EMOTIONAL FIRST AID FOR BABIES AND THEIR PARENTS

Fundamentals and practice of bonding-based parent-infant body psychotherapy

Thomas Harms

Introduction

If we saw a house on fire, it would not make much sense to take time to study the history of its construction or the layout of its rooms. We wouldn't be interested in how the inhabitants relate to each other or what kinds of conflicts have not been resolved within the family. All this can wait, as the priority is to save everyone in the house who is in danger.

During a post-natal crisis, the house is, figuratively speaking, on fire. Instead of there being harmony within the household, a dangerous dynamic develops in which stress and growing insecurity cause the parents to lose their emotional bond with their infant. In recent literature, these insidious vicious cycles have been clearly described. (Papousek et al., 2004; Diederichs & Jungclaussen, 2009; Harms, 2008). Due to the enormous amount of stress during such crises, the parents' empathic and intuitive abilities are increasingly undermined. For the infant, the rupture of the parental bond represents a dangerous situation if it persists for any length of time. The baby loses his sense of security and a safe haven in the world. Nowadays we know that brief losses of contact are a normal part of the interaction between a child and its parents. Under normal circumstances, the infant has the ability to actively invite his primary caregivers to pick up the emotional thread again.

Lasting psychosocial burdens or unresolved traumatic stress from pregnancy, birth and the postnatal period can be fertile ground for this dynamic of tension, inability to relate, and estrangement. During these times, orientation gets lost, the ability to regulate emotions is no longer present, and

even the parents' own baby can be perceived as threatening and rejecting. The infant responds to the loss of relational security with sustained increased muscle tone and by refusing touch and eye contact. Hectic, uncoordinated movements increased whining and excessive crying are further symptoms indicating the acute loss of psycho-physical alignment between parents and their infant.

When parents have their backs to the wall like this, they can be overcome with impulses and fantasies to use violence against their baby. Therefore, efficient tools are urgently needed for them to regain stability and inner security. Emotional First Aid is a systematic approach within modern body psychotherapy, specifically developed to accompany and overcome ruptures in the relationship between parents and their infant.

History and scientific influences of Emotional First Aid

The historic roots of Emotional First Aid (EFA) go back to the pioneer's work of the physician, psychoanalyst and natural scientist Wilhem Reich (1897–1957). In the 1940's, Reich developed his theories about how to apply his methods of body-oriented psychotherapy, which he called vegeto-therapy or orgontherapy, in short term therapy with highly stressed parents, infants and young children (Reich, 2010). It is in this context that Reich first mentions Emotional First Aid (Reich, 1987). His daughter Eva Reich, who worked as a physician and peri-natologist in the USA, took up her father's preventive work, developed his methods further and made them into an important element of the preventive use of body psychotherapy which she called 'gentle bioenergetics' (Reich & Zornanszky, 1993, 2006; Overly, 2005).

In the mid-1980's Eva Reich started to visit Berlin on a regular basis where she taught her method of neurosis prevention and infant therapy in seminars (Meyer, 2014). It was in that context that I first got to know about these body-based bio-energetic concepts of infant therapy. At the same time,

I was following the then growing research into infant psychology and bonding, more specifically the newly discovered phenomenon of excessively crying babies. In the early 1990's I launched the first ‘Crying emergency service’ in the neighborhood centre of the UFA factory in Berlin Tempelhof where parents with inconsolably crying babies could get help. However, in the attempt to support and assist parents and their infants get through the crisis it soon became apparent that the currently developed tools were insufficient for the demands of crisis management. Massages, touch and expression techniques of Reichian therapy could only be applied in a very limited way. For instance, babies who had only little ability to sooth themselves would refuse the touch or cry even more which, in turn, would exacerbate their parents' distress.

These early experiences increasingly shifted the focus of our work towards a different direction: instead of trying to loosen blockages in the emotional and physical expression of the child another question became central; What can be done, with the help of body psychotherapy, to strengthen the parents' intuitive relational abilities? How can approaches of body psychotherapy be used in order to give parents insight into the specific patterns of their infant's loss of contact? And what body interventions are useful in order to increase the parents' ability to respond when their baby is crying?

The current research status of Emotional First Aid (EFA), as I present it here, has gone far beyond Reichain origins. Today, EFA combines the knowledge of modern body psychotherapy with findings of neurobiology (Porges, 1998, 2005), psycho-traumatology (Levine, 2010; Van de Kolk, 2014), and bonding research (Bowlby, 2010; Brisch, 2000, 2013). The analysis of the mechanisms of parental contact ruptures, the emphasis on affective-cathartic expression processes on the part of the infant, as well as the inclusion of the therapist's psychosomatic resonance information are still rooted in Reichian character analysis and bioenergetic research (Reich, 1997). The emphasis on bodily self-observation, however, was inspired by awareness and trauma research (Odgen, 2010;

Siegel, 2010; Weiss, 2010). The increased focus on pre- and perinatal body language of the infant comes from the pioneers of prenatal psychology (Emerson, 2012; Terry, 2006, 2014). And the therapeutic relationship model prevalent in today's EFA is very similar to concepts used in humanistic psychology (Eberwein, 2009; Eberwein & Thielen, 2014).

Where can Emotional First Aid be applied?

This bonding-based body psychotherapy approach has three main areas of application. These three areas or 'pillars' are:

- bonding promotion
- crisis intervention
- parent-infant bonding psychotherapy

Infants display an enormous capacity for change within psychotherapy which is why in many cases, only a small number of sessions are sufficient to remedy specific problems in the early development of the child. In the area of prevention, our work focuses mainly on coaching parents and children with a high level of resources and a strong ability to bond. Many parents seek answers to specific questions about how to handle their child's emotional outbursts, in particular their infant's crying. How long can one let a baby cry without him suffering damage? How should the child be held and positioned during crying? And what can parents do to prevent themselves from getting bound up by a current of raging emotions?

Often in EFA counselling, the goal is to show parents simple methods to regulate emotions, in order to enable them to stay in touch with their own body awareness during stressful moments in the relationship with their child. Prevention sessions consist of short psycho-educational units during which the parents learn about the importance of bodily self-awareness and are taught simple

breathing, imagination and perception techniques. Short videos demonstrate how to support a child during intense expression processes. In many cases, the main aim of these short interventions is for the parents to develop new ways of seeing and perceiving their child (Cierpka, 2012).

The second pillar represents classical crisis intervention with parents, infants and young children who already display disturbances in emotional regulation when it comes to crying, sleeping and feeding. Here, interaction processes between parents and children have already suffered serious disruption. This is the main application area of Emotional First Aid. Crisis counselling generally consists of three to six sessions during which specific body intervention methods are applied in direct contact with the child. Through mindful self-observation or with specific changes in their breathing patterns, parents learn to better regulate their child's crying, and be with him through the crisis. The main aim of body psychotherapeutic crisis intervention is to strengthen the parents' ability to sense their child and resonate with him.

Many EFA counsellors and therapists now work not just in specialized crisis intervention centres, but also within the context of clinical obstetrics and intensive birth assistance. Here, counselling sessions are held in the hospital, either at the mother’s bedside, in the delivery room or in the neonatal care units.

The third pillar of EFA is directed towards parents whose ability to relate and regulate emotions has suffered as a consequence of pre-, peri- or postnatal trauma. In those cases, increasing the parents' sensitivity is not enough. Here, body-oriented parent-infant psychotherapy offers parents and children a space in which to recapitulate and integrate early relationship ruptures. Reenactment of overwhelming experiences during pregnancy or birth as well as separation traumas the family has not come to terms with, is of special significance in these situations. In later chapters I will describe baby-centered work models in more detail (Evertz, 2014; Schindler, 2011).

