Clinical Perspective

Essential Clinical Principles For Prenatal and Perinatal Psychology Practitioners[1]

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Abstract: The burgeoning research in attachment theory, affective neuroscience, polyvagal theory, epigenetics, and trauma treatment has given new directions for the practice of prenatal and perinatal psychology. The authors offer essential fundamentals for the integration of these new principles into clinical practice with individuals and families from pre-conception through adulthood. Within attachment theory, affective neuroscience, and the clinician as key instrument in the healing process, the authors delineate six phases of pre- and perinatal therapy, including specific principles and practices for each phase.

Key words*:* Prenatal, Perinatal, Psychotherapy, Attachment, Epigenetics, Affective Neuroscience, Mindfulness, Therapeutic Relationship.

In the past two decades scientific discoveries across disciplines have given new credence to what professionals in prenatal and perinatal psychology have long believed. We are seeing dramatic paradigm shifts in what we know about the experience of babies and what it takes to raise healthy, resilient children. The research concerning our capacity for healing and change throughout the lifespan has likewise contributed to these important new paradigms.

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[1] Due to the broad scope of practice in prenatal and perinatal psychology, we use the terms patient and client interchangeably and the terms therapist, clinician, practitioner and helping professional as equivalents.

These new perspectives are a convergence of the diverse disciplines of epigenetics, neuroscience, brain imaging studies, attachment theory, and the prevention and healing of trauma. Even Nobel Prize-winning economists, business and economic leaders are seeing the importance of investing in our earliest development (McCarty & Glenn, 2008).
Some of these findings that impact our work include:

- The expression of our DNA is largely determined by our environment.
- The development of our brain is shaped by experience from the beginning and throughout the lifespan.
- Our capacity for self-regulation, connection, and resiliency is determined by the *quality* of our first relationships from conception onward.
- It is through experience in relationship that we can change the brain, strengthen our capacity for self-regulation, and improve the quality of our connection with others at any time throughout our lives.
- Our capacity to produce, read, and accurately interpret cues, such as facial expression, auditory nuances, intensity in vocal tone, the meaning of eye-contact, and other nonverbal cues such as postures and gestures is determined by the health of our own social engagement system initially defined by our earliest development.

We in prenatal and perinatal psychology now have solid and increasingly recognized science behind us. It is therefore vital that we strengthen our leadership role in creating healthy families, children, and adults who thrive. Given this groundbreaking research we need to take a new look at the way we practice our art and craft.

This paper offers a fresh perspective on the essential fundamentals needed for effective practice in prenatal and perinatal psychology. These include a rationale for the incorporation of the latest research in epigenetics, affective neuroscience (the psychoneurobiology of our earliest development), attachment theory as well as trauma prevention and treatment, and the principles needed for integrating this new research into our work. These principles and techniques apply

regardless of whether one is practicing with pregnant couples, birthing families, children or adults.

The fundamentals presented here emerged from several decades of clinical practice, trainings, and supervision for experienced pre- and perinatal clinicians. They are informed by years of teaching and conducting research with graduate level pre- and perinatal therapists. Blending of the emerging research in these disparate yet related fields mentioned here demand that we bring to the forefront of practice the relationship between patient and clinician. It is also obvious that we need to embody the very principles of our work with birthing families, infants, and adults.

Consequently, this paper explores the healing relationship and the importance of being an embodied clinician. We examine the rationale for the importance of relational healing including early brain development, especially the process of attachment as well as the promise of healing at any stage of development. Next, we explore what we mean by the person of the therapist, the clinician as tool or self as instrument and specifically how any clinician can become more present, more embodied so that the relationship is deeper and healing is more evident. Finally, we look at therapeutic protocols that access pre- and perinatal issues within the early attachment system and help integrate multiple aspects of the brain, promoting optimal healing.

