

PEDIATRIC CRANIOSACRAL THERAPY

PART ONE - ESTABLISHING CONTACT

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An infant is fully conscious at birth. In fact, it is known that moments after conception a human being is uniquely human in shape, position and structure (Bleichschmidt 1977). In each stage of development whether it's an embryo, a fetus, a newborn, a child, etc. a human being is whole and complete. Even the young conceptus is conscious and capable of experiencing pain and pleasure. It has decision-making capacity even without a nervous system. The study of embryology teaches us this principle: wholeness is our conception right. Yet, along the way the human embryo undergoes stress and trauma. We develop through certain specific stages, which have been well documented both in embryology and developmental psychology. Within these stages of development there are numerous specific differentiations that occur that give us our individual uniqueness and personality. However, when we experience stress, trauma or shock in any stage of life, but especially during the pre- and perinatal period, there can be devastating consequences to our health throughout the life span. This fact was recently reported on the cover of Time magazine in September of 1999.

Along with these consequences of prenatal trauma and shock such as maternal cigarette and alcohol use, thoughts of abortion, adoption and others, there is yet another hurdle to cross. We must be born nine-months after being conceived. Here in the West the "medicalization" of the birth process, while saving many lives also leaves scars on the mind and body of the infant and future adult. Emerson (1999) reports that 95% of western births involve shock and trauma to the infant. This number in itself is shocking. This chapter is not about the right or the wrong of western birth practices; it is about the use of craniosacral therapy when encountering birth dynamics, whether in an adult or in an infant, from the point of view of pre and perinatal psychology. How does the craniosacral therapist meet the shock and trauma in an infant or the infant in the adult and hold it in a way that allows resolution to occur?

I have encountered numerous protocols for treating infants and children using craniosacral therapy. My experience spans over the last twenty years with a particular focus on infants and children with brain damage and/or developmental delays. The protocols I've learned in the past while valuable for some children were non-the-less formalistic and biomechanical in nature, which frequently disempowers the child. A different set of skills needs to be learned and incorporated into the treatment of newborns and who experience shock and trauma in utero and during birth. Part one of these chapters on pediatric craniosacral therapy discusses how to make well-bounded contact with an infant (or the infant in the adult). The principle is to honor the consciousness of the infant and therefore pediatric craniosacral therapy is infant centered therapy.

To begin with the therapist must understand that the newborn is undifferentiated from the mother. The infant is actively involved in a process called self-attachment and bonding. This process is the foundation of love. It includes somatic and neurological development as well as the integration of emotions which is the primary neurological job in the first two years of life. The mother and father are part of the metabolic field of the child. The infant in turn must take care of the parents in order to insure its own safety and protection. This principle of growth is a very strong force in the infant: to take care of the mother or primary caregiver. I have often seen an infant try to stroke or cuddle their mother in a nurturing way

when they sense that she is under stress. Likewise the parents must protect and resource the infant as much as possible through nurturing physical touch, eye gazing (which develops the right hemisphere on the brain), verbal mirroring and a host of non-verbal contact skills. These behaviors or instincts support the healthy development of the baby in this critical time of its new life. Therefore the first role of the therapist is to evaluate shock and trauma in the whole family system as well as the self-attachment and bonding sequence. The mother is the primary resource and she must be supported in a treatment session as much as the infant. Are they bonding via breast feeding, etc.? Where is the stress in their relationship?

Resourcing the infant through eye contact is crucial. If the infant and mother are not able to make deep eye contact with each other, it may be an indicator of shock. The mother and the infant metabolize each others feeling states through non-verbal contact such as eye gazing, skin to skin contact, respiratory and cardiovascular entrainment (Schoore 1996). The infant helps to absorb and process the mother's emotional states as much as the mother absorbs and processes the infants through her own mind and body. They are metabolically linked together, each one helping the other by a similar means. Likewise, the therapist enters the metabolic field and begins to exchange with or holds the difficult places in the infant-mother relationship. In part four of this series on Pediatric Craniosacral Therapy, I will go into some detail on this process of co-metabolism.

The therapist must find out the story of the birth but without the infant present. Otherwise it can be retraumatizing to the infant. Remember, infants hear and understand everything but in their own way. Infants experience and process the world with their whole body. We construct a body image as the world communicates to us through our skin to our internal soft tissue and fluid systems, the home of our inner world of knowing who we are. Our body is our original ego in the first six years of life. The limbic system, especially the amygdala, which is the prime signifier of emotions, is quite active in babies and directly connected to the right hemisphere, the emotional cortex. The first few sessions of craniosacral therapy with an infant involve a process of discovery and observation of these deep physical and emotional interactions. The therapist must learn how to support both the mother and her child, especially allowing the infant to be in ready physical contact with her. Thus the early sessions of craniosacral therapy are more observational and contained. The therapist watches how the story of this birth is being played out between mother and child and senses slowly into the field of love and bonding being created moment by moment. I really enjoy being in the presence of the mother-infant bond. It is so incredibly warm and tender.

The infant needs to be fully informed of the purpose of his or her visit with the therapist. The craniosacral therapist must speak in the first person to the infant. "Do you know what I do?" The therapist explains to the infant what they do and who they are. Infants are quite capable of responding to this information except with certain kinds of shock. They often shake their head knowingly from side to side to indicate "no". So the therapist carefully observes the infant for their communication style. Infants will use their whole body to speak in response to a question or comment. They will also verbally talk to the therapist. The conversation skills are emotionally based and developed in the body ego i.e. skin, muscles, vocal tones, micro movements, macro movements, etc. It may take a session or two for the therapist to intuit the infants unique style of communication. It is equally important to state questions and comments to the infant simply in a way that only require yes and no answers. The infant just went through a very intense experience and wants to

tell the story. Someone needs to listen and the infant needs to know it's being heard for healing to occur.