[INSERT IMAGE – 3 PILLARS OF EMOTIONAL FIRST AID]

Theoretical foundation of Emotional First Aid

Bonding-based perspectives of Emotional First Aid

Today's research in the field of Emotional First Aid uses a bonding-based perspective for its therapeutic models. This is in accordance with other modern approaches within parent-infant counselling and psychotherapy which all focus on the reconstruction of a safe bonding relationship between parents and their children (Brisch, 2000, 2010; Cierpka, 2007; Israel, 2007; Papousek, 2004). The paths towards that goal, however, i.e. the body-based concepts used in EFA, differ greatly from psychoanalytical or behavior therapeutic approaches of parent-infant therapy. Let us consider first the notion of bonding. What exactly do we mean by ‘bonding’ in the context of body psychotherapy with parents and babies? How can we integrate the classical term with the holistic, psychosomatic view as adopted in body psychotherapy?

As discussed in a previous chapter, the notion of bonding refers back to the research of the psychoanalyst and founder of modern attachment theory John Bowlby. He proved that the human need for closeness and intimacy is not the result of the child's oral-sexual needs as assumed by psychoanalytical development theory. Bowlby considered the need for bonding as being a motivational system in its own right (Bowlby, 1975). The need for closeness and intimacy is therefore just as important for the survival and thriving of a human being as the air we breathe and having enough food.

Bonding, according to John Bowlby, is an invisible emotional connection through time and space between two or more people (Brisch, 2010). Bonding represents a special form of relationship. Although bonding always means relationship, not every relationship allows for bonding. The most important characteristic is that the sustainable bond is a source of safety for the growing child. Successful bonding relationships are therefore a secure base that a person can refer to in moments

of distress when they need support. It comes as no surprise that in times of great emotional need people do not refer to remote acquaintances like their neighbours or members of their local sports club! In times of crisis, we look for emotional and physical support with those that we subjectively consider capable of providing us with a sense of safety.

For the infant, a safe bonding experience is a prerequisite for physical relaxation and letting go. Only the experience of the emotional availability of another allows the infant to withdraw his attention from the external world and refer back interoceptively to his own organism. At the same time, the repeated experience of bonding-based safety is an important condition that needs to be in place so that the infant can explore and feel comfortable in his environment.

From the perspective of the parents, a successful bonding relationship will contribute to their ability to decipher their infant's non-verbal body and behavior signals more accurately. Successful coherence or alignment with the child is felt as a sense of full bodily relaxation in the parents. Their breathing becomes deeper, their muscle tone lower and they have a calm heart beat.
From the perspective of body psychotherapy, physical relaxation and an ability to bond between parents and child are inextricably connected (Thielen, 2009; Geuter, 2015). Bonding and safety create openness and relaxation. Additionally, physical relaxation creates the fertile ground for successful bonding experiences. It is this connection that we make use of in parent-infant body psychotherapy.

The continuum and variability of parental bonding

The practice of body therapeutic crisis intervention allows us to closely observe the rapid changes in states of emotional regulation and bonding between parents and their child. The continuum stretches from very relaxed moments of connection between parents and infant to overwhelming

feelings of threat, powerlessness and estrangement during times of rupture of the emotional bond. In the following section we will describe a phenomenological presentation of the individual stages of the parental bonding experience. What does a young mother feel when she is in close connection with her infant? And what happens physically and emotionally when the connection to the child is weakened or even ruptured during phases of increased stress?

The state of reinforced bonding

When bonding and regulation capabilities are well developed, parents are able to move freely between times of contact with the child and moments of self-contact. The ability to align with, and tune into, the behavioral signals and needs of the child as well as being able to be aware of her own inner physical states are sufficiently developed. Physiologically, the mother is able to relax during calm contact with the child, for instance, while feeding him. Her breathing flows easily and is deep and connecting. This ability to take deep breaths is a direct consequence of the relaxation of the diaphragm which, in turn, is a function of general opening and relaxation processes inside the body. The subjective experience in contact with the child is described in terms of safety, intimacy and well-being. Although the mother is intimately connected with the child, her attention rests with her own body. It is a simultaneous awareness of self and other. This ability to self-observe allows the mother to check inwardly whether the interaction she offers her child is being experienced as ‘right’. We are talking, in this context, about the parental ability to ‘self-connect’ (Harms, 2008). Self-connection enables the parents to be co-regulators who are able to create and maintain an attentive connection with the stream of their own bodily and inner sensations. Bonding patterns as described in the context of attachment theory find their equivalent in similar patterns of safe, avoiding or ambivalent self-connection. Thus, building an internal and external ‘relational thread’ are two functionally identical processes within the parents' ability to provide stable and sufficiently safe bonding.

The state of weakened bonding

In the state of weakened bonding and ability to make coherent contact, those accompanying the child often have a sense of insecurity, lack of orientation and disconnection in the contact with the child. Often, these emotional states are exacerbated when attempts to soothe the infant during times of crying and restlessness fail. Important indicators of a growing spiral of stress and fear on the part of the parents are;

- increased muscle tension
- shallow breathing
- increased heart rate
- physical restlessness.

The focus of the parents' attention during those stressful phases shifts towards the crying child and the parents no longer manage to redirect their attention towards the inner sensations of their own body, even when the child is in a relaxed state.

Due to stress being generally dominant, the parents are less and less able to sufficiently grasp and guide the emotional expressions of their child. Quickly, a process of what is termed ‘negative mutuality’ arises: the child senses the stress-related loss of parental sensitivity and reacts with even more restlessness and crying (Papousek, 2004). This, in turn, intensifies the parents' insecurity and physical tension and so on. Independently of the background and specific reasons for these regulatory and relational problems, the main aim of body psychotherapeutic intervention in EFA is to break this weakening vicious cycle as quickly as possible and return to a process of ‘contagious health’.

In the above-described stress and alarm state, the parents still possess an ability, albeit limited, to maintain the connection inward and outwardly. Although all concerned experience a state of

insecurity and tension, they are still able to perceive the ‘real child’ with all his needs. In this regulatory state within the therapy, they are also still capable of identifying and localising inner physical and emotional clues such as ‘each time little Johnny cries I've get a lump in my throat’ etc.

The state of bonding rupture

The third regulatory stage in the parents' ability to bond occurs when during contact with the infant, unprocessed trauma on the part of the parents is reactivated by the stress-triggering behavior of the child such as excessive crying fits, and chronic avoidance of eye contact. The intensity of stress and agitation in those phases is overwhelming and leads to a complete breakdown of the emotional connection with the child. Those involved find themselves trapped in a desperate state of powerlessness, unable to think, feel or act. While the baby lies crying in her mother's arms, the connection with the inner stream of bodily sensations disappears. This los of self-connection on the part of the parent manifests in a sense of numbness, paralysis and the inability to focus.
During those dissociative episodes, the disconnection is twofold: On the one hand, those involved lose their capacity for introspection and self-awareness. On the other hand, their connection to, and sense of intimacy with, the ‘real child’ is lost. Fear of death as well as feelings of despair and hopelessness are nearly always present when parents experience these bottomless and totally unstable episodes of contact rupture with their child.

Bonding rupture, the loss of the ability to regulate emotions, as well as the collapse of bodily self-awareness are inextricably interlinked during these phases of the bonding continuum. From the perspective of the child, the parental safety system collapses with the onset of dissociation.

