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As It Was in the Beginning: The Significance of Infant Bonding in the Development of Self and Relationships

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Abstract: For many years, psychologists have speculated about the influence of early bonding experiences upon subsequent development. In this article, one of the pioneers of body psychotherapy considers recent research. in the field of pre- and perinatal psychology to suggest how infant bonding might have a profound effect on the emergence of Self and relationships. Implications and methods of practice are described and discussed.

Zusammenfassung: *Wie es am Anfang war: Die Bedeutung früher Bindung auf die Entwicklung des Selbstes und der Beziehungsfähigkeit.* Über Jahre haben die Psychologen den Einfluß früher Bindungserfahrungen auf die spätere Entwicklung erforscht. In diesem Artikel bespricht eine der Pionierinnen der Körpertherapie die neuere Forschung im Bereich der Pränatalen und Perinatalen Psychologie und überlegt, wie früheste Bindungsprozesse eine tiefgreifende Wirkung auf die Entwicklung des Selbstes und der Beziehungsfähigkeit haben. Implikationen und Methoden der Praxis werden beschrieben und diskutiert.

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Bonding or Bondage?

Through direct involvement in the lives of children, most child and youth care practitioners tend to view each individual life as a unique blend of personal essence, developmental needs, and contextual conditions.

With experience, however, few can fail to notice the appearance and reappearance of common patterns that seem to emerge, not only within individual

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lives but across the kaleidoscope of the childhood experience. Those who remain curious often find themselves probing deeper into each scenario and reaching further and further back into the experiential history of each child, looking for some general propositions that might account for such consistencies.

This article, drawn from the traditions of Integrative Body Psychotherapy (Rosenberg, Rand, and Asay 1985), is based upon three such propositions: (a) that each child brings a unique essence of Self into the world; (b) that the child's developing sense of Self-in-the-world is formed within the context of primary relationships; and (c) that this process begins well before the development of cognitive and intellectual capacities.

All of this implies that patterns showing through individual and situational variables may be traced back to these primary processes and that growth, change, and healing may not occur until these deeper issues are addressed.

In Integrative Body Psychotherapy (IBP) the goal is to reach the essential Self, or the essence with which we are all born. People who are connected to this experience of Self from the beginning will always have a place to go – on the inside. With this connection they are instinctively functional, able to feel, to move from the known to the unknown, to face change without fear. They are responsive rather than reactive, are creative and receptive, incorporating the heart and the emotions. They are balanced, maintaining a sense of trust and self esteem.

The origin of this experience appears to be located within the process of primary bonding. It now seems clear that bonding begins before birth!

Recent research in pre- and perinatal psychology is pushing the origins of consciousness earlier and earlier (e.g., Chamberlain 1994; Emerson 1989; Verny 1981). How the infant bonds becomes the blueprint for all future relationships. Therefore, it is imperative to return to the original imprint in order to understand, heal, and reconnect with the essential Self. The evidence firmly suggests that the original imprint is to be found within the prenatal period of development.

Bonding means love and the absence of fear. Bonding creates connection and safety. It allows the infant to experience the world as a friendly place. If bonding doesn't occur, the connections to Self, Other, and the rest of the world become fragile and unsafe. Poorly bonded people are generally insecure, locked into hindsight, and vigilantly trying to control, predict and anticipate. They feel powerless and afraid of the unknown. They do not want to be questioned, yet they always have an answer, know how to do things, and consider themselves to be always right. They both dominate and cling: using and abusing to meet their own needs. They live their lives on alert, trusting only in their own defenses. For them, love and intimacy become fearful.

When someone else moves close, they find excuses to distance themselves (not too close, not too far away).

Recent research has shown that the lack of bonding (skin contact, sensual stimulation, etc.) leads to shutting down the emotional (right) hemisphere of the brain, leaving people to live in the thinking (left) hemisphere. This could, perhaps, be the origin of the mind/body split. When people live from their head, rather than their emotional center, they are driven to figure out how to cope and how to get by. Most of all, they have to figure out what the other person wants – constantly looking to the outside because they are split off from the inside. In IBP termi-

nology, this is referred to as "Agency," or more accurately, "Other-Agency." In this condition, the person lives his or her life according to the perceived needs of others and thereby closes off from the nutritional and expressive needs of the Self.

