children. Research has so far put no emphasis on the quality of fetal-maternal interactions as prenatal biological precursors to secure bonding and adaptive infant development, which has been examined in a study (Novak, 2004). This is why I made the prenatal origins of intersubjective engagement the focus of my current research.

During the same session, Andrea told me that she had always refused to take drugs and with anger made a gesture of nearly taking the tube off. She stated that she certainly didn't want to give any "drugs" to Rosy (meaning formula milk). Yet mastitis was preventing her from breastfeeding, revealing her implicit embodied conflict. Then she said, "I wanted an active birth, as I believe in nature. I have always thought that the best gift I could give my baby would be the breast milk." Throughout her pregnancy Andrea had planned to breastfeed and now she was disappointed and discouraged by her perceived inability to do so. Despite being a breastfeeding supporter, my goal for Andrea was to promote self-compassion and reassure she had a lot of gifts to offer her baby such as holding, touching, and cuddling, which were indeed more important and nourishing than the milk itself. I explained that several studies have shown that continued close contact is fundamental for the baby's sense of security and wellbeing and has just as positive effect as does breastfeeding.

For the first time, Andrea allowed for a long pause of silence. Her face turned pale and her voice slowed and was trembling. She was close to crying. We can see in this abrupt change, dramatically visible through her body narrative, a turning point. I felt something moving inside me as well. It was as if we were embarking onto a deeper understanding and connection, based on empathic perception and similar to that pursued in meditation practice. The therapist's capacity to "notice, allow (for being and transformation in the client as well as therapist) and embrace," common with mindfulness practice, implies letting go of intellectual verbal interpretations and a judgmental attitude. This constructive process in the therapist is often not valued in Western psychology and psychotherapy. From that turning point on, it was Andrea leading me to her primal trauma and the answers to her transference with me.

I shared with Andrea that her breastfeeding problems might be a symptom of a difficulty between her and her baby, explaining that when a parent is distressed it often seems that echoes of painful childhood experiences have been stirred up by the pregnancy and/or birth of the

baby. We explored the possibility that mastitis was not her failure but the tip of the iceberg in this turmoil of pregnancy and the neonatal period. Suggesting that breast symptoms could be seen as a positive force, helping her understand the connection between the problems in the present and her primal life, I asked her to consider that the use of her body would allow her to establish a healthy interaction of mind and body, increasing her ability to adjust to the baby's needs. The mother's perception of herself as healthy and ready to mother her baby seems to be crucial. I drew her attention to breathing to allow awareness of body sensations, while deeply breathing myself and trying to synchronize with her breathing.

Developmental Trauma

Bit by bit, Andrea began to recall her history of emotional deprivation in her childhood. Drawn back to an early set of memories, she started talking about her mother. "What I remember of her is going out with a friend and walking around to look at the shops. She never stayed at home and never had time to hug or cuddle me," Andrea said with a hint of anger. For the first time I heard how unhappy she felt, a sense of physical abandonment, loneliness, and longing to be held and comforted. Recalling these experiences prompted a welling-up of feelings of sadness, vulnerability, and anger. She recalled her sister taking drugs and being rebellious and yet, being to her mother the perfect daughter. She had always felt that her mother had so much more time and love for her sister than she did for her. Interestingly, a midwife told me that when Andrea's mother went to see Rosy after her birth she did not touch the baby but just said repeatedly, "Sweetie! Sweetie! Sweetie." Strikingly, the midwife's mimic sounded precisely like Andrea's words while breastfeeding during my earlier visit.

McDougall (1989) argued that people who develop psychosomatic symptoms, as a result of their incapacity to elaborate verbally their emotional suffering or trauma, unconsciously evoke in others (by their ways of talking and acting) the feelings that they themselves have repudiated. In fact, they frequently talk and act in the way their parents did when they were little. Because emotions are psychosomatic, these parents' incapacity to meet a child's emotional needs may lead the child to develop the symptom as a defense against emotional suffering. The core belief in having to be strong enough, characteristic of many people who develop chronic illness, is a defense (Mate, 2003). The child who perceives that her parents cannot support her emotionally had better develop an attitude of, "I can handle everything myself." Rosy would have probably had the same destiny if the cycle had not been mitigated through Andrea's body self-awareness. In fact, Rosy staring at the ceiling during the first sessions may have been an early sign of a need for self-holding. I wonder whether the link between Rosy's poor motor behavior and sluggish

emotional nuances and the mother's mind/body state might have formed prenatally as a blueprint.