[INSERT IMAGE – CONTINUUM STATES OF BONDING]

Neurovegetative perspectives of Emotional First Aid

Now that we have seen a phenomenological description of the different regulatory states of parental bonding, I want to examine the physiological background of the parent-infant relationship and its disruption. Basic ideas and research can already be found in Wilhem Reich's work, who saw the relational abilities of parents and children as deeply interwoven with the ‘regulations’ of the autonomous nervous system (ANS) (Reich, 2010). Since these psycho-physiological findings, especially recent research regarding the autonomous nervous system, are of fundamental importance for the concepts of Emotional First Aid, I would like to briefly sketch them here.

The neuro-vegetative perspective of Emotional First Aid is integrated with recent research by the American psychiatrist and pycho-physiologist Stephen Porges. His polyvagal theory offers an extensive set of explanations that help to underpin the previously described phases of the bonding continuum from a physiological point of view (Porges, 1998, 2005, 2010). Furthermore, Porges’ theory is useful for a more detailed representation of the effects of the specific body psychotherapeutic interventions within the parent-infant therapy. At the core of the polyvagal theory lies the hypothesis that the autonomous nervous system (ANS) contains three neuronal regulation circuits that create and maintain physical survival mechanisms.

According to the classical view of the ANS, the sympathetic nervous system and the parasympathetic nervous system consist of two branches. Within the entirety of the human organism, they are responsible for a large number of inner organ functions that lie beyond the individual's conscious control. The parasympathetic system represents the ‘rest branch’ of the ANS. This system regulates regeneration and digestion and directs the attention inward so that energy resources can be replenished. The sympathetic nervous system, according to the traditional view of the ANS, mobilizes the body in order to counter threats. It activates the musculoskeletal system

(fight or flight), means of expression (shouting, crying) as well as brain activity (efforts to find solutions). In the sympathetic stress and alarm state, we are highly alert and our attention is directed outward (Ruegg, 2007; Reich, 2010; Sunderland, 2006).

The polyvagal point of view distinguishes itself from the classical one in that Porges considers the the vagus nerve to be twofold (hence polyvagal). He differentiates between a younger branch of the vagal system, the ventral vagus, and an evolutionary older part of the vagus nerve, the dorsal vagus. The ventral vagus comes into action when we feel safe, warm and close to others. Under those conditions, it regulates our social orientation towards, and communication with, our most important bonding partners (Odgen, 2010). Turning our gaze towards others, spontaneous facial expressions, turning our head in the direction of the partner, and tuning of the hearing to the frequency range of the human voice are among the functions of the ventral vagus nerve.

This dominance of the ventral vagus system can be very clearly observed in the interaction between a mother and her baby. The mother seeks eye contact with the child; she smiles at him and repeatedly lifts her head, inviting the child to reciprocate her contact initiation. While talking to the child, her voice is of a slightly higher pitch (baby talk) and tuned to the child's auditive receptivity. Her facial expression is lively and open. Subjectively, feelings of safety, intimacy and well-being dominate the interaction.

From the point of view of evolutionary biology, the baby is programmed to begin the communicative exchange with his primary caregiver straight after birth. If the infant experiences those individuals as emotionally available on a regular basis, his ventral vagus system will be activated. The vagus dominance thus becomes the neuro-vegetative counterpart of the emotional experience of safety the child enjoys through the bond with those adults who care for him.

The polyvagal model describes a hierarchical order of specific neuronal regulatory circuits that serve to ensure survival. If the mother feels safe in her contact with the child, social exchange and mutual bonding are easy. If, however, her safe experience of bonding gets disrupted, the sympathetic stress and alarm system takes over. Typical parental stress indicators are hyper-activity (pacing up and down, inability to sit still etc.) along with increased perceptional tension and high thought activity (compulsive thinking, rumination). Only when strategies to avert the perceived threat fail, will the evolutionary oldest regulatory circuit of the dorsal vagus with its 'shutting down mechanism' enter into action. In those existential emergency situations only inner organ systems are supported whilst energy is withdrawn from the periphery of the organism. This becomes very visible in shock paralysis when the legs go weak, the skin becomes pale and the individual is incapable of forming coherent thoughts.

The illustration below summarizes the threefold view on bonding and physical states.

[INSERT IMAGE – THREEFOLD AUTONOMOUS NERVOUS SYSTEM]

Parental sensitivity and optimized windows of tolerance

From modern infant and bonding research we know that successful bonding relationships depend on the sensitive attunement between those caring for the child and the needs and behavioral reactions of the infant (Downing, 2006; Siegel, 2010). From the perspective of body psychotherapy, we can add that this sensitive parental competence requires an organism that has the ability to physically relax. Adults surrounding the child, who are able to regularly enter a state of receptivity and openness, are in a position to connect to the non-verbal signals of the child and adequately respond to them.

As we have described earlier, this mode in which the parents have the readiness to bond has its physiological foundation in the dominance of the ventral vagus function. The parents are able to react with calm and serenity to the various behavioral modes of the child. The successful bonding experience with its associated ventral vagus function inhibits the sympathetic stress and alarm reactions and dissociative trauma responses. In other words, the experience of bonding safety calms down the heart and respiration as well as the parents' raging thoughts. If the ventral vagus-based regulation maintains the experience of safety, ‘negatively contagious’ reactions, as are often observed between parents and their baby, do not occur. One could say that in this mode of openness the parents are like a lightening conductor for the stress reactions of their child. Severe phases of crying and restlessness during the night are tiring and exhausting but the accompanying symptoms of hyper-excitation and threat as can be seen in moments of crisis, no longer occur.

Whilst the parents remain in a state of openness and readiness to bond, the child can rely on their emotionally available presence during his quite draining phases of crying and restlessness. The parents act like a ‘lighthouse’ for their child. As long as the embodied self-connection of the parents is present, they represent an important support system that modulates the child's states of affective agitation. If, however, one or both parents are overwhelmed by the emotional impact, they will

quickly leave this small window of tolerance that allows optimum attention to the infant. The child then loses his co-regulator. His crying remains unheard and the underlying needs and affective states no longer find the response they require. As a consequence, the quality of the crying becomes desperate and unending. If, in those situations the parents are unable to build a bridge to the child, the stress and alarm mode of the infant will be replaced by one of resignation and emotional numbness. The child gives up and enters a state of paralysis.

[INSERT IMAGE – ACTIVATION LEVELS OF THE AUTONOMIC NERVOUS SYSTEM]

Within the neuro-vegetative view on bonding processes between parents and their newborns all types of combinations are possible. A serene and emotionally available mother is there for her highly tense and alarmingly crying baby. Conversely, an inconsolable and angrily crying baby has a dissociated caregiver at his side or perhaps a relaxed infant who is ready to bond meets with an adult caregiver who is emotionally insecure and unapproachable.

For the practice of Emotional First Aid, these neuro-vegetative concepts represent an important diagnostic tool. During parent-infant body psychotherapy, based on the observation of body signals the therapist is able to recognise whether those involved are leaving the narrow corridor of bonding availability. When, for instance, a young mother during a short interaction and observation phase suddenly starts fixating her baby while her breathing becomes shallow and her posture becomes rigid, this indicates that the mother has lost her sense of safety in her connection with the child and is changing to a sympathetic stress mode. During therapy, this moment could be a first point of intervention where a deeper exploration of the mother's stress experience follows. As far as treatment goes, a number of questions arise from those findings:

- What can be done to prevent parents from permanently leaving their optimised attention and

tolerance field in connection with their child?

- How can a body-psychotherapeutic procedure support parents so that they can either maintain or rebuild this narrow corridor of bonding availability during times of crisis?