Along with the emergence of "agency," each individual also develops his or her own configuration of defenses, or "character style." These more general characteristics, usually thought of in terms of "personality," may also be traced back to the birth and bonding periods of development. In IBP terms, the foundations of "character style" are formed when the infant in trauma has no choice but to split off from the body. Hence, the original injury may become trapped in the body or, in later stages of development, a false Self may be created on top of the pain. Here we are not talking about trauma as a rare occurrence but as common response to the birthing and bonding process. This becomes increasingly apparent the more we examine the pre and perinatal experience from the infant's perspective.

Given the compelling evidence that the in-utero infant is a conscious and aware being, how might the unwanted child respond to such parental messages? What about the child whose very existence has been threatened by an attempted abortion? Or, at birth, what happens when the mother is simply "absent" through medication or when the child looks into another pair of eyes that show no sign of recognition or welcome? Infants cannot contain such feelings – they are too overwhelming – so they develop defenses in order to survive. And while these defenses might provide the necessary protection at the outset, they fail to serve the growing child and the emerging adult. Because these patterns are established long before cognitive or intellectual processes develop, they are not amenable to change through talk or insight. They are literally locked into the body and held at a cellular level. In terms of traditional psychotherapy, they might be considered to be "pathological."

Birth and prenatal work is the way to release these pathological ways of surviving. Certainly other forms of childhood trauma may create some pathology, but if you start with good bonding, a good birth experience, being wanted and connected, it is possible to recreate the trust necessary to emerge from the traumatic experience. Clinical evidence clearly suggests that individuals who have a birth or bonding injury respond to subsequent trauma by resuming to their original trauma and acting it out as they did at the pre-verbal stage. They go back to the original imprint, be it anger, frustration, depression, or agency.

At its essence, bonding is a biological need. Most professionals are familiar with the research demonstrating our need for touch. Recent experiments using massage with premature babies shows that they gain weight faster and are able to leave the hospital sooner than babies who do not receive massages. Bonding occurs during a critical period that is probably hormonal Most important is the first hour after birth. Beyond this, the evidence suggests that during the first eight days of a person's life, a relationship pattern emerges that lasts a lifetime. This does not mean that bonding cannot happen later, but, if the hormonal factor is interfered with by drugs or other problems, that interference significantly hampers the bonding process.

It is through the body of the mother that the baby gets its first sensory contact relationship with others and thus with the world. Prenatal bonding injuries consist

of not being wanted, communicated with, or celebrated. Very often, the uterus is experienced as toxic owing to prior unresolved traumas such as miscarriages and abortions, as well as physical toxicity from drugs and other contaminants. If there has been a miscarriage and the mother does not grieve that loss, it will in some way contribute to her belief and fear that she will lose another child. In clinical work, clients will often remember abortion attempts from their own in-utero experiences. Sometimes the images occur in dreams along with feelings that someone is trying to kill them. When they try to verify or validate such experiences, they are often told by their mothers, "I never told anyone. How did you know?"

But the child does know, and the memory is recorded in the body. And further, these things that we are not supposed to know or feel limit us. Some women refuse to admit that they are pregnant, resulting in the infant feeling ignored and not wanted. If, on the other hand, a woman is happy about being pregnant, takes care of herself, talks to her baby, then a loving prenatal bond is created. Mothers need the love and support of the father, who should also be encouraged to participate in this prenatal communication. The baby recognizes these communications, not for their verbal content but for the energy that is conveyed. For this reason, it is helpful for a woman to work on her own birth, even before she becomes pregnant. Without awareness, she can in effect communicate her own issues surrounding birth to the developing child at a cellular level. Working through issues around the relationship with her own mother can also be a critical part of this preparation.

