Being with Newborns: An Introduction to Somatotropic Therapy® Attention to the Newborn: Healing Betrayal, New Hope for Prevention of Violence

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Abstract: *Being with Newborns* represents the essence of the lifework of Ray Castellino (1991,1995), a pioneer and innovator in the realm of Prenatal and Perinatal Psychology. Written in 1996, he introduces Somatotropic Therapy®, which expands cognitive and emotive therapies to include the body—the soma—in the evaluation, treatment, and prevention of prenatal and perinatal trauma. Origins of shock and trauma in the bodies of neonates are identified as well as characteristics exhibited by those infants imprinted by overwhelming events. Therapeutic interventions are suggested for treating these imprints, and seven steps are outlined to heal the thoughts, feelings, and sensations of betrayal. This paradigm shift holds the key to healthier individuals, families, and society at large.

Keywords: prenatal psychology, imprinting, trauma, betrayal, trust

Contrasting passages and new hope: Conception, gestation, and birth are miraculous events. One can easily look into the eyes of a newborn child and be wonder-struck by the miracle of life. Ideally, the little one has two loving parents who prepared themselves spiritually, emotionally, and physically before they conceived. The new conceptus is wanted and joyously welcomed with love. Early in their pregnancy, the parents developed an awareness and felt sense of the new soul's presence, and are also mutually supportive of one another. The parents have learned to treat each other with love, respect, and gratitude. Sharing a deep, intimate connection, they lovingly resolve conflicts with each other. They eat well,

Raymond Castellino, DC (retired), RPP, RPE, RCST®, drew on 50 years of experience as a natural health care practitioner, consultant and teacher. He was a pioneer in the field of Pre- and Perinatal therapy and of using energetic and somatic approaches to facilitate attachment and bonding. His practice focused on the resolution of prenatal, birth and other early trauma and stress and developing teachable methods of supporting families and small groups of adults. He practiced and taught in the healthcare field since 1970 and offered prenatal and birth therapy since 1993.

exercise, self-reflect, give and receive nurturing, and are loving. Moreover, they are able to accept and reflect, to the new life within them, their awareness and awe of that being's profound essence. They offer this reflection without projecting their self-fulfilling desires and expectations on the new one. On his[1] birth day, this baby is supported to fully participate as he finds his way through the birth canal. The parents of this baby and the birth support team know that, given the appropriate circumstances, he is able to be aware and able to participate in the process. This birth passage reflects and expands the joyous welcome he received at his conception. In contrast to this ideal example, most babies find their passage into physical life much more challenging. In fact, I believe the greater percentage of all babies experience some degree of shock in their birth process.

For much of the twentieth century and, indeed, for a considerable time before that, pregnancy care and birth practices focused around the obstetrician's perceptions and needs. By the 1950s, concerns for the mother were growing, but only within the last 25 years has the experience of the baby been an important consideration, and then only rarely. In fact, the prevailing views of parents and health care professionals in 1995 still reflect beliefs that babies are too little and undeveloped for prenatal experiences and birth to have traumatic effects on them. It is an understatement to say that birth, at best, is hard work for the babies.

We, William Emerson, Franklyn Sills (1989), and myself conservatively estimate that more than 85% to 95% (and I personally believe that perhaps 98%) of the population experiences some degree of prenatal and birth trauma. This trauma has lifelong impacts on the individual unless it is somehow healed. We are collecting a mounting body of evidence that indicates that prenates and babies routinely experience trauma which has substantial spiritual, mental, emotional, and physical consequences. We have found prenatal and birth trauma to primarily impact goal structures, life assumptions, self-identity, self-esteem, personality structure, and behavior of the emerging person. Prenatal and birth trauma is so widespread that only the most obviously injured are recognized and identified. Rarely do I meet a parent or health professional who has the ability to relate a baby's behavior and struggles to events that happened in the womb or at birth.

Recently, I had a discussion with a dedicated lactation consultant about a particular baby's inability to attach at the nipple. She was surprised to hear that colic and breastfeeding difficulties can be post-traumatic stress symptoms resulting from birth trauma. The idea that resolution of physical and psychological issues which interrupt bonding between infant and parents could lead to specific improvement in infant

[1] For ease of reading, all babies will be referred to as "he" and caregivers as "she" rather than use "his or her" or "them."

breastfeeding was foreign to her. Though a baby will often display signs of trauma history, few understand that the baby can be assisted in coming to terms with traumatic experiences.

For more than two decades, advocates for prenates and babies like David Chamberlain, PhD (1988, 1992, 1994), Suzanne Arms (1975, 1994), Thomas R. Verny, MD, (1981, 1991), Frederick Leboyer (1975), Michel Odent (1984) and others have gently yet emphatically directed our attention to the experience of the prenate and newborn. As they make abundantly clear, the primary consideration for prenatal and birth experience must now focus on asking: What is the unborn and birthing baby's experience of prenatal life and birth, and how can we best support the unborn, birthing, and newborn baby to reach his or her full potential?

Evolution of an Energetic and Somatic Prenatal and Birth Model

A theoretical basis for the evaluation and treatment of prenatal and birth trauma in infants has been developed by Dr. William Emerson, Franklyn Sills, and Dr. Raymond Castellino. We have developed new tools for assessing and treating prenatal and birth trauma. This new evaluation and treatment model has evolved out of our personal internal quests and seeking. We have correlated our personal regression explorations, our exhaustive inquiries into pre- and perinatal psychology, Polarity Therapy, other bodywork disciplines (including osteopathy, craniopathy, chiropractic, and Chinese medicine), psychotherapy, a thorough study of obstetric and midwifery practices during pregnancy, labor, birth and post birth, pediatric care, and a review of related scientific literature, with clinical observations of thousands of babies, children, teenagers and adults in our practices.