The concept of self-connection in EFA

As discussed earlier, the theoretical foundation of modern Emotional First Aid is inextricably linked to the concept of self-connection. Historically, EFA's theoretical basis goes back to more recent research in the field of body psychotherapy (Davis, 1999; Fogel, 2013; Levine, 2010) as well as models of awareness-based psychotherapy (Weiss & Harrer, 2010; Gendlin, 1998). The main basis of the work, however, is clinical observations of applied body psychotherapy with parents and infants. In that context, it became obvious that initially used emotion evoking techniques (e.g. deep breathing, expression exercises) and bio-energetic physical exercises were only partially useful when it came to helping them with the specific problems they were facing while trying to build a relationship with their baby (Harms, 1999, 2008).

The analysis of post-natal crisis dynamics revealed that parents who lose the emotional connection to their newborn at the same time, lose the connection to their own body sensations (interoception). So the loss of bonding comprises two sides of a single process: on the one hand, the loss of attunement with the infant, and on the other hand the loss of contact with one's own bodily sensations. The most important core statement of EFA is that parental sensitivity requires a sufficiently stable self-connectedness. Secure self-connection means that the parent is able to revert back to his or her inner body and organ sensations. Conversely, loss of parental sensitivity always disconnects from the capacity for subjective experience and bodily perception (Fogel, 2013). Restoration of the parental ability to self-connect is therefore the most important core aspect of EFA methodology. This method enhances the known strategies used within depth-psychology and

behavioral therapy when working with parents and children. The recovery of physical self-reference thus becomes the most important basis on which to modulate and change parental perception, thought and actions. By means of specific biofeedback systems, the parents are taught to become aware at a much earlier stage when they are on the verge of losing connection to their bodily self. One of the main ways of achieving this is the use of abdomen-focused breathing methods, which we refer to as abdominal breathing. By means of these methods, the parents learn to modify the stress-related weakening of their ability to regulate emotions in such a way that a rupture of alignment with and attunement to the child is prevented.

Self-connection therefore means that the parents possess ability to maintain a double focus that enables them to stay in touch with themselves and with their child at the same time. The continual monitoring of the connection with their own breathing provides the parents with a diagnostic tool with which they can influence and regulate the quality of their bonding and their ability to make contact. Many parents put it this way: ‘As long as I am in my belly, I am with my child’ (Harms, 2008).

Practically, establishing abdominal breathing achieves two important effects:

- First, continual self-awareness is maintained. By regularly checking whether she is ‘still in her belly’, the mother practices an important form of self-care. She cares about staying in touch with herself.
- Secondly, the use of abdominal breathing has an effect on the vagal branch of the autonomic nervous system that, in turn, initiates a number of regulatory circuits that will benefit the safe bonding process with the child. Among those effects are: increased eye contact, relaxation of peripheral muscles, improved blood circulation in the skin, warmth being spread throughout the body, increased intuitive attunement with the child's affective needs as well as an increased release of the bonding hormone oxytocin (Jansen, 2015).

PRACTICE OF PARENT-INFANT BODY PSYCHOTHERAPY

Parental focus within EFA crisis intervention

When parents bring their child for treatment, clinicians are often faced with a high degree of despair and helplessness on the part of the parents. The parents are under a lot of pressure due to attempted coping and solution strategies to deal with the child having failed over an extended period of time. Many parents report that they are no longer able to soothe their child with calming activities like suckling (breast feeding, bottle or a dummy), lifting the baby, distraction, dancing or other movements etc. with these strategies being being refused by the baby.

Depending on the severity of the parental distress, the therapist might feel high expectations at the beginning of the treatment with the assumption that solutions should be mainly directed towards the rapid relief of the child's manifest symptoms like crying or sleeping problems. Parent-infant psychotherapists have to be very aware so as not to follow this immanent pressure on them to act. Within Emotional First Aid the specific interaction and bonding problems parents experience with their children are systematically explored and analyzed. I have extensively described his step-by-step procedure as the ‘7 step model’ elsewhere (Harms, 2000, 2008) but I want to summarize the most important aspects of this approach to crisis intervention below.

The opening phase of crisis interventions

After an initial phone call during which the parents explain their problem, they receive a questionnaire to be completed with the medical history of the child plus a cry and sleep journal. These details are brought along to the first treatment session. The questionnaire also gathers information about family members, the child's state of health, pregnancy and birth experiences as well as details regarding the parents’ relationship with the child.

Especially, when regulatory problems in the areas of crying and sleeping are present, a preliminary one-week journal, which keeps note of time and duration of sleep and crying phases, has proven to be very useful. Even prior to the therapy itself, this results the parents being able to get a degree of objective perspective about the problem. Specifically, the extent of crying problems is often emotionally assessed and parents might describe their child's behavior in the following way: ‘my baby has been crying for hours and hours at a time. This has been going on for weeks now. There is practically no let up.’ The crying journal will correct this kind of perceptional distortion. The parents realize that their baby does not cry ‘all the time’ but at particular times, for instance always after breastfeeding or just before going to bed. Often, the parents are able to enter more into contact with the ‘real child’ during this one week’s observation.

The first therapy session will serve to elicit important additional data about the different family members and the development of the child's symptoms to date. At the same time, the therapist is already able to discern important details in terms of body psychotherapy:

- How does the mother hold the child?
- What is her general emotional expression?
- What parental tension patterns can be observed?
- What is the emotional tone of their contact with the child? Is it warmhearted and sensitive or rather abrupt and aloof?

The way parents position their child gives many clues as to their level of sensitivity and the active bonding patterns: Is the four-week old baby held with his belly against the mother's body, his neck supported by his mother's hand or does the mother, immediately at the beginning of the session, put the baby on the floor so that he is hardly able to make eye contact with his parents?

Clarifying the issue at hand and expectations of the therapy

Once the mother or parents have described their problem in a few sentences, we will try to assess together what their wishes and expectations are with regard to the course of the therapy session. Through emphatic listening, the therapist will often be able to clearly discern what steps and goals are predominant. Four main therapeutic goals can be distinguished:

1. An improved bonding experience with the child
2. Improved general orientation when deciphering the child's behavioral language
3. Development of the parental ability to regulate emotions
4. Acquisition of concrete strategies for dealing with the child's difficult behavior such as crying phases in the evening

Within the context of body psychotherapeutic crisis intervention, it is important to frame any expectations the parents have about the therapy process in small steps. This will enable an appropriate assessment of the therapy process at the end of the session. Are the results of the therapy session helpful in dealing with the concrete challenges the parents are faced with? Perhaps, at the end of the session, it might become clear that the session was enlightening because hitherto unreflected conflict processes within the family came into focus (e.g. transgression of boundaries on the part of an over-bearing mother-in-law). It is also possible that despite insights into the specific problems during the session, an improved ability to cope with the crying baby has not been achieved. It is then important that the parents realize this before the end of the therapy session and that it is taken into account when planning further sessions. When parents get the opportunity to voice any possible disappointment with the course of the therapy so date, early termination of the therapy can be avoided.

Observation of parental and infant behavior

During the first phase of treatment, the parents are invited to interact with their child in a natural

and habitual way. Depending on the situation, it can be play, nappy change or feeding interactions that enable the therapist to observe the specific behavior the parents display towards their child. It is often within minutes that the characteristic atmosphere, that dominates the relationship between parents and child, unfolds. It is important to emphasize successful moments of interaction with the baby (for instance, exchanging a loving gaze, a sequence of physical touch) and bring them into awareness. Looking for positive aspects represents the most important guiding system during this initial treatment phase. We will often intensify the experience by inviting the parents to become aware of bodily sensations and localize them internally.