The Patient – Clinician Relationship

Professional training in clinical practice teaches us to effectively explore patients' symptoms, cognitions, and psychodynamics, and to note diagnoses. We learn techniques of therapy, schools of thought, and efficacy studies. Yet, what has been discovered is that, more important than the type of treatment or school of thought in the healing process is the effectiveness of the patient – clinician relationship. Decades of research have demonstrated regardless of philosophy or discipline, the one common element of effective helping professionals whether they are psychiatrists, psychologists, psychotherapists, health care providers or educators – helpers across all disciplines – is the relationship between client and helper (Corey, 2009). A number of studies also reveal that the most important ingredient in effective therapy regardless of the modality, is the empathic capacity of the therapist (Hutterer & Liss, 2006). Both sets of studies point to the importance of the patient – practitioner

relationship. We know that Freud (1900/1965) spoke of the birth experience as the prototype of all later anxiety. He abandoned this idea in favor of his Oedipal theories. However, his protégée, Otto Rank, later explored the birth experience and published his theories in *The Trauma of Birth* (1924/1960). Over the following decades, many other psychoanalytic writers addressed the birth experience and its impact over the years (Ferenczi 1938/1989; Fodor 1949; Winnicott, 1958). In the early 1960s, Carl Rogers began developing the Humanistic (person-centered) approach to psychology. In spite of the fact that the patient-clinician relationship has been studied and highlighted for decades, training in psychotherapy has focused very little on the vital aspects of the body, being and experience of the therapist (Shaw, 2004). Even with an awareness of the profound impact of the relationship on the healing process, we often lose sight of the fact that the therapist is half of the healing relationship! The essential ground of any healing resonance between patient and therapist resides in the body, person and being of the therapist. The therapeutic encounter must be an embodied encounter, where the therapist tracks her own process as well as that of the client. In pre-and perinatal therapy, the embodied clinician- patient relationship is even more vital, given the formative aspects of this developmental period and re-wiring of the brain, and healing early traumas, are built on non-verbal, bodily actions and responses.

For the pre- and perinatal practitioner, an embodied relationship is especially critical for two reasons: First, for the optimal healing of the patient, which will be discussed here. Second, the relationship is vital for the optimal personal and professional functioning of the practitioner, which will be discussed later in this paper. For now, we will demonstrate how the therapist is key in helping the patient of any age access and heal their current malady, the foundation of which most likely rests in the pre- and perinatal period and therefore affects the attachment system. We are additionally well aware that this early developmental period provides the foundation for development of our attachment strategies and subsequently the mechanisms imperative to our capacity for self-regulation, relationship and resilience throughout life. So whether we are supporting patients for optimal outcomes, preventing or healing trauma, the embodied patient – clinician relationship and the attachment strategies of both are foundational (Mallinckrodt, B.

2010; Wallin, D., 2007). We note that the attachment components are the same for the infant – caregiver dyad and the patient – clinician dyad.

Attachment

In pre- and perinatal psychology we know that babies are conscious, aware, learning and relating from the beginning. At birth, it is human nature to seek a continuation and expansion of the connection that was present within the womb. The events surrounding birth and the *quality* of this connection, as well as the attachment strategies that continue to develop over the next few months, determines one's experience of safety, the capacity to connect, explore, and develop a sense of self and healthy relationships. Given this, we now know that attachment theory provides a solid foundation for our work as pre-and perinatal clinicians.

Attachment is simply defined as the emotional bond between a parent and child. We note that this also includes significant others. John Bowlby (1969/1982) first described attachment as a "lasting psychological connectedness between human beings" (p. 194). A secure attachment offers the infant a safe haven of comfort in times of threat or fear and a secure base from which to explore the world (Bowlby, 1969/1982). Mary Ainsworth (1978) added several important dimensions to Bowlby's work including an understanding of infants who do not have a secure beginning. She identified ambivalent and avoidant insecure attachment strategies. Main and Solomon (1986) later added disorganized, another dimension within the differing attachment strategies. In 1994 Schore defined attachment as the interactive regulation of biological synchronicity between organisms, bringing affective neuroscience into the study of attachment. Here we provide a cursory look at the building blocks of attachment and the development of the brain in service of deepening the effectiveness of our work as pre-and perinatal clinicians. It is prudent for us now to develop a broad base of understanding of these overlapping areas and bring them into our work with infants, young families, and adults.

As pre- and perinatal clinicians we are acutely aware of the importance of our earliest development and know that the development of our attachment strategies actually begins much earlier than the first extra-uterine contact baby has with mother.