Bearing in mind Andrea's ballerina pose during breastfeeding, I asked Andrea about her experience as a dancer. She said that she began studying ballet when she was very young but had to give up due to knee problems. When she recovered she took up contemporary dance, which she enjoyed very much. "But my mother wanted me to be a successful ballerina," she pointed out, while touching her swollen sore red breast and making an expression of pain. This gesture revealed, by itself, the important connection between her early experience and the present, and Andrea's intuitive understanding of it as her ego defenses and related body tightening were weakening.

Another striking link emerged in her idealistic description of breastfeeding, when she went back home three days after delivery, accompanied by a sense of disillusion. "I breastfed in a Victorian bed, imagine, with lots of cushion and in a ballerina pose. And now….lots of problems!" We know now that even though the traumatic event occurred in the past, the emotional brain (amygdala) keeps generating sensations in the present that the sufferer feels unbearable (Levine, 2015). This is why "talk" therapy only may aggravate a traumatized client's difficulty by leading them further away from solving what is stored in the nervous system.

The simultaneity of her gesture and her words left me wondering about the association between her mastitis and her knee problems, and thus about Andrea's unconscious use of her body set in early life. I reflect upon her use of her body to avoid contact with her true feelings and needs by developing a symptom (mastitis). Did perhaps her knee problems express her rebellion at her mother's control over her body and her inability to meet her needs? A child's self-model is profoundly influenced by how the mother perceives him/her (Hopkins, 1990). Whatever the mother (and the father) fails to recognize, the child is likely to fail to recognize in him or herself. In this way, major parts of a personality may be split off (dissociated) and unintegrated to protect against the pain. I reflect upon Andrea's feeling of failure and guilt about not being able to please her mother. Some painful memories about her father also came to light. "He worked in the Armed Forces and was an alcoholic. He liked going out with different women. Andrea said, "He used to say that I was not a good daughter. When he died I didn't want to go to his funeral."

In another session Andrea revealed, "She only cared for dressing me up, like a doll. I had to do what she wanted. She never forgave me for not having succeeded as a ballerina" and, referring to her father, "When he returned home from work I wished to be cuddled but he was drunk, as after work he used to go to a pub." While speaking, the complexion of her face changed, her voice acquired an emotional density and slowness and her body became still. For the first time her words did not sound "far away" from her bodily feelings. The long pause of silence and inward eye

focus gave me the feeling that a reliving of earlier emotions was unfolding. These were all signs of the healing process: the reenacting, instead of repression, of the core wounds and bodily feelings—a reconciliation of mind and body.

There are many psychoanalytic considerations to take into account when exploring such rich material, for instance Andrea's perception of her husband being angry with her for not being able to breastfeed. It is relevant to see how intergenerational patterns of mental health and behavior act in the present—during pregnancy, birth and beyond—sowing the seeds for a psychosomatic symptom like mastitis (or other forms of breastfeeding difficulty).

Vulnerability to trauma begins far before birth—before conception and is especially important in the period from conception to year two when the brain is particularly susceptible to experience. Trauma affects the bonding process and physiological activities such as breastfeeding. Andrea's unconscious working model about her baby Rosy was derived from what she had picked up as a very young infant. This misperception and identification with her child-self had been recreated in her pregnancy and birth of her baby.

Intergenerational Transmission of Mothering Model: Relevant to Breastfeeding?

The belief that parenting patterns are passed on may be well founded. Many studies have revealed that the way in which we are cared for and nurtured as infants and children affects how we parent, as well as how we interact with other people in general (Klaus, Kennel, & Klaus, 1996). Bowlby (1979) and Winnicott (1991) have documented how a parent's own experience of mothering becomes an inner model for their own future care-taking.