More severely affected babies often take only a few minutes before their behavior suddenly changes. Some of those babies suddenly change from an initial phase of relaxation and openness to restlessness. Others will enter a state of unexpected high pitch crying. The nature of those behavioral changes is important markers in EFA intervention: Firstly, they offer an opportunity to observe how the parents respond to the initial stress and expression process of the child. Secondly, the subjective experience during these challenging moments with the child can be more clearly identified and named. Thirdly, the parents can try out specific techniques to strengthen bonding and experiment with new behavioral strategies.

During this therapeutic exploration phase, the therapist is able to follow the parent's coping strategies. How exactly do they go about handling the child? For example, what are the individual steps in the parents' behavior before the crying escalates? Often repetitive and unconscious clusters of forms of behavior become visible. Those specific strategies are intimately related to the character and neurotic predispositions of the parents. It is important to allow this exploration to reach a point when the parents' hopelessness and loss of orientation typically begins (Downing, 2006).

Body perception, internal exploration and somatic markers

When parents reach the point at which the strategies they use to deal with the problematic behavior of their child no longer work, agitation levels of all involved will quickly rise. Typically, behavioral sequences in contact with the child will speed up. Many parents will then cradle their child in a somewhat hectic way; the speech flow is more concentrated and faster. Everything in the parents' expression is accelerated. Furthermore, psycho-vegetative signals become visible such as blushing, blotches on neck and breastbone, trembling and vibration of arms and legs, breathing becoming faster and more shallow. So far, the parents might have seemed controlled and at a safe observational distance from the behavioral reactions of their child but now their expression processes become stronger and livelier and the therapist is able to empathize. This tangible affective change in quality is a further turning point at which the therapeutic exploration is directed towards the subjective stress experience of the parents. The parents are being instructed to feel and name their conscious bodily sensations. By focusing on the process of their bodily sensations, the parents are more easily able to adopt a non-judgmental attitude towards their inner experience. The goal of this approach is to link specific behavior patterns with patterns of bodily sensations. So, for instance, when the mother suddenly starts to cradle her child in a more agitated way, she might identify tightness in her abdomen. She feels how she holds her breath and how ‘everything is being pulled into the upper body. It is as if I am no longer able to feel the lower half of my body and 'forgot' it.’

This exploration of body sensation has multiple functions: Firstly, it helps to recover the lost self-awareness of the parents. Secondly, the conscious sensing of the body, similar to interoception, supports the individual's connectedness to reality. Bodily self-awareness creates a feeling of safety and orientation. The recovery of self-connection generates a self-strengthening cycle of relaxation and openness. At the same time, the baby benefits from the regained self-awareness. At the

moment that the parents have reconnected with the information flow perceived from their own body and begin to feel themselves as a whole again, they become emotionally available and represent a safe ground for their child. The 'lighthouse' role of the caregivers is thus inextricably linked to adequate bodily self-perception and awareness (Fogel, 2013).

Another important focus that plays a major role in future releasing strategies is the identification of different areas of the body – Damasio calls them 'somatic markers' (Damasio, 2006) – that are associated with weakening bonding experiences. In the example above, it is the tightness of the chest that represents the initial rupture in the contact with the child. These somatic markers serve as signaling systems that later on in the treatment can be used as early warning signs. The sensation of a tightening chest, for instance, tells the mother that the emotional connection with her child is in the process of being eroded. She can thus become aware of the fact that she is about to lose the emotional bond with herself and the child. This kind of bodily signal could serve as an identifiable signal in a state of agitation that specific stabilizing counter-measures are required.

Further body interventions that strengthen parental bonding availability

Modern body psychotherapy offers a whole array of specific tools to help parents regain a sense of safety and openness. Parallel to the previously described body awareness, Emotional First Aid makes use of specific breathing techniques, physical touch and imagination exercises in order to support parental sensitivity and the ability to connect. I will now elaborate on a few of these interventions.

The use of physical touch to create safety

Physical touch in EFA is used to improve coherence and relational abilities. Before exploring areas of stress between parents and their child (whether those situations happen in real time or them being accessed through retrospective imagination), we ask the clients to indicate on what part of the body they would like to receive physical touch. This should be a place that they experience as stabilizing and strengthening. These so-called 'safety stops' are parts of the body that, when touched, trigger a maximum of attunement and connectedness. It is important that the individual experiences the touch in the most positive way possible. Particularly if the client has already entered a state of intense stress and alarm, they will experience the touch of a safety stop as extremely opening and safety-inducing. The touch initiates a process of generalized resonance and attunement that comprises affective, somatic, neuro-hormonal and behavioral aspects. Seeing that the infant is normally present when the parents receive the touch, the induced affective attunement has an effect on the relationship between therapist and parents as well as that of each parent with their child (Harms, 2008). Through the generation of a sense of safety, this specific touch enables the parents to reconnect with the inner sensations of their body. At the same time, the vagal regulation circuits that are responsible for the pro-social activities of the mother are being activated (Porges, 2010). The mother is thus more in touch with herself whilst at the same time she begins to intuitively connect with the baby.

The use of supportive touch within the couple's relationship

One specific technique we often use in the context of bonding-based physical touch is to position the mother on the father's lap. The father is sitting on the floor whilst leaning against the wall. The mother sits on his lap and leans against his belly. The baby lies with his belly on the chest and belly of the mother.

This position allows mothers, who are experiencing high stress levels during moments of crisis, to physically feel a sense of closeness and support that is often missing in daily life. Most clients report that having their back supported helps them to let go of the need to control the situation and better tune into the needs and affective expressions of their child. In situations of extreme strain over a period of weeks and months (such as after long hospitalization due to a premature birth) this whole-body touch quickly opens up deeper emotional layers of the parents' self-awareness. Often the supportive touch of the partner opens the door to the expression of long repressed emotions. Fathers also greatly benefit from this body based experience of the relationship. Many report that, after long phases during which they were unable to act constructively, they regain the feeling of being useful and needed.

Physical touch in trauma-affected parents

The use of guided breathing processes is one of the most important interventions within EFA to specifically strengthen the parents' capacity for sensitivity and self-connection. The basis of this approach is the idea that initial states of stress and distress engage the activation of the sympathetic aspects of the autonomous nervous system. One of the main effects of dominant stress reactions is that the inhalation aspect of the breathing rhythm is emphasized. The diaphragm tightens and the breathing amplitude is reduced. A predominantly inhalation-based breathing pattern is often encountered when parents have been in stressful situations with their child for a long time (as in the care for excessively crying babies). EFA makes use of breathing patterns in various ways.

Breathing as diagnostic instrument

The observation of an individual's breathing pattern gives the therapist important clues as to their emotional state. If, during a massage session for instance, the mother holds her breath as soon as

the child starts whining, this can possibly be a marker for an intial perceived threat on her part. The therapist then has the opportunity to draw the mother's attention to the stress-related change in breathing rhythm and then, through the exploration of the mother's body-awareness, the cause of the occurring tension can be clarified.

Breathing as modulator of the autonomous nervous system

By instructing the parents to adopt an abdominal breathing pattern, we encourage a counter strategy. Abdomen-oriented breathing normally only occurs in situations of regeneration and safety. Consciously directed abdominal breathing assists the vagal branch of the autonomous nervous system, which, in turn, is responsible for the parents' intuitive behavior patterns (like turning towards the child, modified tone of voice etc.). The mother's attention to the physical perception of her abdominal breathing triggers a release of bonding-relevant hormones, an increase in skin temperature and relaxation of the peripheral muscles. Through resonance, the baby gets 'contaminated' by the mother's modified vegetative emotional state. The objective is thus to change vicious cycles into beneficial ones by means of altered breathing patterns (Papousek, 2004).