Standard hospital procedures often create a lack of bonding. For instance, the epidural anesthetic (the current procedure of choice) does not stop contractions although it does slow them down. Although the mother might not feel the contractions, the baby does. If the mother is anaesthetized, it will blunt the hormones in her body that provide an essential biological bond. This in itself creates an energetic mismatch, or lack of attunement, between the two of them. Anything that creates fear jeopardizes bonding. In all of this, the presence of the father as a participant throughout the birthing can play a vital role in ensuring that the newborn feels welcome, celebrated, and subsequently attached.

The baby should be held by the mother immediately after birth. If she does not see the baby when it is born, this will also disrupt bonding. The cord should not be cut prematurely, as all the senses are activated. Skin and eye contact, soothing sounds, and smiles are all necessary for optimal bonding to occur at this time. This means, of course, that the mother must be fully present and aware. Bonding is a two-way street. Parents who have not been bonded as children often find it difficult to be "there" for the newborn. In later life they tend to abuse, neglect, and abandon their own children.

To enhance bonding there must be extended periods of contact between mother, father, and baby. If there is support for the mother and she feels that she has the power to care for her baby, then bonding will continue to be enhanced. If breastfeeding starts right away, the mother's instincts and hormones will promote bonding as nature intended.

Unfortunately, this critical issue of bonding is often overlooked by professionals who work with children, as well as by those working with adults and families. Given recent advances in the field of pre- and perinatal psychology, the implications of this oversight might well be monumental. One thing, at least seems clear.

People who do not become bonded in early infancy spend the rest of their lives looking for it, one way or another. Unfortunately, most people in our society find substitutes in their intellects or in material things. From this perspective it really does seem that lack of bonding serves to create a life of bondage.

Integrative Body Psychotherapy with Infants and Parents

There is nothing new in the idea that prenatal and birth experiences are primary influences in the formation of character defenses (e.g., Grof 1975; Janov 1970), but until recently most of the therapeutic methods associated with this perspective worked only with adults. More recently the pioneering work exemplified by Dr. William Emerson (1991) has opened up new opportunities to work with infants and parents on issues of birth trauma as early as possible after the event. Some of this work has also been distinctly preventative in nature, working with couples prior to conception and during pregnancy to interrupt and alter repetitive multi-generational patterns.

One of the most exciting developments in this area has been a creative and fortuitous combination of IBP methods with the ground-breaking work conducted by Emerson (1996) and his colleagues. Because the earliest trauma is buried deepest in the body, working with an infant whose trauma is still recent and more accessible allows for the creation of change that will affect an entire lifetime. Infants are nothing but process and there is nothing for them but the present. Their only history is their intrauterine life and their birth experience. With special attention to boundaries (in infants they are diffused), it is possible to work with bonding injuries before trauma becomes set in rigid defense systems.

As a psychotherapeutic system, IBP works with the concepts of presence, containment, boundaries, mirroring, empathy, and the body as an energetic system. These concepts and tools are ideally formulated for working with children and parents on issues relating to early trauma and bonding. Bonding, along with its attendant injuries, is the essential developmental task. "Bonding is the process by which parent and infant become connected, intimate and attached to each other. Bonding is a dialogue between parent and child that begins even before birth and continues for a lifetime" (Paris and Paris 1992). It creates the energy that sustains human compassion and understanding. In the bonded relationship, safety, survival needs, and deep acknowledgment of a common knowing are internalized. Bonding leads to self-actualization and relational autonomy. But without respect and empathy for the pre-born and newborn's boundaries and inner being, bonding cannot take place. This, then, must be the therapeutic stance taken in working with infants and their parents.

From an IBP perspective, the primary intention is to connect the Self of the infant with its experience. In this context, the term "Self" is used to describe the coherence of the infant's subjective experience described by Daniel Stern (1985). The focus is not about strategy, technique, or symptom removal. The primary healing aspect of the work is relational, not technical, and the success of treatment depends upon the quality of those relationships. The therapist's job is to observe, hear, see, sense, and reflect the experience of the infant in other words, to "mirror" that experience. Mirroring is the skill of putting words to the non-

verbal experience of the infant. Accurate mirroring will help infants to discover their feelings and thus to discover themselves. When mirroring in this way, the words are not as important as the tone of voice and the emotional energy conveyed to the infant. Together, the energetic presence of the therapists and the parents is corrective because during the infant's birth, the parents may not have been emotionally and energetically present. Both therapist and parents must now be present and connected to their own bodies and emotions in order to be fully there and empathic.