Ghosts of past experiences in early life can deeply affect parental feelings and behaviors (Fraiberg, 1980). Thus, long before a woman herself becomes a mother, she has learned from the way she was mothered and through observation, play and practice, a repertoire of mothering behaviors. These behaviors are taken in by the child through a complex mental process and become unquestioned imperatives throughout life. They sow the seeds of parenting far before conception. Unless adults consciously re-examine these internalized attitudes, they will unconsciously repeat them when they become parents through the use of their bodies—posture, facial expressions, quality of movements, gestures, and prosody.

What we learn in our earliest life is recorded in our muscular and visceral memory, our nervous system, and manifests in our body narrative and the way we deal with relationships (Sansone, 2004). In Murray's study on postnatal depression (1997b), the importance of maternal preoccupation with infant and child development was examined. The

infant appears to internalize the mother's trauma, representations, and the reciprocal effects on the actual relationship, which impinges on her development. For instance, a baby records the mother's voice not just by hearing it but also perceiving the emotional quality. This blueprint forms during prenatal life, as evidence of the newborn's recognition of mother's voice suggests (De Casper & Fifer, 1980). In the same way, the baby records the emotional quality of the mother's gestures. Maternal voice, touch, holding, eye contact, facial expression, and smell are co-regulators of emotions and physiological activities such as respiratory, cardiac, digestive and shapes behavior in both mother and infant (Sansone, 2004; Porges, 2011).

Today, epigenetics shows that this passing down of trauma and attitudes to next generations occurs through modification of gene expression, unless the trauma is processed and healed months before conception or even during pregnancy (Bowers & Yehuda, 2016; Lipton, 2008). Bowers and Yehuda demonstrated the association of preconception parental trauma with epigenetic alterations that is evident in both exposed parent and offspring, providing potential insight into how psychophysiological trauma can have intergenerational effects and how important preconception support and body self-awareness are to mitigate those effects.

It follows that the way in which a mother was nurtured as a child through touch, warmth, and holding influences the way in which she touches, holds, and cares for her baby (Hopkins, 1990). Nurture in our species is more nearly an art form passed from mothers to subsequent generations (Hrdy, 2009). When you have been nurtured as a baby, you know how to nurture your baby. My clinical and research work and that of others' indicates that these primal lived (embodied) experiences shape mother-unborn baby interactions and prenatal attachment, considered precursors of infant healthy development.

The pre- and perinatal periods are crucial in that early experiences resurface unexpectedly, without the parent being able to recognize their source or their effects on body/physiological regulation and the appropriate arousal needed to respond to the baby's needs. The success of breastfeeding is to a large degree dependent on the way a woman copes with the emotional surge aroused during the transition to motherhood, a major challenge for modern women. This capacity unfolds when a pregnant and new mother feels supported and thus safe.

Fostering Attuned Interactions and Reflection

As Andrea began working through memories and feelings from early experiences and paid attention to her bodily sensations, an important step was to encourage her to hold her baby, make skin and eye contact, and use these interactions as a source of healing. This helped Andrea face her

feeling of strangeness towards Rosy, rather than fleeing by entrusting Rosy to someone else. The mutual interactions, through skin-to-skin contact, eye contact, cuddling, massaging, and talking gave Andrea a sense of Rosy's actual experience, taught her to understand her body cues and reflect back and mirror what she felt Rosy's experience to be. I proposed the Kangaroo technique and infant massage after explaining their benefits, with the goal of facilitating the establishment of the biological regulatory systems of the dyad and further attune interactions and communication (Trevarthen, 2001; Sansone, 2004; Porges, 2011). There is much research and observation to show the different ways in which parents and infants affect each other physiologically, socially, and psychologically (Schore, 1994; Feldman, Greenbaum & Yirmiya, 1999; Trevarthen, 2001).

Mothers have been supported in difficult moments for millennia. Working with parents and infants is a process of sensing and communicating emotional states alongside the exploration of meanings. Andrea seemed to gradually internalize my interest in her baby and in her through mirroring. She became able to allow herself to enjoy holding Rosy, which would have not been possible without her acceptance of her inability to breastfeed and her enjoyment of her physicality. Winnicott (1987) comments that what is important for the baby is not the softness of the clothes and having the bath water at just the right temperature, but the mother's pleasure that goes with the clothing and bathing of him/her. This pleasure and love are transmitted in intrauterine life through a warm, softly pulsating uterus or pelvis (Piontelli, 1992). Likewise, these nurturing feelings are transmitted through a warm, softly feeding breast.