We (Emerson, Sills, & Castellino) have cross-correlated energetic, mental, emotional and physical patterns observed in adults while they were in prenatal and birth regressions, with energetic, mental, emotional and physical patterns observed in babies and children. These patterns have then been correlated with what is known about their birth histories. Often historical prenatal and birth events discovered during therapy sessions were positively confirmed by parents' recollections and/or medical records *after* the therapy sessions.

We have charted specific body structural patterns, cranial molding patterns, cranial lesion patterns, fine micro body movement patterns, and larger gross body movement patterns in relationship to what happens to babies during the birth process. Specific structural, cranial, and movement patterns of the baby relate directly to the pelvic shapes, soft tissue tension patterns of their mother, and how they move through the birth canal. It is interesting to note that the bulk of this clinical research was done by observing how babies, teenagers, and adults presented during therapy sessions *before* we researched obstetric literature. When we reviewed preexisting obstetric research dating back to the 1930s and still

being reported in modern obstetric texts (Oxorn-Foote, 1985), we found confirmation of our empirical, personal, and clinical research in medical x-ray studies of babies and moms while they were in labor (Caldwell & Malloy, 1933).

Prenates and newborn babies are capable of much more than previously believed. Prenates and newborn babies are conscious, sentient beings. Sonography reveals that prenates communicate through expressive body language with self-initiated, reactive, and interactive movements (Chamberlain, 1994). Newborns and babies actively and passively communicate their needs, their feelings, and their stories. Their behavior and body language teach us how to contact and support them.

Stressful and traumatic events during prenatal life and birth imprint both the baby's body and the baby's psyche. Traumatic imprints overlay the true self and profoundly impact the emerging person and how they will be later on in life. Body structure, movement patterns, sense of self, and lifelong strategies manifest from these early traumatic imprints. Simply stated, trauma impacts can result from a single event or series of events that, in any way, cause overwhelm to a person's spirit, psyche, or physical body. A trauma to one level of being will necessarily affect other areas. An impact to a person's psyche will have a corresponding record in the body and vice versa. The severity of trauma impacts is directly related to the degree of overwhelm, the extent to which a person's system experiences shock and the ability of the individual to recover.

When trauma imprints a prenate or birthing baby, stress responses or reactive patterns are also established. These stress patterns are then repeated and reinforced throughout life unless something happens to resolve that trauma. This pattern response is initiated during prenatal life and set into physical structure during birth. We hypothesize that people with unresolved prenatal and birth trauma have higher levels of catecholamines in their blood levels, which have been correlated with acceleration of the aging process and the loss of elasticity in connective tissue. We suspect the reverse to also be true. Those who have resolved their prenatal and birth trauma have reduced levels of catecholamines in their systems. The long-range effects expected in people who have resolved their prenatal and birth trauma include longer, more productive and creative lives, less stress, and fewer chronic health concerns.

We (Emerson, Sills, & Castellino) have well documented case histories of babies treated with the innovative methods we have developed. Over the years, we have seen babies heal their birth trauma, often within their first year. Many of these babies are now children. Some of them are teenagers approaching adulthood. These young people are turning out to be rather extraordinary people who are physically well coordinated, emotionally clear, and mentally alert. Moreover, they appear to have profound spiritual depth and compassion for their fellow human beings and other living creatures. These children tend to show leadership

qualities, clear boundary structures in their relationships, and clear communication skills. Their parents often describe them as being the "most together" people in their families. Lastly, these children show interests, aptitudes and exceptional abilities in areas not necessarily related to their parents.

William Emerson reported to the 4th International Congress on Pre- and Perinatal Psychology in Amherst, MA in 1989 the results of a 14-year study that included 30 babies. Fifteen babies were treated and 15 were in the control group. All of the babies were from normal and psychologically healthy families. All were thought to have had normal births. Eighty-seven percent of the children in the treatment group showed early signs of individuation. In the non-treatment, control group only 14% of the children showed signs of individuation. Individuation is the process whereby individuals learn to perceive themselves as different and unique human beings, able to discover their own uniqueness and materialize their deepest interest, talents, and abilities.

Treating the Neonate—The Transition from Birth Shock

Shock imprinting results from any event that overwhelms an individual spiritually, psychologically, physiologically, and/or structurally. Unless resolved, shock imprinting will impact one on all levels throughout their life. Trauma and shock imprinting overlay and interrupt access to the primary self, psychological development, learning abilities, sensory and motor function, autonomic and organ function, proprioception, balance, coordinative function, and structural integrity. Resolution of pre- and perinatal shock imprinting occurs when shock imprinting is transformed to allow one unimpeded access to his or her primary being and integrated functioning of their organism. Somatotropic Therapy® provides people of all ages, including infants, the unique opportunity to heal and resolve prenatal and birth trauma and shock.

Shock from the pre- and perinatal period clearly affects the neonate on the imprinting level. Generally, it takes a baby three weeks to emerge from a shock affect state after birth. Some babies can take three months and longer. Emerging out of shock affect, however, does not mean the baby heals the shock trauma. Most babies emerge from the shock affect period by developing survival and compensation habits that are directly influenced by shock imprinting.