Epigenetics has added to our depth of understanding with the knowledge that gene expression is in large part dependent on the environment (Lipton, 2005). That is, our DNA expresses itself in response to current conditions within the organism and its environs. Affective neuroscience teaches us that brain development is also dependent on experience (Schore, 1994). Our evolution as a species helps us adapt to our environment and, as individuals to our physical development. Our capacity for self-regulation, connection and resilience is especially determined by our environment and experience, beginning prenatally. It is this experience dependent aspect of development that interests us because it guides us in the possibility of change.

Within the embryo the brain structures are some of the first to form. Beginning with the neural tube and continuing development throughout gestation results in a fully functional brainstem at birth. This means that our sense of safety, and the fight – flight – freeze mechanisms, vital body regulatory functions, thirst and sleep are present at birth. Throughout the gestational period the foundational structures that will support the attachment strategies begin to develop within the baby's brain. It should be noted that unattenuated levels of maternal anxiety or depression can have detrimental effects on the baby's developing brain and nervous system and the ensuing attachment between mother and baby (Mulder, et al, 2002; Salm, et al, 2004; Sandman, Davis, Buss, & Glynn, 2011). We note that there are important aspects not covered here, such as the mother's physical health and habits, as well as environmental factors.

We know that the process of birth itself has tremendous and lasting impact on the infant's sense of safety and capacity for connection (Chamberlain, 1988; Verny, 1981). Our pre- and perinatal literature is replete with strong evidence of this vital experience. Here we emphasize that these first experiences form the foundation for the attachment strategies and therefore for ongoing brain development. From our clinical experience we are also aware that these first experiences create imprints that tend to be repeated at times of transition and high stress throughout life.

From the very beginning and as the infant develops, attuned communication and a relationship that enjoys what Schore (2003b) calls affect synchrony builds connections between the limbic and neocortical areas of the brain. "Synchrony develops as a consequence of each partner's learning the rhythmic

structure of the other and modifying his or her behavior to fit that structure" (Lester, Hoffman, & Brazelton, 1985, p.24). In the infant-parent interaction, "the mother must be psychobiologically attuned not so much to the child's overt behavior as to the reflections of his/her internal state." (Schore, 2003b, p. 39).

The developing limbic areas of the brain receive cues nonverbally through the senses, heart and gut. Porges (2003) indicates that through eye contact, facial expression, tone of voice, gesture, posture, touch, timing and intensity we assess for safety and contingency in our earliest relationships. It is through these early exchanges the attachment strategies are formed. Recall that Bowlby (1983) stressed the importance of the quality of infant/caregiver relationship as a determinate for the overall quality of attachment. Advances in technology have helped to substantiate these early observations by Bowlby and others demonstrating that the quality of the primary relationships is instrumental in the development of the brain. Through nonverbal cues we assess, both from other and from within, whether the present situation is safe or not, and whether we should engage or retreat. Our formative experiences impact our ability to assess friend or foe accurately as a function of the early attachment experiences and subsequent adaptive brain development.

Research by Vrtic˘ka , et al (2008) reveals that individuals who utilize the differing attachment strategies demonstrate differing levels of brain activity in the regions of the brain associated with states of joy and fear respectively. It follows that the infant who has not been provided a bodily experience of safety subsequently will be less able to recognize safety when it is provided. Additionally, the infant who receives only intermittent experience of safety demonstrates adaptive brain development that reflects his experiences as well, leading to difficulty with the recognition of safety and a preoccupation with re-acquisition of that safe experience such that he has difficulty being present to social engagement attempts when they are provided. Ultimately both these experiences often culminate in the misreading of the social cues of others and either trusting too easily or having too great a defensive stance.

This challenge with the reading of social cues of others is most easily identified in children with insecure attachment strategies. . This is especially notable in those utilizing attachment strategies with any unresolved/disorganized overlay (Siegel, 2010). When children with insecure attachment

strategies encounter someone whose words are not congruent with their nonverbal cues, they will be more likely to tune into the incongruencies thus vigilant to avoid their early experiences of either absent or inconsistent safety. Sometimes cues the child picks up are either overly amplified or generally not giving them accurate information. The child, and later the adult, must then learn to trust appropriately. Learning to experience trust requires repeated experiences with an attuned other to begin to internalize a felt sense of safety.