As the therapist discusses his or her intentions with the infant they begin to pay close attention to the infant's physical movement patterns. The goal of tracking these movements is to see where the infant's personal space extends via the amount of extension the infant is capable of making with their arms. Spastic, jerky and uncoordinated movements are often signs of shock. When the therapist has a clear picture of the physical space the infant inhabits then contact is negotiated at that point in space. The therapist asks for permission to touch the infant. Often an infant will say no at first with a definitive movement of their head, their body or a vocalization. Follow the infant's lead and talk to them a little more about why touch is important. Here is a key: It's important for the therapist to give up any intention of being clinical with their hands in the early sessions of craniosacral therapy. The actual intention is to establish safety and trust with the infant so that the physical contact is contained in loving kindness rather than the lifting of a frontal bone, etc. Structural work comes later; evaluation of shock, trauma and the bonding sequence is first. The therapy is playful rather than clinical.

When first contact is made on the periphery of the infant's physical space it is usually done by touching part of their hand. The therapist inquires verbally if that touch is comfortable. Then the therapist begins to follow the infant's gestures playfully while acknowledging and mirroring the infant. The therapist must track if the contact is activating the infant sympathetically. The therapist always allows the infant to be resourced with the mother. Often an infant will push or brush away the therapist's hand when he or she wants to take a break. I have found that infants like to take a break quite often especially if they carry shock and trauma. This may include the transference onto the therapist as the obstetrician that delivered the baby. This disengagement of contact must be allowed and actually encouraged. The infant must always win when they express a need especially regarding a boundary around physical contact. The therapist is carefully watching the cycle of the autonomic nervous system as it goes into activation and then settling. This is an important principle: the ability of the therapist to observe autonomic nervous system. There can be little value gained from a therapeutic intervention until the therapist is clear how the infant resources themselves both internally and externally. How does the infant settle or resource itself once he or she has been activated? Is the infant hungry or does it need to be held by the mother?

Shock babies will often become distressed quite suddenly during play or contact with the therapist. If this activation occurs spontaneously the therapist acknowledges that to the infant, "Yes that is a very difficult place and you have every right to be upset". Everyone's feelings must be acknowledged in some way for deep healing to take place. This is especially true of the infant's feelings and emotions. If the infant has an anger response then it's important to acknowledge him or her by saying, "I see you're angry" or "I see you're happy", etc. The therapist must accurately reflect the feeling states that are evoked in the infant during the treatment. The shock that results from medical interventions during the birth process not only must be acknowledged but also requires an apology. As a therapist I often find myself saying to an infant "I'm sorry that happened to you when you were born". Many medical interventions are necessary and many are completely unnecessary. Regardless, they frequently shock and traumatize the infant necessitating an apology. This is true even if a therapist encounters someone's birth issues when they are an adult. The client, the infant must hear an apology to heal that wound. The infant experiences a deep sense of emotional betrayal as result of the shock and trauma from birth interventions. The message they get at birth is "You do not get to do it your way, you

are forced to do it my way". At some point in the first or second session when working with an infant and when I know they are available for the listening, I'll offer them an apology. I will also let the infant know that everyone was worried about them when they were born and felt they had to do what they did to save their life.

The two most fundamental things that infants need in their primary respiratory system are space and choices. Birth dynamics involve compression and very few choices especially if there is a cascade of medical interventions. One intervention frequently leads to another. Therefore the therapist who eventually establishes well-negotiated contact with the infant makes these two offerings of space and choices to the infant's primary respiratory system. These offerings comprise the first clinical protocol when treating infants. Once the preliminary evaluation as I've just talked about is thoroughly negotiated, then the therapist can make these telepathic suggestions to the infant. The therapist is attempting to contain the physiological and psychological aspects of the infant's shock and trauma. The therapist holds the shock and trauma silently as an inner witness. Certain elements of the birth can be referred to while the therapist is working with the infant but without being too literal or descriptive. When the therapist senses part of the trauma schema in the infant's craniosacral system he or she might say "Oh, that was a lot for you" rather than saying "Oh, those forceps were big and nasty". The difficult parts of the birth story are held by the therapist within their heart, who then retells the story wordlessly while in the presence of the infant. In this way the shock and trauma of the birth events are acknowledged and held in a silent container. This communication is received and integrated by the infant's fluid system. The therapist suggests space "Would you like some space here?" Then the therapist suggests choices to the infant "Would you like to do something different here?"

All together, the above suggestions usually involve the first several sessions in which a craniosacral therapist sees an infant. Typically I am with an infant no more than 20 or 30 minutes. If the time goes beyond that it must be carefully negotiated especially for infants with shock and trauma. In part two I will continue to discuss the next themes for a therapist to explore with an infant in craniosacral therapy, which are the four stages of birth, conjunct sites and conjunct pathways. In part three I will continue to discuss the biodynamics of the ignition process in the fluid system of the infant during birth and evaluating specific biomechanical parts of the whole body and craniosacral system. Finally in part four I will discuss emotional development in infants. I am most grateful for my mentors, Ray Castellino and Franklyn Sills, for showing me a common sense approach to treating infants.

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