Andrea's awareness that mastitis was not her key problem increased over time. The bodyself awareness put her in touch with her inner world and her physiological processes. When a mother acquires bodyself awareness she can honor the baby's needs. She can regulate in her body the right arousal needed to respond to her baby's needs. And if she is dis-attuned, this is absolutely normal as a source of development, as long as her awareness allows her to repair (Stern, 1985). This flow of back and forth in mother-baby relationship has been guided by ancient wisdom for millennia.

Andrea's interaction with Rosy increased. She made regular eye contact with her and appeared to enjoy their interactions and union, often accompanied by joyful moments and smiles. They were maintaining more mutual gazes and Andrea found massaging her baby a playful experience. Attending a baby massage group also contributed to the dyad's improvement. The skin sensations evoked by massage relieved Andrea's muscular tightening and brought memories of being vulnerable and not held close to the surface, so that they were accessible to reflective exploration. Breathing awareness and the infant massage both rely on interpersonal rhythms, visceral awareness and vocal and facial communication, which helped Andrea reorganize her perception of danger and increase her capacity to manage the relationship with Rosy. We can

see clearly how Andrea's rigid breastfeeding posture, her rapid talking, and mastitis were defenses used to avoid contact with her baby, which would revive her "missing experiences."

After nine sessions, these mother-baby meetings gave me the opportunity to see Rosy in an alert state. Klaus, Kennel, and Klaus (1996) placed an emphasis on the importance of skin and eye contact in the first hours for the infant healthy development, which Rosy had missed, as well as for the mother's wellbeing. It has been identified as leading to a progressive increase in the infant being in quiet, alert state in response to being held by her mother. Andrea was also beginning to express a newfound liveliness, curiosity, and eagerness for interaction. These changes were made in the context of a positive relationship with me, leading to identification with me as someone who could enjoy playing with infants and who understood this in terms of transference through the body narrative (the mother's relationship with her own mother and her relationship with her baby both being re-experienced through the transference).

Mindful observations of the mother-baby narrative during gestation, birth, and beyond and its manifestations in their bodies and behaviors help the mother experience a sense of what her baby really needs in an atmosphere of safety and respect. The mother becomes able to narrate the day both prior and after birth; "Now you're awake, do you feel my touch?" or "Rest peacefully" (to her unborn baby), or, "The sun is out…" and observe the baby's responses. Bodyself awareness allows a pregnant mother to mindfully observe the links between her touching the belly and the baby's movement in the here-and-now moment.

Through mindful attunement to the body's experience and tracking sensations, rather than paying too much attention to the story, mothers can get a sense of what their bodies require to protect themselves. It is this realization that unleashes the potential of prenatal attachment/bonding by mitigating the transmission of unprocessed trauma. This awareness of sensations is crucial as it provides the baby with a vital avenue for thriving. The baby, beginning in intrauterine life, primarily learns through sensations or bodily experiences. This awareness is coupled with greater awareness of relationship and attachment, as well as bringing into consciousness those familiar patterns we grow to defend ourselves. If the memory of trauma is encoded in the viscera and skeletal muscular system, mind-brain-body communication is the royal road to emotional regulation and healing (van der Kolk, 2015).

Implications for Prenatal and Perinatal support

Evidence suggests maternal prenatal attachment towards her unborn baby is a good predictor of the mother-infant relationship, as indicated by the videotaped mother-infant face interactions at about 12 weeks postpartum (Siddiqui and Hagglof, 2000). We learned early on that fetal-

maternal interactions have a psychobiological effect and predict secure bonding and adaptive infant development (Novak, 2004). Attuned interactions channel and enhance physical and visceral energy, thus have a neurophysiological effect and impact on infant wellbeing (Trevarthen and Delafield-Butt, 2013). These findings provide a foundation for assessing and improving prenatal attachment and intersubjective engagement through nurturing support, to enhance mother mental state as well as help give children a healthy head start before birth.