From a therapeutic standpoint, in order to effect a change in the attachment strategy we must effect a change in the patient's system that assesses safety. When our patient has an experience of their own accuracy of assessment, their own power, they can see or experience from a different prospective.

Attachment in Prenatal and Perinatal Therapy

In pre-and perinatal therapy we most often see infants or adults who may have experienced early trauma and/or whose attachment system has been disrupted. To understand our role in the healing process, we again turn to affective neuroscience. As early as 1949 Donald Hebb published his theory that experience creates neuronal connections: neurons that fire together, wire together. We now understand that all the facets of an experience begin to coalesce and create what we call neural nets (Siegel, 1999, 2012). We might think of these neural nets as encoded representations of a type of event (Badenoch, 2008). In an act of current recall, a small part of the net lights up and, potentially, accesses the entire net. In so doing, every remembrance has the potential to engender change (Siegel, 2012). This is an exciting finding for us as clinicians.

Metaphorically, inside these neural nets reside our mental models or a system of thoughts, behaviors, beliefs, expectations, and emotions relating to ourselves and others that were created during our earliest experiences with caregivers, especially prenatally. Our mental models contain our usually unconscious beliefs about ourselves and the world as well as decisions about how we have to be in the world to survive and have our needs met. These include beliefs such as, "I'm not enough; I'm not lovable" and "The world is not safe; no one will ever meet my needs." The decision is then some version of "I have to be good, take care of others, not have needs" or "I have to be demanding or act out in

order to have my needs met." These mental models become the foundation of our worldview, our "Truth" about others and ourselves. It follows that it is through this perspective that we view the world and imagine the world is viewing us. This perceptual bias literally colors what we are able see and receive, and creates an expectation of how others will respond to us. While our mental models and our perceptual biases initially help us survive in our particular family, they skew our perception of reality bringing negative and false information, keeping us from a sense of coherence within ourselves and healthy connections with others.

Since these mental models, perceptual biases and the early attachment strategies are pre-verbal and unconscious, emanating from the right hemisphere and the more primitive structures of the brain – the limbic system and brain stem – (Schore, 2003b) they are most readily accessed through right brain and limbic processes at any point in life. Furthermore, since they were generated in the context of relationship, change is best facilitated in present moment experience within an attuned relationship.

Given this, we must consider that some of the philosophies and techniques we used in pre-and perinatal therapy decades ago, and some we may continue to use today, may need to be re-examined. We now know that changing the brain is dependent on experience and what is needed to prevent and heal early trauma is authentic, safe, consistent connection. Deeply healing (and certainly preventative) work has at its foundation an experience of contingent communication with an attuned other, affect synchrony and moments of meeting (Sander, 1992; Stern 1985), all part of healthy attachment relationships.

In light of this, what has emerged is a simpler, often softer, more effective set of principles for therapeutic work. We may need to examine the approaches we use with clients and ask ourselves: Does this intervention support the patient's feeling of safety, their ability to connect with their experience and/or to feel deeply held or met by a trusted other? Do I rely on behavioral interventions and more left-brain, cognitive therapies that may overlook early pre- and perinatal experiences and attachment needs? On the other end of the spectrum, we may ask ourselves: Do my patients sometimes move quickly into their trauma history without being resourced or dive deeply into feelings, such as primal work, without connection to another or the present

moment? Do my patients dissociate or "disappear" during our work? The objective is no longer to simply discover one's history, re-experience birth and/or express feelings. It is to follow the body/psyche's process with curiosity and support so that the patient can experience having emotions that arise naturally in the context of a safe container, within the larger story and in relation to an attuned other who supports their natural expression. The objective is to have an experience of being met within a caring relationship. This process helps the patient create new neural pathways and new mental models. It also supports the long-term goal of formation of a coherent narrative and greater self-regulation (Badenoch, 2008).