Breathing-assisted parental emotional safety

The recovery of self-connection quickly leads to alterations in the parents' prevailing mood. If they were unsure, hesitant and unable to make decisions before, access to embodied self-awareness now creates a foundation for the renewed experience of safety and general connectedness (towards the child as well as self).

Breathing as early warning system

In addition to the effects described above, the parents have the possibility to utilize the observation of their breathing as an important early warning system in the daily contact with their child. If the parents have a good grasp of the basic principle, this approach works astonishingly well. In many cases, the parents consider abdominal breathing a great help in all the everyday aspects of bringing up their child. On the one hand, they have a clear inner parameter to determine whether their availability towards the child is still present. On the other hand, they have an instrument at their disposal that allows them to counter any dysregulation or weakening of the sensitivity in their contact with the child.

Strengthening the readiness to bond by way of imagination

In Emotional First Aid, we often encounter the problem that the difficulties the parents have with the child are not immediately observable within the therapy setting. This is particularly true for regulatory disturbances in the area of the child's sleep or similarly, for situations of overwhelm during crying fits in the evening. Oftentimes, the baby will exhibit perfectly normal behavior during therapy sessions. In those cases, parent-infant psychotherapy will make use of imagination techniques in order to get closer to moments of strengthened bonding between parents and child. Here, the ability to visualize periods of successful bonding plays a particularly important role. The parents are invited to imagine a beautiful situation with their child and while doing so, to observe their inner bodily reactions. For instance, imagining cuddling the child in the morning might lead to a feeling of widening of the chest together with a sense of happiness and contentment. Parents who have permanently lost the connection to their baby will find it difficult to remember the successful and positive moments with their child, although those are often still present. Positive imagination helps to attenuate negative self-judgment and enables a realistic new assessment of the concrete experience of the relationship with the child.

Similarly, imaginative approaches are used to create a state of ‘safe’ distance in order to observe problem situations more objectively. Hereby, the focus continually switches between the external observation of behavior and the exploration of inner bodily and affective experiences. When the baby has fallen asleep on the mother's breast, she imagines the crying fits of her four months old son. She can see in her mind's eye how his imagined body expresses tension and distress. During imagination, the mother can grasp the concrete physical and affective signals of that situation by turning her attention to her body. She feels the tightness in her chest and the shallowness of her breathing. With the help of the therapist, she can link the bodily sensations of the ‘now’ with the stressful situations she experiences with her child in the evenings. Another possibility is the connection of body-intervention techniques with imagination exercises. The mother is invited to direct her attention to the calm and expanding breathing movements in her body. Once she feels how warmth and relaxation spread through the body, the therapist invites her to take this abdominal breathing into the (imagined) stressful evening situation. Now, the mother sees herself holding the crying baby in a serene attitude of connectedness. By linking imagination and bodily self-awareness, the client develops new practical perspectives in dealing with problem situations in daily life (Harms, 2008).

A few remarks about body psychotherapy with fragile parents

We would like to point out that these specific body-therapeutic interventions are not always possible. If the parent is too depleted or the degree of their trauma too high, the use of touch and breathing can be counter-productive. In those cases, less emotionally-focused approaches will be more adequate to support parents in the contact process with their child. Video-based interventions are one useful tool. The parents and the therapist watch successful interaction sequences that are subsequently discussed and analyzed in a positive way. The therapist has a twofold role when showing the video material (Downing, 2001): On the one hand, he helps to describe and interpret

the child's expressive behavior and its functionality. On the other hand, he will emphasize the successful interaction and the resulting beautiful moments in the relationship between parents and child, thus drawing the parents' attention to those aspects (Cierpka, 2012)

A further possibility. which we cannot elaborate on here, is to use successful interaction between the therapist and child as an example. Here, the therapist will lead the play or therapeutic touch with the infant while commenting on the child's expressive behavior, his specific perception of the child and the intention of his intervention in dialogue with the child. The objective is not so much a modification of the parents' mood and physiology but to cement the idea of other possibilities in terms of interaction.

The baby at the centre of Emotional First Aid

Besides the body-oriented strengthening of the parents' relational sensitivity, direct body-psychotherapeutic work with babies themselves is a main characteristic that distinguishes EFA from other cognitive and behavioral parent-child therapies. The baby's behavioral reactions not only reflect the quality and the level of sensitivity in the parents' relationship with their child, they also place the child at the centre of the therapeutic process. In the following, we would like to describe the main models of baby-centered body-psychotherapy as used within the concept of EFA.

Baby-centered body work

Babies suffering from regulatory disturbances display a high degree of bodily tension. Due to the acute stress, their ability to balance their emotions is limited on the vegetative level. Practically, many babies show paradoxical reactions: the parents' offering touch and eye contact does not lead to relaxation and openness on the part of the child but instead triggers physical resistance,

withdrawal, and emotional outbursts. In this situation we use ‘bonding through touch’ (Deyringer, 2008), a bonding-oriented development of a technique developed by Eva and Wilhelm Reich called ‘butterfly touch technique’. This is an approach that invites the baby to gradually tolerate gentle skin and body touch. The main rule is to only touch the infant to the extent that he can remain in a state of openness. Duration, intensity and location of the touch have to continually be adapted to the child's ability to accept and tolerate it. For instance, even the gentlest touch of an infant's skull after extreme birth trauma such as vacuum extraction (ventouse) can trigger clear physical withdrawal and the avoidance of eye contact. The EFA therapist will reflect this stress reaction back to the baby and the parents with a phrase like: *‘Ah, you do not like this. Now you are getting restless’*. He will then move on to a different are of the body where touch is not experienced as a threat. During this body-centered interaction, the infant slowly regains trust and learns to enjoy full body touch again.

This approach is very effective in a number of ways: Firstly, the babies experience a sense of safety and respect for their boundaries during the touch sequences. Astonishingly, even traumatized babies will quickly become mellow and return to a psycho-vegetative balance without the traumatic patterns having been activated (Meyer, 2015; Wendelstadt, 1999). One could say that this body-oriented method paves the way for successful moments of interaction between the baby and his parents, the positive experience being the healing agent. The main objective is a modification of the current vegetative reaction state.

[INSERT IMAGE – SELF-CONNECTION AND RETURN TO PARENTAL BONDING ACTIVITY]

Secondly, through minimal tactile stimulation, the parents become aware when and where they lose emotional connection with themselves and their child. Through the use of perception and breathing

techniques, they also learn to sense insecurities as they arise and are able to modify them so that they can recover the ‘relational thread’ to their child. Thirdly, during the guided massage sessions the parents can feel directly with their own hands how a very stressed baby will start to let go and relax physically. For parents who find emotional access to their child difficult, this is an especially effective way for them to notice the positive effect their touch has on their child.

Bonding-based support for the child's emotional outbursts

Another important aspect of the baby-centered work is paying attention to the infant's crying and outbursts that occur during therapy sessions. Our experience is that many babies have paradoxical reactions to the improved relaxation and contact shown by their caregivers. Oftentimes short periods of openness are followed by a strong wave of emotional and physical expression. Suddenly, and often unexpectedly, the baby changes from a situation of clearly relating, to a stress state that includes intense crying. This is as a result of the improved self-connection and relational abilities of the parents creating the atmosphere in which hitherto repressed experiences of pain, powerlessness and existential distress can be expressed by the baby (Solter, 2009).