In this paper, the newborn period is defined as the time a neonate takes to transition from shock affect behaviors. Non-traumatized or trauma-resolved babies do not demonstrate shock affect behaviors. Most babies, however, demonstrate affective shock behaviors through physiologic, physical, and emotional patterns immediately after birth and for several weeks. Several neonatal examination and assessment tools have been developed. The more widely used medical and pediatric examination tools include physiologic, physical, neurologic, Dubowitz

Scoring System, and the Brazelton Neonatal Behavioral Assessment Scale (Brazelton, 1984; Reeder et al., 1992). These evaluation systems are indeed useful. However, they do not account for the long-term effects of shock imprinting on the newborn. It is our hypothesis that the current infant developmental norms are based on traumatized populations not on non-traumatized or trauma resolved populations. Later in this paper, lists of characteristics, behaviors, and abilities of the non-traumatized neonate and shock affect characteristics in neonates are presented.

Infant-Centered Approach

One goal of the Somatotropic process is to resolve prenatal and birth shock imprinting. This approach is infant centered. The baby is more important than assessment scales and assessment processes. All therapeutic interactions are to be conducted with the baby's permission and the parents' protection of the baby. The practitioner needs to develop contact, trust, and rapport with the baby and the parents. The practitioner's responsibility is to advocate for the baby and educate the parents.

The Somatotropic practitioner observes and acknowledges the neonate's pacing cues, attention responses (the direction he moves his attention to the external world and how he withdraws his attention away from the external world), states of consciousness, movement patterns, reflex behaviors, musculoskeletal tonality and tonal changes from hypotonic to hypertonic, verbal expressions (murmurs, coos, giggles, different crying states), facial expressions, and postural preferences. Practitioner, caretaker, or parent acknowledgments may be verbal, empathic, and/or physical. Practitioners' acknowledgment responses, particularly emotional reflective responses are modulated to accommodate the neonate's ability to integrate them. For example, a baby may be in a concentrated state and experimenting with new behavior by picking up an object or turning himself over. The unmodulated excitement of attending adults may distract the baby, thus interrupting the continuity of the baby's concentration and movement pattern. Modulating practitioner responses will be discussed below under the heading, "The importance of negotiating distance and boundaries." The practitioner attends to the neonate's environmental needs as well, especially with respect to room temperature, need for covering, ambient and sound levels in the room, ambient and direct light in the room. Room conditions are monitored to support the infant to discover a state of present relaxation. All therapeutic interactions are done with gentle verbal forewarnings to the infant, acknowledging their responses, and soliciting their active cooperation. This principle is so important that it holds true even if emergency care is needed or the baby appears asleep or unconscious.

Characteristics, Behaviors and Abilities of the Non-traumatized Neonate

Non-traumatized Neonates Demonstrate the Following Characteristics, Abilities, and Behaviors:

- eyes are clear and present
- eyes coordinate normal convergence
- ability to orient to visual, auditory, and tactile stimuli
- ability to smoothly move from one sensory stimulus to another without breaks in movement continuity
- general balanced tonicity throughout the body
- appropriate homeostatic autonomic responses to stimuli (i.e., if the light changes, the pupils will respond in kind; if activity demands change, respiratory and pulse responses will meet the demand)
- Moro or startle response is present with clear and present danger only
- movements of the extremities are smooth and without breaks in continuity
- smooth trunk movements of the body in flexion, extension, lateral flexion, and rotation movements at will
- accurate proprioception (they know where they are in space)
- strong sucking response
- holds head up and turns head from side to side to orient at will
- balanced cervical and suboccipital muscle tone
- absence of shaking or tremors
- deliberate response to near or direct touch
- matches gentle tactile pressure with extremities, head, or trunk of body
- crying corresponds to need

- able to cry with full range of sounds and emotional content
- able to differentiate emotional expressions
- enjoys experimenting with movements, sounds, and expressions
- body positions and movement patterns do not interrupt ability to orient
- vibrant skin color
- chooses to make contact deliberately
- voluntarily moves attention from inside to outside
- shows interest in new experiences
- voluntarily grasps
- moves to mom's breast, latches on, and feeds

Subtle Energetic, Fluid Tide and Cranial Characteristics of Non-Traumatized Neonates:

- full palpable energy field with distinct clear boundaries
- free flow of vital energy throughout the body
- round, full cranium, absence of cranial molding
- full strong potency of vital fluid tides
- full fluid tide inspiration and expiration patterns with appropriate physiologic reciprocity
- easy expansion and contraction of the cranial field within normal physiologic movement patterns
- able to meet stress with appropriate energetic fluid responses, lateral fluctuations, and still points

Shock Affect Characteristics in Neonates

Gross Observable Shock in The Neonate Is Indicated by the Following:

- glossy eyes
- eyes do not converge normally, but cross or split
- total or partial inability to orient to visual, auditory, and tactile stimuli
- generalized or body area specific hypotonicity
- involuntary changes in autonomic responses including pulse, respiratory rate, skin color changes, pupil changes in the eye
- Moro response or startle response to sound or movement
- jerking movements of extremities
- inability to hold head up
- hypermobility of neck, especially at occipital-atlantal junction
- involuntary shaking or tremors
- tactile sensitivity to near or direct touch
- total or partial inability to match gentle pressure from direct touch with extremities, head, or trunk of body
- weak, hollow, or empty crying sounds
- high pitched crying sounds
- crying inconsolably, getting lost in their emotions without ability to make visual, auditory, or tactile contact
- frequent crying without apparent reason
- lack of skin color
- total or partial absence of alertness during awake states

- withdrawal sleep to light, sound, or movement sensory stimulation
- inability to voluntarily shuttle attention from inside to outside or outside to inside
- inability to grasp

Subtle Energetic Fluid Tide and Cranial Shock Affect Indicators:

- weak energy field without clear boundaries
- erratic energy field patterns
- counter-clockwise umbilical pattern
- unresolved cranial molding
- unresolved postural patterns
- weak potency within vital fluid tide
- total or partial inability of fluid tide potency to build
- long weak still points
- stops in the fluid tide patterns
- cranial strain patterns
- non-physiologic cranial movement patterns

All Behavior Has Purpose

Every expression and movement a newborn makes has purpose. Babies do not do anything without purpose. Breaks in the continuity of movement patterns are obvious and easy to identify. An obvious movement pattern which demonstrates breaks in the neonate's integral continuity is jerky movements. The baby's nervous system is unable to deliver an integrated motor signal in a consistent even flow from their neocortex. Non-traumatized babies, including neonates, are observed to move their limbs and body in even continuous patterns.