In so doing, we help our patients *experience* the components of a healthy attachment through which they can heal their early trauma and begin to build an "earned secure" attachment. Even if the client demonstrates a secure attachment strategy, the early trauma resides in the pre-verbal unconscious structures of the brain and therefore, the attachment system. We want the patient to have an experience of being deeply seen, a feeling of "you understand what this is like for me, you are here with me, you can help me hold this and not judge me or leave me." Accessing the patient's attachment system, the clinician becomes the attuned, regulatory relationship for the patient.

The patient watches our nonverbal cues and if they are congruent and attuned, the patient can move toward greater trust and an experience of synchrony. Just as it is through the non-verbal, somatic cues that infants learn to evaluate their surroundings, so are these same factors formative in an effective, healing therapeutic relationship. Although they are simple, these factors, such as eye contact, facial expression, tone of voice, gestures, posture, timing and intensity, can strengthen or destroy therapeutic progress. The client unconsciously watches the therapist to ascertain such things as, "Am I safe here?"; "Do you understand me?"; "Can I trust my experience?"

This requires that we pay close attention to the patient's cues, know when to move forward or back, sense the best pacing and timing and be available for nurturing eye contact. As we are truly *with* the patient, having eye contact as appropriate, reading and responding to non-verbal cues, making sure our pacing, timing and intensity matches, in effect, really "getting" his experience, the earliest attachment mechanisms are touched, memories arise and an opportunity for healing ensues.

To do this, as clinicians, we must be aware of and *track our own experience*. We must allow the patient's story to *affect us*. We must remain grounded and go there with them, and, in some way, feel the angst they express, know the pain, "get" the fear. As we do this in an authentic way, the patient consciously or unconsciously experiences the contingency between us. The longed for connection is experienced, and the patient is able to continue exploration, to bear the unbearable, and feel deeply seen and held.

These most vital principles and practices depend on the capacity of clinicians to be fully present, engaged, and able to track themselves while simultaneously tracking the client. We also call this tracking of your experience self-reflection and/or reflective practice. It is a skill that takes mindful practice. This means that, as clinician, we must be a finely tuned instrument, deeply resonate and responsive. This takes intention and a commitment on our part to practice.

Reflective Practice

At first, this may seem simple. You may hear yourself say, "I already do that." And perhaps you do. Yet, for many of us, our focus is mostly external, on the other person, on what we are doing now and what needs to happen next. As such, the focus is not so much on how we are *being*, right now, with another, in this moment. It is more on doing. Yet, it is the *being*, not the *doing* that is the foundation of our healing practice (Siegel, 2010).

Check this out: Just now, take stock of your current experience. Ask yourself, "How present am I right now (or how present have I been in my interactions today)?" By present we mean, free of distractions, focusing only on this moment and the person I'm with right now. I'm able to be with another and myself as though there is no one else to consider right now and nothing else I need to do or think about. I am just here, open, curious, calm and compassionate. How would you gently evaluate yourself? Could you benefit from becoming more present and self-aware? Most of us could.

If most of my energy is spent tracking the client and paying attention to what I need to do next, I can easily lose sight of *me*. When my focus is largely external, I may become uncomfortable, stressed and unaffected by what is happening in the session. Or, some counter-transference may unconsciously

arise and remain outside of my awareness. This lack of self-awareness will be reflected in my nonverbal communication. The patient unconsciously picks that up and may hold back, begin to take care of me and/or not feel that I am totally with them. Also, sometimes, focusing too much energy and attention on the patient, getting too close energetically, is overwhelming for the patient. If I am tracking my own process as well as the process of the patient, it is like a beautiful dance where we are both very present, moving back and forth, and there is a healing flow that happens between us. This is contingency or contingent communication, which is paramount in the healing process. Most of us learn how to track the client. Many of us need at least some work in effectively tracking ourselves. This intention becomes a dedicated, moment-to-moment practice. The benefit is reflected in the deep healing of our patients and in every area of our own lives.