[INSERT IMAGE – PHOTO OF ASSISTED CRYING PROCESS OF A BABY]

Within Emotional First Aid, paying attention to the infant's emotional expression process plays an important role. The aim of the ‘assisted crying’ process is to enable the parents to stay centered and strongly connected to their own body despite the strong emotional expression of their child. The previously described breathing, perception and touch techniques ensure that the parents are adequate ‘containers’ that can hold the baby's emotional expression. By maintaining their self-connection during a crying fit, the parents ensure that they do not get overwhelmed by unreleased ‘ghosts’ (Fraiberg, 2011) and trauma from their own personal history.

Clinical observation has shown that babies are only able to come through their crying fits and enter a lasting state of relaxation if the parents maintain their self-awareness. The babies are usually being held against the parent's body during the crisis but it is not the physical support that is decisive. It is the reconnection to self on the part of the adult caregiver that creates the relational foundation for the child to regain their lost emotional balance. During those bonding-based crying cycles, the babies go through a typical sequence of agitation and expression processes. I have described phases of the crying process in detail elsewhere (Harms, 2008, 2013). To summarize we can state that the baby-centered EFA crisis intervention aims at a transformation of the expressive quality of the child's crying. The baby feels, physically supported by his caregivers, the pain of previous ruptures in bonding and relationship. What is new, however, is that the babies now experience emotional connectedness during those regressions, which was not the case during the original pre-, peri- and postnatal ruptures.

It is often astonishing how quickly the expression and regulatory abilities of babies change after sessions of bonding-based expression assistance. Especially impressive is the fact that after the assisted crying crises, the children have far more ability to tolerate closeness to their caregivers and allow relaxation through physical touch.

Regressive approaches to pre-, peri- or postnatal trauma

As soon as the parents' co-regulatory abilities have been sufficiently developed, babies often start to ‘tell the story’ of their pregnancy and birth during therapy sessions. We then focus on the specific body language and expression processes of the child that give us clues as to the time and type of the pregnancy or birth trauma. In therapy sessions, infants spontaneously repeat the body postures that were linked to especially high stress points during the pregnancy or birth. Through body language

they not only convey at what point it was ‘too much’ and what their distress was, but they also display what kind of support they would have needed in order to successfully complete the birth process by themselves (Hildebrandt, 2015; Renggli, 2013). During baby-centered process work, the therapist remains in constant dialogue with the child. He ‘mirrors’ the infant's body language and translates it into a language that allows the parents to view the origin of their child's problematic behavior (e.g. desperate non-stop crying) from a different and emotionally new perspective.

Case study

Daniel is four months old and was born by emergency cesarean. During a therapy session he lies on his side during one of the observation sequences. He repeatedly starts a rotation movement. Although he has already learnt to roll from his back onto his belly, he suddenly stops and rolls back. His mother, who is watching, had been talking in detail about her pain and her ‘stuckness’ in the last phase of Daniel's birth. The child now rolls again onto his right side. He groans and a few moments later, starts sobbing. He keeps turning his head from left to right as if he was trying to wrench himself away from something. His scalp is red and big drops of sweat appear on his forehead. I get the intuitive impulse to put my hand on the right hand side of his skull. He now pushes his head into my hand and pushes against it. I start saying to Daniel: ‘Yes, you are doing well. Show me what happened. I am with you’. I glance at the mother, who is following the process and she, too, feels that her son is repeating and experiencing something important. I tell Daniel what I see: ‘Your mum is also very close to you now and sees what is going on. Show us what happened and what your body wants to do”. Daniel's movements now become increasingly intense. I can see how he is struggling whilst pushing forward with his head. He is unable to get anywhere as if he was stuck. His crying is now desperate and high pitched. I keep encouraging the mother to connect with her child through the breath. Suddenly, Daniel stops as if to take a creative break. With renewed momentum he successfully rolls onto his belly and starts to kick with his feet. I get

the impulse to put my hands against the soles of his feet. Daniel is still sobbing but now he starts to push his legs vigorously resulting in him moving across the mat in two or three movements. This is followed by a deep sigh on the out-breath. I now invite the mother to receive her son who literally pushes himself into her hands. She picks him up and takes him into her arms. He is still breathing fast and is somewhat agitated. But it takes only a few moments for him to rest his head, relax his body and 'land' on his mother's belly. A few minutes of intimate silence pass. The room is filled with profound emotion and gratitude. The mother caresses Daniel gently and lovingly. 'Now I have the feeling that we are very close. I have never seen him like this' she says at the end of the session.

Conclusion

This small case study is an example of birth regression. This baby-centered regression method has its place in Emotional First Aid where the mothers and fathers have already gained the ability to self-connect securely. In this case, the infant relived an unfinished 'gestalt' of his birth process. However, the therapeutic benefit does not just consist in reliving and repeating a perinatal pattern. What matters most is that the baby experiences his parents as present and available co-regulators. Only newly-felt relational safety creates the foundation for the infant to release and re-integrate specific developmental traumas.

I would like to conclude by emphasizing that within EFA, as opposed to other models of prenatal body psychotherapy, it is not the re-framing of overwhelming birth and pregnancy experiences that is the centre of our focus. It is the development of an altered present-moment state that encourages embodied centeredness and emotional availability that this approach aims at (Stern, 2010). The infant has to be able to feel the embodied experience of safety and being held. Developing embodied self-awareness on the part of the parents creates the necessary foundation on which implicit physical memories can be expressed and relived by the child. In my opinion, the benefit of this method does not so much lie in re-enactment but in the fact that during the therapeutic

regression of the child, the parents feel so safe within themselves that even in the most difficult moments, they are able to ‘stay with’ their child.

REFERENCES

Bowlby, J. (2010). *Frühe Bindung und kindliche Entwicklung*. München: Ernst Reinhardt.

Brisch, K.H. (2000). *Bindungsstörungen. Von der Bindungstheorie zur Therapie*. Stuttgart: Klett-Cotta.

Brisch, K.H. (2008). *Die Anfänge der Eltern-Kind-Bindung: Schwangerschaft, Geburt und Psychotherapie.* Stuttgart: Klett-Cotta.

Brisch, K.H. (2010). *SAFE. Sichere Ausbildung für Eltern.* Stuttgart: Klett-Cotta.

Brisch, K.H. (2013). *Schwangerschaft und Geburt. Bindungspsychotherapie – Bindungsbasierte Beratung und Therapie.* Stuttgart: Klett-Cotta.

Cierpka, M. (Hrsg.). (2012). *Frühe Kindheit (0–3 Jahre). Beratung und Psychotherapie für Eltern mit Säuglingen und Kleinkindern.* Heidelberg: Springer.

Cierpka, M. & Windaus, E. (Hrsg.). (2007). *Psychoanalytische Säugling-Kleinkind-Eltern-Psychotherapie. Konzepte – Leitlinien – Manuale.* Frankfurt a.M.: Brandes & Apsel.

Damasio, A. (2006). *Der Spinoza-Effekt. Wie Gefühle unser Leben bestimmen.* Berlin: List.

Diederichs, P. & Jungclaussen, I. (2009). Zwölf Jahre Berliner SchreiBabyAmbulanzen – eine Positionierung körperpsychotherapeutischer Krisenintervention und früher Hilfen. In M. Thielen (Hrsg.), *Körper – Gefühl – Denken* (S. 209–251). Gießen: Psychosozial-Verlag.

Deyringer, M. (2008). *Bindung durch Berührung*. Berlin: Leutner.