Muscle Tone Change in Response to Shock

Muscle tone, body and extremity movements factor together in the process of emerging from the shock affect period. Hypotonicity in any muscle layer is indicative of preceding shock trauma. Hypotonicity at the occipital atlantal junction has been positively correlated with sudden infant death syndrome (SIDS; Schneier & Burns, 1991). The degree of hypotonicity present correlates to the degree of shock the neonate has experienced. Movement patterns and interruptions in movement patterns are also indicative of previous shock experience. As babies grow, increase in size, weight, and muscle tone will compensate for the unresolved shock affect patterns in their bodies. The increased muscle tone will override and mask the underlying discontinuity in the motor impulses resulting in movements that appear smooth but are actually not fully coordinated.

Parents, caregivers, and healthcare practitioners will often mistakenly assume that babies have grown out of the shock affect period because the jerky movement patterns and other indicators like Moro reflexes have gone away. More often, it means the babies have learned to compensate for the shock trauma by developing survival strategies and behaviors. As babies gain muscle tone, they will necessarily have more physical sensations in their bodies. At first, these feelings can be uncomfortable, painful, and disorienting. Seemingly calm quiet babies who were actually withdrawn may all of a sudden become irritable and inconsolable several weeks after their birth as they emerge from the neonatal shock affect period.

The Importance of Negotiating Distance and Boundaries

Neonates in the shock affect period are often hyper-responsive to outside energy including the intentionality of people around them. Practitioners must learn to monitor their own intentionality and observe when and how a baby reacts to the energetic tension fields originating from the practitioner. The practitioner, parent, or caregiver may, out of concern, move their attention toward the neonate, which has the potential to create an energetic pressure on the neonate that stimulates an overwhelm, or shock affect, response in the baby.

A practitioner must first negotiate distance and boundaries with their intention so they can know the parameters of what the baby can accept. Once this is accomplished, the practitioner will be able to intentionally track the baby's energetic patterns, fluid tides, emotional and autonomic responses, and physiologic and physical patterns. This kind of tracking will reflect the baby's subtle movement patterns in a way that affirms his presence and the choices he makes for his consciousness and his body. This reflective affirmation process on the intentional level increases the baby's ability to know for himself his individuated felt sense and sense of safety within the environment. When he is truly not safe, he will

communicate that lack of safety by motioning for support and making sounds that elicit support from caregivers (a baby's way to ask for help).

Strategies for Establishing Contact through Touch or Near Touch

Parents, caregivers, and health care practitioners need to know that the process of coming out of the shock affect neonatal period can be painful. As the babies come out of shock affect, they become increasingly aware of their bodies. It is a process of coming into their bodies. The process of coming out of the shock affect period is multilayered. Practitioners must titrate this process. If babies come out too fast, they will be shocked into their bodies. This was the problem with hanging babies upside down and spanking them at their births (a procedure discontinued for about 20 years).

A conscious process is necessary to establish the contact, safety, and rapport which allows the practitioner to develop a primary therapeutic relationship with the baby. Babies need to be forewarned of any therapeutic intervention, no matter how gentle the intervention appears. The same care needs to be taken when establishing near or direct touch with the neonate, whether the baby appears awake or asleep.

A useful strategy in establishing contact with a neonate who is demonstrating mild shock affect behavior is to first watch his movements. Observe him move an arm toward you or to the side. Note the degree of jerkiness or weakness in the movement. Put your hand out as an offering and allow him to choose to come to you. In this way the babies initiate the contact. Then follow the infant. As the baby makes contact with you, the presence of your relaxed, open, stable hand supports him to experience stable movements with the extremity that you are following.

In contrast, if the practitioner moves their hand toward the baby, especially if it is inadvertently moving toward a trauma site, they will more than likely stimulate a reactive response in the baby. Such stimulation can often activate an infant into his trauma and recapitulate his preexisting trauma. This can happen especially if the practitioner is moving fast. Their hand will move through energetic boundaries, thus activating trauma memories in the infant. My preference is to observe a baby's movement patterns first. Then I simply put my hand at the edge of the baby's movement pattern so that he contacts my hand as he continues his movements.

Babies Mediate Their Sensory World

Watch what the baby does with his consciousness in relationship to outside input. Is the baby capable of moving his consciousness or attention toward the outside input? Does he move his attention visually, auditorily,

or kinesthetically? Watch him on all three of these planes. The outside input is typically over-stimulating to a baby with shock imprinting.

A baby can't really stop outside sound, but the first thing he can modulate is the muscles of his eyes or eyelids. He can look away from overwhelming stimuli or he can close his eyes. He may close his eyes when there is too much light, to cut out the stimuli and to have some control over it. He may also close his eyes in an attempt to ward off overwhelming mental/emotional or psychic intention from others. The eyes are said to be windows to the soul. By watching a baby's eyes, the trained practitioner can observe where the baby is placing his attention in time and space and note if the baby is withdrawing from certain stimuli or moving his attention toward stimuli. Neonatal overwhelm can impede an infant's ability to orient to space or primary caregivers. Moreover, neonatal overwhelm can impede the infant's ability to realize how to observe, show interest, and make contact with his world.