Beginning with conception, the environment signals "all the way down" that the child is loved and welcomed (Emerson, 1997; Lake, 1997). This energy state is transferred to subsequent generations, as studies of epigenetics indicate. Lipton (2008) discusses the importance of a mother's emotional wellbeing during pregnancy and the powerful impact her emotional state has on her baby. This shows why it is essential for mothers to care for themselves or be supported as they care for their children. This paper is an urgent call for viewing breastfeeding within this whole picture, not as a separate function.

The quality of prenatal attachment, which was underdeveloped during Andrea's pregnancy, is essential for development, because the interactions upon which it is based provide an embodied intersubjective matrix as the material from which the mind is created. Clinical accounts argue that parents' anxiety, depression, and stress may harm the vital intersubjective bonds, birth, and development (Ammaniti & Gallese, 2015; Verny & Kelly, 1981). Bonding far before birth is vital for growth (Branjerdporn, Meredith, Strong, & Garcia, 2016). I wonder whether Rosy's small size was to some extent related to the missing bonding.

Unfortunately, when I began to see Andrea, three days after birth, it was too late for the breastmilk to flow back. However, Andrea's growing awareness of her bodily feelings and narrative and their links with the neglect she experienced as a child opened up to new possibilities other than automatic, habitual reactions. Mindful observations put her in touch with the transitory nature of her feelings and perceptions, recognizing the ebb and flow of her emotions. These transformations led her to three subsequent fulfilling pregnancies and extended breastfeeding experiences.

Neuroscientist Joseph LeDoux and his colleagues have shown that the only way we can access our emotional brain and bodily feelings is through self-awareness, i.e. by activating the medial prefrontal cortex, the part of the brain that notices what is going on inside us and thus allows us to be aware of what we're feeling in the present moment, process called "interoception" from the Latin "looking inside" (Moscarello and LeDoux, 2013).

It is of utmost importance that all pre and perinatal healthcare professionals be aware of the delicate body narrative between mother and baby and how it impacts on the wellbeing of both, so as to promote interoception. To quote Winnicott (1987), "A baby cannot exist alone, but it is essentially part of a relationship" (p. 231), therefore any feeding or

other developmental problems need to be seen in the context of this relationship, which is also open to environmental influences.

A becoming/new mother needs to be mindfully nourished on body, mind and spiritual levels, not simply being provided with information-based education. Observing the baby's patterns over time, the links with gestation and birth experience help us to understand the baby, but also promote reflective functioning in both mother and baby. Recall that baby mirrors all that is going on in the mother, and mothers can mirror a mindful compassionate caregiver, who can inspire mother's compassionate relationship with her baby. Attunement and reflection are foundations of fulfilling pregnancy, parenting, and a parent-caregiver healing relationship.

Unfortunately, the correlations between mastitis or breastfeeding difficulties in general and maternal emotional/mental health or developmental trauma are still relatively unexplored and more studies should be done. Yet these correlations frequently appear in perinatal conditions. There is an urgent need for addressing this widespread societal problem and missed breastfeeding opportunities for mothers' and infants' wellbeing. Shouldn't we really be asking the question why so many women have issues about breastfeeding? Why did women find extended breastfeeding uncomplicated for millennia? It may be because they received constant support from other experienced mothers and as young girls they were constantly exposed to other women breastfeeding as a matter of routine, as it still happens in indigenous and traditional societies.

Donald Winnicott (1987) insightfully suggested that the mother's milk does not flow like an excretion. This flow is a response to a variety of elements: the sight, smell, feeling, and thinking of the baby. I recall the "thinking breast" described by Bion (1962), which I would replace with the "feeling breast." The periodic feeding develops as a communication between mother and baby based on rhythmical exchanges of cues, a song without words, or a dance, in which the infant's need to be fed and comforted are both met.

Pre- and perinatal healthcare professionals as well as policy makers should adopt this perspective and tackle the underlying problems by creating mindful environments that support breastfeeding, its prenatal precursors, and the mother's whole experience of it, as well as honor motherhood and invest in new families.

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