Downing, G. & Ziegenhain, U. (2001): Besonderheiten der Beratung und Therapie bei jugendlichen Müttern und ihren Säuglingen – die Bedeutung von Bindungstheorie und videogestützter Intervention. In H. Scheuerer-English, G.J. Suess & W.-K. Pfeiffer (Hrsg.), *Anwendung der*

Bindungstheorie in Beratung und Therapie (S. 271–295). Gießen: Psychosozial-Verlag.

Downing, G. (2006). Frühkindlicher Affektaustausch und dessen Beziehung zum Körper. In G. Marlock & H. Weiss (Hrsg.), *Handbuch der Körperpsychotherapie* (S. 333–351). Stuttgart: Schattauer.

Eberwein, W. (2009). *Humanistische Psychotherapie. Quellen, Theorien und Techniken*. Stuttgart: Thieme.

Eberwein, W. & Thielen, M. (Hrsg.). (2014). *Humanistische Psychotherapie. Methoden, Theorien, Wirksamkeit.* Gießen: Psychosozial-Verlag.

Emerson. W. (2012). *Behandlung von Geburtstraumata bei Säuglingen und Kindern.* Heidelberg: Mattes.

Evertz, K., Janus, L. & Linder, R. (2014). *Lehrbuch der Pränatalen Psychologie*. Heidelberg: Mattes.

Fogel, A. (2013). *Selbstwahrnehmung und Embodiment in der Körperpsychotherapie. Vom Körpergefühl zur Kognition.* Stuttgart: Schattauer.

Fraiberg, S. (Hrsg.). (2011). *Seelische Gesundheit in den ersten Lebensjahren*. Gießen: Psychosozial-Verlag.

Gendlin, E. (1998). *Focussing – orientierte Psychotherapie. Ein Handbuch der erlebnisbezogenen Methode.* München: Pfeiffer.

Geuter, U. (2015). *Körperpsychotherapie. Grundriss einer Theorie für die klinische Praxis*. Heidelberg: Springer.

Harms, T. (1999). Instroke und frühe Säuglingsentwicklung. Theorie und Praxis der bioenergetischen Säuglingsforschungen Wilhelm Reichs. In H. Lassek (Hrsg.), *Wissenschaft vom Lebendigen* (S. 163–193). Berlin: Leutner.

Harms, T. (Hrsg.). (2000). *Auf die Welt gekommen. Die neuen Babytherapien.* Berlin: Leutner.

Harms, T. (2008). *Emotionelle Erste Hilfe. Bindungsförderung, Krisenintervention, Eltern-Baby-Therapie.* Berlin: Leutner.

Harms, T. (2013). Eltern-Baby-Körperpsychotherapie im Spannungsfeld von Trauma und Bindung. In M. Thielen (Hrsg.). *Körper – Gruppe – Gesellschaft. Neue Entwicklung in der Körperpsychotherapie.* Gießen: Psychosozial-Verlag.

Hildebrandt, S. (Hrsg.). (2015). *Schwangerschaft und Geburt prägen das Leben*. Heidelberg: Mattes.

Jansen, F. & Streit, U. (Hrsg.). (2015). *Fähig zum Körperkontakt*. Heidelberg: Springer.

Israel, A. (Hrsg.). (2007). *Der Säugling und seine Eltern. Die psychoanalytische Behandlung frühester Entwicklungsstörungen.* Frankfurt a.M.: Brandes & Apsel.

Levine, P. (2010). *Sprache ohne Worte. Wie unser Körper Trauma verarbeitet und uns in die Balance zurückführt*. München: Kösel.

Meyer, A. (2015). *Sanfte Schmetterlings-Babymassage.* Frankfurt a.M.: Meyer-Info3.

Odgen, P, Minton, K. & Pain, C. (2010). *Trauma und Körper. Ein sensumotorischer orientierter psychotherapeutischer Ansatz.* Paderborn: Junfermann.

Overly, R.C. (2005). *Gentle Bioenergetics. Theory and Tools for Everyone.* Greensboro: Lifestyle Press.

Papousek, M., Schieche, M. & Wurmser, H. (2004). *Regulationsstörungen in der frühen Kindheit*. Bern: Huber.

Porges, S. (1998). Love: An Emergent Property of the Mammalian Autonomic Nervous System. *Psychoneuroendocrinology, 23*(8), 837–861.

Porges, S. (2005). Neurozeption – die drei Regelkreise des Autonomen Nervensystems. In *Trauma-Newsletter 3* (S. 3–5). Zürich: Zentrum für Innere Ökologie.

Porges, S. (2010). *Die Polyvagal-Theorie. Emotion. Bindung. Kommunikation und ihre Entstehung*. Paderborn: Junfermann.

Reich, E. & Zornànszky, E. (1993). *Lebensenergie durch Sanfte Bioenergetik.* München: Kösel.

Reich. E. & Weaver, J. (2006). Emotionale Erste Hilfe. In G. Marlock & H. Weiss (Hrsg.). *Handbuch der Körperpsychotherapie* (S. 823–828). Stuttgart: Schattauer.

Reich, W. (1987). *Children of the Future. On the Prevention of Sexual Pathology*. New York: Giroux, Farrar & Strauss.

Reich, W. (1997). *Charakteranalyse*. Köln: Kiepenheuer & Witsch.

Reich, W. (2010). *Die Entdeckung des Orgons I. Die Funktion des Orgasmus*. Köln: Kiepenheuer & Witsch.

Renggli, F. (2013). *Das goldene Tor zum Leben: Wie unser Trauma aus Geburt und Schwangerschaft ausheilen kann.* München: Arkana.

Schindler, P. (Hrsg.). (2011). *Am Anfang des Lebens. Neue körperpsychotherapeutische Erkenntnisse über unsere frühesten Prägungen durch Schwangerschaft und Geburt*. Basel: Schwalber-Verlag.

Siegel, D.J. (2010). *Die Alchemie der Gefühle*. New York: Kailash.

Solter, A. (2009). *Warum Babys weinen. Die Gefühle von Kleinkindern.* München: Kösel.

Stern, D. (2010). *Der Gegenwartsmoment: Veränderungsprozesse in Psychoanalyse, Psychotherapie und Alltag.* Frankfurt a.M.: Brandes & Apsel.

Terry, K. (2006). Therapeutische Arbeit mit »Schreibabys«. In G. Marlock & H. Weiss (Hrsg.), *Handbuch der Körperpsychotherapie* (787–796). Stuttgart: Schattauer.

Terry, K. (2014). *Vom Schreien und Schmusen, Vom Weinen zur Wonne*: *Babys verstehen und heilen.* Wien: Axel Jentzsch Verlag.

Thielen, M. (Hrsg.). (2009). *Körper – Gefühl – Denken. Körperpsychotherapie und Selbstregulation*. Gießen: Psychosozial-Verlag.

Van der Kolk, B. (2014). *Verkörperter Schrecken. Traumaspuren in Gehirn, Geist und Körper und wie man sie heilen kann.* Lichtenau: G.P. Probst Verlag.

Weiss, H., Harrer, M.E. & Dietz, T. (2010). *Das Achtsamkeitsbuch. Grundlagen, Anwendungen., Übungen.* Stuttgart: Klett-Cotta.

Wendelstadt, S. (1999). Heilung durch Berührung. Eva Reichs Baby-Schmetterlingsmassage zur Erhaltung der Gesundheit und Vorbeugung von Biopathien. In *Emotion, Band 14* (S. 34–48).

Berlin: VKD-Publikationen.