Babies can even move away from another person or overwhelming outside stimuli. For example, if you move your hand toward a baby, he may move his arm away or turn his body away if he doesn't want to be touched. The contraction wave that moves through the tissues as an intentional moving away from a stimulus starts on the inside and moves to the outer layers because the contraction is a motor response.

If the baby doesn't physically move away but just withdraws his attention from the stimuli, the practitioner will see or feel an energetic and/or tissue contraction wave move from the outside inward. You can experience this in yourself by slowly and intentionally pulling your attention inward and mildly resisting the withdrawal at the same time. This can feel like a slight sinking in the body. The resistance you create will amplify the sensation of withdrawing your attention.

Suggested Therapeutic Interventions for Approaching the Neonate Demonstrating Shock Affect

1. Track the baby's energetic and autonomic responses.
2. Verbally acknowledge what he is doing and give him permission. The practitioner may make statements like, "Oh, going in. That's right."
3. Suggest the notion that he is making a choice. The practitioner statement might then be, "Oh, going in. That's right. It is a choice."
4. Change the environment. If it is too bright, dim it. If it is too loud, lower the volume. If it is too tactilely coarse, give the baby softer textures.
5. Slow the pace down by relaxing, slowing your own energetic, autonomic responses and voice.

Crying, Comforting and Nursing for Comfort

Many new parents have difficulty "letting" their babies cry. They may feel uncomfortable, ashamed, or guilty and attempt to soothe them. Addressing the baby's need to cry and the parent's need to soothe is a very important aspect of therapy. Having parents identify, process, and repattern their own feelings about their baby's need to cry can be helpful. Some practitioners are adamant that babies need to cry to discharge unresolved emotions. William Emerson, Peter Levine (1991), Aletha Solter (1984, 1989), Wendy McCarty, and I all agree that an infant crying should be supported to not get lost in the emotions. We all agree that babies should not be left alone "to cry it out." When babies cry, I believe it is the primary caretakers' responsibility to rule out the most obvious reasons for crying such as hunger, wet diapers, physical pain, and discomfort. The primary caretaker is then responsible to maintain visual, emotional, and physical contact with the baby until the crying resolves.

If a mother is consistently using the breast to soothe her baby, then she may be giving the baby the message that it is not okay to cry. This process can result in fetal therapist (Emerson & Schorr-Kon, 1994) inclinations in the baby. The baby may be inclined to take care of the emotions of the mom and other primary caregivers. If the mother nurses the baby for her (the mother's) own comfort, then the baby becomes the mother's emotional caretaker.

Or the mother may have unresolved feelings of guilt that come from previous generations, her own personal unresolved issues, and/or from traumatic events that occurred during pregnancy and birth. She may then over-compensate by attempting to subdue the baby's cries when the baby needs to cry. These, I believe, are primary confusing factors for babies that can potentially lead to dysfunctional behavior such as eating and sleeping disorders in the future.

Some nursing support professionals counsel new parents to be careful not to mix feeding with satisfying the baby's need for comfort. They state that it is best to nurse only when the baby is hungry. These practitioners hold the view that the purpose of breastfeeding is for eating. Breastfeeding, they feel, should not be used to soothe the baby. In their view, babies should be encouraged to manage their emotions with different resources other than at the breast. This strategy can be useful for babies who do not demonstrate shock affect behaviors or babies who have access to other resources to console themselves or be consoled by others. This strategy can be counterproductive for babies during the neonatal shock affect period.

I do agree, however, that it is not in the baby's best interest for mom to put the baby to breast in an effort to quiet him. When a baby cries, the cry has a purpose. Obvious indicators such as hunger, wet diapers, physical pain, etc. should be ruled out first. Aletha Solter (1984, 1989)

points out that babies need to cry to discharge stored feelings. However, Dr. McCarty and I find that, as we train babies and parents to discover the ability to go to a state of quiet presence within themselves, babies are more able to express deep felt emotions with contact and consolability.

Shock affect often inhibits access to consolation. Babies with shock affect behaviors often cry inconsolably and will appear to cry themselves to sleep. It is my observation that this is not sleep at all. These babies may actually be crying themselves into a dissociated shock withdrawal state that appears to be sleep. It is essential to take into account that during the shock process, different emotional sets are compressed together (Levine & Graybeal, 1991). This means the baby will experience several emotions and sensations that at least cause confusion and at most can cause the psyche to compartmentalize this condensed experience or split. (Levine and others report that adults with post-traumatic stress symptoms often compartmentalize emotional states or aspects of themselves as a survival strategy.)

In the BEBA Clinic, Dr. McCarty and I worked with a baby who was born at home and was hypotonic at birth with weak respiration and poor neurological signs. This baby was separated from his mother, transported to the hospital with his father in an ambulance, and spent three days in a NICU. In our opinion, this baby did not have the resources to separate out all of these complicated emotions and compressed experiences. This baby's energy and physiological systems were dissipated and weak. His basic system was not strong. He exhibited hypotonicity in the neck and atlantal-occipital junction, which rendered him a candidate for SIDS (Schneier & Burns, 1991). In this and similar cases, we feel that nursing for comfort and, more importantly connection, is a very appropriate approach. Confusing feeding with consolation should not be a consideration in this case and others like it. The first thing is to establish the resources.

When caregivers and the environment are able to support the baby's ability to experience the felt sense (Levine & Graybeal, 1991) of that internal quiet, slow, warm, soothing parasympathetic place, the baby will then be able to make the choice himself to come out of the shock affect period. This quiet slow way out of the shock affect period will allow the baby's nervous system to build the necessary sequences within for smooth connection from the brain stem, through the limbic system to the neocortex. Thus, the baby's sensory motor integration, proprioception, balance, emotional and mental clarity will be free to function optimally without interruption from shock and trauma.