According to the basic principles of IBP, catharsis does little to eliminate trauma. In fact, clinical experience suggests that unrestrained cathartic release may well create the conditions for re-injury. The concept of "containment," on the other hand, implies the ability to experience what is happening in the body with awareness and being able to tolerate one's direct experience without moving into defensive styles or discharge. Containment improves contact between parents or therapist and infant while promoting the resolution of trauma and eventual integration. In the words of William Emerson, "Healing depends on the extent to which infants or children remember, express and/or re-live their traumas, and on the degree to which understanding, compassion and empathy is extended to them during the treatment process" (1984).

The notion of "boundaries" implies safety and respect. Infants and children are dependent upon others knowing, recognizing, and honoring their boundaries. The therapist should attend to the infant's responses and follow the baby as she/he sets boundaries by vocally or physically expressing "no" or "yes." Given the sensitivity of the adults, the baby will generally respond to the intentions of those present, as well as the spoken word, direct touch, and energetic contact. Although the infant is undoubtedly non-verbal, it is worth keeping in mind that approximately 75 percent of all human communication is actually non-verbal. As in working with adults, the purpose of the boundary is to meet the other person, not to do something or perform a technique. In this particular case, it is important for the therapist to have worked on his or her own birth trauma or it will be stimulated, producing a loss of boundaries along with counter-transferential issues. While it is important to support defenses (saying "no"), attention to boundaries will gradually replace defenses and allow re-patterning, healing, and integration, resulting in freedom and choice.

In this sense, the essential process is no different than that supported by the therapists in any other clinical context. The body component in working with infants is energy work – near touch and touch – always starting with the least invasive method. From this perspective, the organism is considered to be an energy field. In the newborn, the boundaries are so diffuse that all trauma and shock is recorded in the energy field and in the body. Because placing one's hand in the energy field of an infant is to touch the mind and emotions of the baby, how it is touched and who touches it can have either traumatic or healing effects. Trauma sites can be located in the energy field. Observation of the infant's responses will show where the trauma sites are and what emotions are involved. Patterns of energy flow and movement are blocked according to the degree of trauma. The physical body expresses the impact of trauma in movement, structure, function, behavior, and emotional expression of the newborn. Pressures on the body during the birth

process impact the infant. Re-stimulation of these pressures on the body can re-activate the trauma. As William Emerson (1994) has demonstrated, the release process must be done in stages, as there are no effective defenses.

In introducing this work to infants and parents, experience suggests that the therapist should spend time in demystifying birth trauma. It is important to point out that many infants (perhaps most) experience some form of trauma in entering this world. Sharing information and modeling empathy are important preparatory moves. In addition, the therapist should help the parents to understand the normal needs and communication of babies. The role of the therapist is to work with the trauma and to teach the parents how to work with the trauma. During the work, the parents should allow the baby to cry and empathize with the feelings being expressed. In this way, the interruption to the initial bond during the original birthing process is addressed. The therapist should set boundaries with the infant and the parents by always giving them permission to stop at any time. The infant always leads the sessions. The infant will choose when to work on trauma and when to stop and nurse or be nurtured.

While many therapists, counselors, and child and youth professionals may never work directly with infants, the issues of birth trauma and bonding have clear implications for practitioners who deal with a broad range of behavioral, emotional, and relational issues presented by children and adults. Understanding how intrauterine life, birth trauma, and early bonding can create patterns that last a lifetime can assist in orienting practitioners toward the lives of their clients. Replacing intrusive, coercive, and potentially harmful techniques with such approaches as expressive empathy, treating and respecting boundaries, and accurate mirroring are more likely to offer clients a connection with Self rather than create an experience of frustration and possible re-injury. Of course the work described in the latter part of this article calls for extensive training, but the clinical experiences of the handful of practitioners currently working in this area will undoubtedly continue to enhance our appreciation of the pre- and perinatal experience along with our understanding of the persistence of those problematic patterns that seem to beset the lives of both ourselves and our clients.

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