Here is a simple, yet foundational, exercise in tracking ourselves and becoming more present. Take a moment to check in with yourself. Notice your current experience. Describe to yourself sensations you may be experiencing. For example, you may notice something like: expansion or tightness in the chest, warmth or a knot in the abdomen, shoulders heavy or light, etc. What do you notice as you pay attention and follow the sensation? No need to label it; simply notice it and see what happens as you track your awareness: "Now I'm aware of tightness between my shoulders. Now I'm aware of warmth in my chest. Now I'm aware of a bird that just flew past my window. Now I'm aware of thinking about what I will have for lunch." As a clinician, this noticing of my current experience, of tracking my awareness is part of being fully present and available to another.

The benefits of this very simple practice, this process of tracking ourselves, can be realized when we set an intention and consciously create our own reflective practice. Over time, the process of tracking our current experience, of bringing our authentic selves into the consulting room, becomes second nature. And, this practice becomes the foundation of our genuine presence and capacity for authentic attunement with the patient's inner process. As we continue to do our own "human homework" we become more available for those precious "moments of meeting" (Stern, 1985) that often lay the groundwork for client healing. Susan Aposhyan (2004) calls this attunement "relational somatics or *interactive psychobiological regulation*." She describes this

relating from a session: "There was no content, no chatting, no education. Just the moment to moment labor of birthing a more mature version of Hank's self" (p. 174).

The Person of the Clinician; Self as Instrument

In addition to tracking our own process, we take a broader scope now in seeing ourselves as instruments in the healing process. Regardless of whether one is a musician, surgeon or carpenter, your instruments – the tools of your trade – are studied, practiced and cared for. Instruments of anyone's craft must be in some way valued, finely tuned, and honed. Here, we are that instrument! Our person, how we show up, our ability to *be* ourselves and *be with* our experience is our instrument. Having a clear sense of ourselves as embodied, an experience of ourselves in relation to "the other" is our therapeutic tool. As instrument, we are *being* more than *doing*, practicing presence and truly *being* with another in the present moment.
As the primary instrument of our craft, we gain or increase the capacity for self -reflection, self-exploration, awareness and somatic inquiry, which includes an experience of the sensorium and sensate vocabulary. We learn to name and describe internal experience for the client and ourselves. For example, if my chest feels tight, I might ask myself, "tight as in pinched, heavy or dark? And, what happens if I simply stay with the experience of tight? What do I notice?"

If I stay with an experience, I discover the place where the most energy resides in the body. This is often called potency. This internal, holistic knowing is frequently- more beneficial than the knowing that comes from a thought, a habit or from something I think might work in the therapeutic encounter. This knowing comes from deep inside. Track your own internal process to discover your potency while also tracking the client's process. From this place of presence, discover, track, meet and support the client's potency. It is from experiencing my own place of potency and meeting the patient in her place of potency that there is impetus for change, completion, and wholeness.

With this reflective practice, we attain a heightened awareness and find ourselves practicing at our "center" more of the time. Another aspect of this practice is developing the "observer self." Some Eastern traditions call this the "witness." We also think of it as "the seer, the knower, the one who watches."

This is not, however, the judge and critic. Developing awareness naturally leads to cultivation of the wise observer or the witness: the one who quietly observes without judgment and compassionately comments as needed. By this practice of presence we not only enrich our own lives but the very act of being in this receptive, present state elicits a feeling of safety and helps the patient access their earliest material.

The principles needed for helping the patient to heal prenatal and perinatal experiences include the ability of the therapist to bring his or her authentic self into the present moment with the client. To do this most effectively, we must commit to a personal practice that helps sustain self-awareness, the witness self and presence. Any practice that increases mindfulness is helpful, such as meditation, yoga, tai chi, chi gong, or other centering type practice. A mindfulness practice helps us focus on the attuned relationship and identify the clinician's ways of being that contribute to an effective therapeutic relationship. These practices also help us increase awareness of our attention, intention, and their effects on the therapeutic relationship.

Here we identify, experience and begin to practice with clients the principles of awareness, centering, witness, presence, orienting, pacing, timing and boundaries. In so doing we become available for what Daniel Stern (1985) calls intersubjective moments or moments of meeting. These are those precious moments between patient and clinician that are savored, sweet, and can be life-changing.