Healing Betrayal: New Hope for the Prevention of Violence

I believe that the problem of betrayal is epidemic in our culture and is a significant contributor to personal and psychosocial dysfunction. Betrayal is unknowingly and unwittingly perpetrated on our prenates, neonates, and children. Left unresolved, betrayal leads to domestic and

social violence. The pre- and perinatal perspective offers hope for the healing of betrayal and the prevention of violence.

The American Heritage Dictionary of the English Language (1969/2015) defines the word "betray" as follows:

1. a. To give aid or information to an enemy of; commit treason against. b. To deliver into the hands of an enemy in violation of a trust or allegiance.
2. To be false or disloyal to.
3. To divulge in a breach of confidence.
4. To make known unintentionally.
5. To reveal against one's desire or will.
6. To lead astray; deceive.

I think each of these definitions is relevant to pre- and neonatal consciousness especially 1b, 4, and 5. Statements like: "I didn't know it would be like this," to, "How could you! How could you let them do this to me?" exemplify different intensities of betrayal.

Emotionally, betrayal affect is a profound constellation of rage, terror, separation-loss-grief and shame: rage that I was handed over to the "enemy;" terror of not knowing what the "enemy" will do to me; grief from the separation and loss of a trusted ally; and, the lingering sense of shame that I should have, or could have done something to make it better or keep it from happening, that I somehow caused the other to betray me.

Trust

Ideally, parents, caregivers, and healthcare providers are supposed to be trustworthy. The building and maintenance of trustworthiness necessitates clear communication. Trust is not something that happens automatically. Trust must be earned and maintained by consistent behavior. If trust is broken, something must be done to heal the broken trust and rebuild it. It is incumbent on us as parents, caregivers, and healthcare providers to earn our children's trust. Without trust, our children are left betrayed.

I think one of the most common examples of betrayal our babies experience comes from the previous mistaken assumption that our babies are too little and too young to know what is going on. Parents, caregivers, and healthcare practitioners can often be observed talking about a baby to another adult in the baby's presence. There is little or no awareness that the baby's expressions might have something to do with what is being said. I am suggesting that talking about our babies in front of them without including them in the communication breaks down trust and leaves the baby in the feelings of betrayal.

Until very recently, few professionals and parents knew that prenates, birthing babies, and newborns are conscious, sentient beings, possibly as early as conception. This means that prenates, birthing babies, and newborns have a sense of what is going on. They know when they are disconnected, not acknowledged, and not included in decision making. Whether or not they are capable of making decisions, they still have something to say about them. Prenates and babies are conscious, sentient beings who deserve our attention and respect in the same way we would offer it to anyone our own age.

During pre- and perinatal life, betrayal is unwittingly and unintentionally perpetrated onto the pre- and neonate. The neonate feels unprotected, delivered into the hands of the enemy and betrayed. Clinically, I have seen betrayal feelings reported by adults and portrayed in babies and children from all of the following: alcohol or drug use at conception or during pregnancy, abortion ideation (thinking about abortion while pregnant), abortion attempts, scalp fetal heart monitors at birth, anesthesia or analgesia, forceps, vacuum extraction, cesarean section birth, cutting the umbilical cord too soon or too rapidly, eye drops, insensitive bathing after birth, pediatric interventions after birth, heel sticks to draw blood for medical tests, vaccinations, and circumcision. This list is by no means complete. Betrayal feelings can easily be recapitulated by parents just by telling the birth story without including the baby in the conversation. Parents, caregivers, and healthcare professionals often do not understand, nor acknowledge protests and tears babies express while experiencing procedures or while someone is talking about them without including them. Research has shown that babies do experience perceptions and express feelings in direct response to what is happening to them.

These unresolved betrayal feelings undermine the primary trust the neonate has of his parents. Without trust firmly in place, parenting and being parented is unnecessarily encumbered. Unresolved betrayal inhibits the child parent relationship and, more often than not, results in power struggles between the child and his parents.

Parents often ask about behaviors like biting or hitting during nursing. Unresolved, these behaviors will transfer to other siblings, children, and animals as the children get older. I believe that hurt babies and children desperately want others to know and acknowledge the pain they have experienced. When a child hits me or attempts to bite me, I will gently restrain them from hitting or biting me. I will then say, “Oh you were hurt that much. Ouch. I get it. I can see and experience the pain under your anger. No, you may not hit me. I am here to hear how you feel.” My actions will be consistent with the words I use.

Unacknowledged pain can lead to anger, frustration, rage, ambivalence, and then, finally, to depression. We are looking at a betrayal cycle. If, when our babies bite us or express anger toward us, we

acknowledge them and set a limit for them, they would quickly learn more constructive ways to express their pain and anger.

I think it is impossible for a child to be born and grow up in this and many cultures without knowing some level of betrayal. To start with, we don't understand that our children are being betrayed. Then, when our children are acting out betrayal behaviors, we don't understand that either. Finally, we don't know how to appropriately respond to the child's behavior. Both parent and child remain confused, and the betrayal cycle continues.

Paradigm Shift

The BEBA work or Somatotropic Therapy® that I do with patients of all ages represents a profound paradigm shift. This work includes and integrates aspects of pre- and perinatal psychology, bodywork disciplines, Polarity Therapy, Osteopathy, Chiropractic, understanding about trauma impacts and the resolution of trauma, and midwifery and obstetrics knowledge. However, Somatotropic Therapy® does not look like any of these individual disciplines. Somatotropic Therapy® is based on specific principles, knowledge, and philosophical premises. The principles govern what is done. Words do not give us experience. The work is best experienced. With videotape you can see what happens in treatment sessions and how the principles are applied. I videotape all the work I am doing with infants because it is much easier to show than to talk about. The work is happening on many levels, because many patterns exist.

Dr. McCarty and I worked with a family and baby who started labor at home, were transported to the hospital, and ended up with a cesarean section birth. I didn't do any work with them prior to the birth. I was called by the grandmother and, with the parents' consent, was asked to meet them at the hospital to join the birth support team. This family is now involved in the BEBA project. At this writing, the baby is three months old.

Just this last week the mom was telling the story about how hard it was to receive the spinal anesthesia during labor. As she was talking, the baby was connected at her breast. Mom and baby had extraordinary eye contact. It was really touching. Tears welled in the mom's eyes. The mom was describing how the anesthesiologist was talking about her in the third person to an assistant. Mom felt enraged and betrayed by the way she was being treated. She was having to sit up straddling a table bending over her full womb in the middle of Pitocin driven contractions so that the anesthesiologist could get the needle into her spine. They told her to put her head down farther. She felt she couldn't go any farther.

At one point during the story, mom emphatically stated, "I felt alone. There was no one else there!" Her baby immediately and abruptly disconnected from breast and let out a huge whelp that sounded angry and hurt at the same time. Mom looked into her baby's eyes, who was by

this time in a full cry and said to her three-month-old infant, "Yes, and you were there too!"

The baby then calmed, looked into his mother's eyes and reattached to the breast. I believe that this young mother's response to her baby's cry served to help heal the betrayal that they both felt during the anesthesia process. Had she not acknowledged her baby's presence there and the baby's response to her statement about feeling alone the baby would have continued to cry, re-experience, and reinforce or recapitulate the betrayal feelings.

The level of betrayal that we hold in ourselves is massive in our cultures and is unconsciously passed on to our children. It is the source of tremendous rage that is entangled in our family dynamics and affects our ability to protect our children, set boundaries, and set limits for them.

Conception, gestation, and birth are profound events that have significant impacts on consciousness, physical development, and later life. Culturally, we are just beginning to explore these outer edges with the reporting of near-death experiences, as seen in the extensive works of Kubler-Ross and of Steven Levine. This kind of writing about death and near-death experiences has recently become more popular in our culture. We can look at the other side of the death experience and consider the conception experience. Those of us who have been doing different forms of regression work have been exploring the time frame of conception through birth. Patients report significant realizations about what happened to them during their conception, prenatal life, birth, and early infancy that helps free them from the traumatic influences of those events. To consider the pre- and perinatal perspective is indeed a paradigm shift.

Imprinting and the Trauma Mechanism

As we consider the lack of boundaries that the experience of betrayal leaves in its wake, we must raise the questions: What are traumatic influences and what is the mechanism of traumatic imprinting? What is the stress or trauma mechanism?

Imprinting is most profound when our endorphin or catecholamine hormones are being secreted into our system. Endorphins are our pleasure hormones. If we are having some kind of intense pleasurable experience, endorphins are secreted and we experience pleasure and sometimes euphoria. When we are having some kind of stressful experience that drives our adrenal cortex, our fight or flight responses are stimulated and the level of catecholamine hormones in our system rises. It is during these kinds of heightened experiences that our body memory patterns, emotional memory patterns, and mental memory patterns get imprinted. Imprinting occurs in a triad of body first, emotions, and then mind. The earlier the event in prenatal life, the deeper the imprinting.

Imprinting and COEX Systems

We are seeing how these single imprinting events build on top of each other. Later traumatic events, which include betrayal, compress on top of or "recapitulate" the earlier imprinting events. Some of you may know Stan Grof's work (1975, 1985, 1988). He speaks about a COEX matrix. He describes how similar emotional sets and memories form a system of "condensed experience" that are formed during events of strong emotional charge of the same quality.

In Somatotropic Therapy® we look at similar mental, emotional, and physical sets or COEX systems. Unconscious expressions that have their origin in prenatal and birth imprinting are expressed countless times during a single day as emotional sets, facial expressions, and physical postures by all people. Just watch newscasters on TV for example. You will see their heads constantly tilt and turn in the same direction. You may notice a repetitive facial expression or body movement. These are postural imprintings and movement patterns that are most often left over from their births or, less often, other traumatic events.

We've been talking about betrayal and how betrayal and separation get compressed together and imprinted in early experience. We have talked a little bit about how trauma events stack on top of each other. So, when a person goes into an event that raises those same issues again, it doesn't just bring up the issues surrounding the present event, it also brings or triggers into the present moment, sensations, feelings, sensory awareness, physical expression, movement patterns, and posturings that are left over from similar events that happened in the past.

Memory

Every traumatic event has an effect on the person. A traumatic event threatens to overwhelm or does in fact overwhelm one's system. There are a series of stress and trauma responses that are predictable and occur in relationship to all traumatic events. There are certain things that happen during our human development that compound or compress unresolved traumatic memory patterns into present time.

Memory is an interesting mechanism. In the moment we are living in the present, right now. Memory of what happened in the past is more illusionary than what is presently happening. This moment is more real than anything that happened in the past. But anything that is left unfinished, that hasn't come to completion or resolution, is carried by our being into the present moment. The mechanism for this is little understood. Psychologists and physiologists are just beginning to have some understanding of how memory works. Moreover, we seldom consider that our physical body is also a primary carrier of memory.

The Somatotropic perspective broadens the way we consider memory. Usually, we think of memory as only a conscious mental process. However, memory really involves more than just having mental thoughts. Memory includes mental, emotional, and physical information. Each aspect of our being has its own way of remembering. Mentally, we remember thoughts, pictures, images, words, sounds, symbols, and ideas. Mental memories occur on the level of thought.

We remember emotions. They are the passions that drive us. Emotions are a complex of sensations that are coupled with emotional feelings: i.e., love, joy, happiness, gladness, warmth, grief, sadness, greed, anger, rage, lust, fear, jealousy, betrayal, etc. Emotions involve both the feeling and a commensurate sensation or physical experience. Each emotion has its own energetic sensation that is part of the "feeling." It is the emotions that link the mental aspect of our minds to our physical bodies. We can think thoughts and not necessarily feel anything. Our emotions connect our thoughts to our passions and our physical bodies.

Unresolved emotions from prior traumatic events are held in our body's nervous system, connective tissue, muscles, and organs as unconscious energetic and physically manifest tension patterns. These tension patterns are simultaneously activated every time a specific memory pattern is stimulated or "triggered." These patterns are unconsciously activated many times in a day. The repetition of these activated patterns manifest as specific behaviors, movement patterns, facial expressions, and postures. Dr. William Emerson calls these "psychological leaks." These unresolved memory activation patterns contribute to the asymmetry of the body.

The physical body is not symmetrical in nature. The physical body is asymmetrical. True, we have several paired organs: eyes, ears, lungs, for example. However, by design we are not symmetrical. We have several single organs, some of which are not even in the center of our body, like the liver which is off to the right side of the abdomen, tucked under our diaphragm muscle. Even our heart is positioned a little to the left in our chest cavity. Moreover, we have only to look at our anatomical features, especially our faces, to see asymmetrical anatomical variation. These asymmetries, together with breaks in the continuity of our movement patterns, are amplified and exaggerated by traumatic prenatal and birth experiences.

Lastly, the Somatotropic perspective includes the physical body as having somatic memory. The shape of one's head is strongly influenced by one's birth process and the shape of the mother's pelvis. The shape of one's head can be strongly influenced by being stuck in the birth canal for a period of time. This is called "cranial molding." Despite what most obstetricians and pediatricians counsel us to believe, not all of the cranial molding resolves within several hours or days after birth. Cranial molding often does not fully resolve and can be sustained throughout life. Unresolved cranial molding is an example of how the body remembers

traumatic birth experience. The head or cranium holds or remembers aspects of the shape from the birth molding experience. As babies resolve their prenatal and birth trauma, their cranial molding will also resolve.

Parents often bring in children who have a habit of bumping their heads in the same place. Babies and children frequently display patterns of falling and hitting their heads in the middle of the forehead, on the side of their heads, or back of their heads. They will often have an uncanny ability to hit the same place over and over again. The babies that repeatedly bump their heads in the same place will often do so in a place where their head happened to have been stuck or compressed during birth against mom's pelvis.

The body also remembers specific movement patterns from birth. Most parents have experienced their baby or toddler arching over backwards while they hold them in an upright position in a seemingly spontaneous fashion. This arching movement is a specific movement pattern that is imprinted in the body during the latter part of birth as the head crowns and is born. So, memory is not just a mental phenomenon. Memory is mental, emotional, and physical.

Parents or healthcare practitioners who don't know how to perceive and properly identify babies' movement and recurrent behavior patterns as expressions of prenatal or birth imprinting are unable to be in relationship to that part of the babies' experiences. When they have learned how to connect movement patterns and recurrent behaviors to earlier traumatic experience, they can relate to the baby from a very different and more effective place.

Some of the parents we are working with are learning to identify their baby's birth patterns and have developed new ways to relate to their children. When observing her baby hitting her head, a mom may say empathically, "Oh. That reminds me of when we were stuck. I was stuck, and you were stuck inside me. We were both struggling really hard during that time." This enables the child to then relate to his mom in a way that helps resolve the underlying pattern which caused the head bumping in the first place. Babies will do what they need to get their parents' attention. The more awareness the parent has, the more experience can be included in the memory and interaction of the child and parents. The relationship can then become a deeply healing one.

Conception, gestation, and birth are major events that are closer in time to a baby's immediate experience than they are for adults. When we have something big happen, like the death of a friend or someone close to us, we tend to talk about that event with others until we get some distance from it. I think we do this so the impact of that event does not occupy so much of our psychic space. Receiving empathic, reflective attention from others helps us overcome our loss. Babies do the same thing with their body and emotional language. Giving empathic reflective attention helps babies resolve their prenatal and birth trauma.

Seven Steps to Healing Betrayal

Conception and birth are as impactful for a baby as the loss of a close friend is to us. New babies need a quality of attention and acknowledgment we are just beginning to understand. Newborn babies and children have the capacity to comprehend and heal unresolved broken trust and betrayal. Parents, caregivers, and healthcare professionals can support the healing of betrayal with the following behaviors:

1. Connect with your own internal felt sense and knowing of betrayal.
2. Acknowledge the baby's feelings. Give the baby appropriate containers to express his betrayal feelings. Biting and hitting others are not appropriate expressions of rage or anger.
3. Communicate empathically with the baby from that place of knowing.
4. Acknowledge to the baby our part in the betrayal cycle.
5. Tell him we are sorry.
6. Protect our children from outside harm. Respond to the baby's cues about having his or her space encroached upon or invasive environmental influences like too much light, sound, or movement.
7. Set clear and appropriate limits for our babies' and children's behavior.

Betrayal feelings do not need to be lost in our shadows. They can be healed. Professionals trained in the Somatotropic approach for the resolution of prenatal and birth trauma in infants and children can support families to heal unresolved betrayal. Domestic and social violence can be prevented. This, in turn, can allow parents and children to have open, trusting, expressive, and growth-filled relationships, free of betrayal.

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