Therapeutic Protocols

The therapeutic protocols presented here are the result of decades of research and practice in prenatal and perinatal psychology. These principles safely access pre- and perinatal issues within the early attachment system and help integrate multiple aspects of the brain, providing optimal healing. These protocols are carefully situated within the context of a contingent relationship and are intended to help patients move toward an "earned secure" attachment. This process begin to re-wire the brain (Siegel, 2010, 2012) and helps patients achieve their therapeutic and life goals.

We know that our patient's earliest experiences reside in the developmental structures of the body/brain and cannot be reached by "talking about" them or simply telling a story from a

logical perspective. We must access the limbic area, where these implicit memories are initially processed. For example, telling a disembodied story, "I was a C-Section baby" imparts some important information but will not be sufficient for healing the experience. Many theorists and researchers in pre- and perinatal psychology have discussed how the body and subconscious processes hold our earliest experiences and may stay with us, affecting our lives (Rank, 1929; Grof , 1975; Chamberlain, 1988); Verny (1981).

The latest research in attachment, brain development and especially trauma points to the fact that not only can we not "just talk about" what happened to us, we must delve into those early memories slowly, with care and within the context of a safe, attuned relationship. Going too quickly into an early experience and having "big" feelings creates disconnected catharsis, increases the possibility of re-traumatization, and makes it much less likely that the client will be able to reflect upon and integrate the experience.

Telling their story to an attuned other, reflecting on their experience, "getting" their experience in the body, including having any emotions that may arise, feeling "felt," and understood all help the patient develop a reflective function (Fonagy & Target, 1997). This capacity for insight and empathy is necessary for a healthy relationship with self and others. Within an experience of being met, the patient can then reflect on these earliest experiences and begin to "make sense of them." Then the person can integrate the experiences into a coherent narrative, a story that makes sense, which is a measure of healthy functioning. As noted earlier, this work helps to rewire the brain. Thus fulfilling the adage: "change your experience, change your brain, change your life."

This section suggests a series of principles and specific procedures that help create a sense of safety within the therapeutic relationship, and assist the patient in beginning to experience sensation in the body where these early memories are stored. These are not prescriptive but do help provide a container and vehicle for moving from current, logical, linear thinking into the bodily experienced early events, memories and emotions. The following principles help facilitate "coming out the other side" to help patients make sense of and integrate early experiences with a new template for their world view, their mental models and belief structure.

Phase 1: Anchoring the Process and Creating Safety

The first and most fundamental aspect of this process is to create safety. This includes orienting our patient to people, places and things, anything he needs to know in order to settle, including how much time we have and how much this will cost. With this we begin building trust, which requires that we track our own non-verbal cues, be present, listen carefully and match the client's energy.

Also included in this first phase is exploring intention and purpose, discovering why the patient has come, and what she wants to accomplish. There is a cognitive telling of the story. Sometimes some education can be helpful here to reduce the shame, blame and fear of the patient's current experience. For example, "It is not unusual for those who spent time right after birth in intensive care to respond this way." Just to note, you may stay in this first phase if the patient needs it, if she is not resourced enough to go into deeper material. In that case, education or cognitive solutions may be in order. Otherwise, save problem-solving for the closing of the process, when the patient is preparing to go home. This way, the patient has an opportunity to ascertain her own solutions.

Phase 2: Moving Inward

Here we begin to slow the pace. Just slowing down and lowering the tone of voice a bit helps move from the faster paced, outside world, thinking mode into more of the experienced realm. Help the patient stay in the experience while telling the story or the presenting issue. "As you talk about being a procrastinator, always putting things off, what do you notice in your body?" As clinician, you become curious, less verbal and allow more space for the story to unfold. The practitioner continues to invite awareness of sensation: "What are you noticing in your body just now?

Sometimes some judicious, genuine, self-disclosure is appropriate: "I understand. I had a very similar experience with my mother." If there has been a disruption of any kind, something you failed to "get" or do, take the opportunity for repair. "You're right, I was moving a bit fast. I'm sorry. Let's try that again." A genuine apology – repair – is one of the most important vehicles for building trust.

Phase 3: Felt Sense, Images and Memories

Here we continue to work within the relationship, being very aware of our own sensations, how it feels to me, in my body, just now "being with" this person and their material. These are present moment, "here and now, I and thou" (Buber, 1965a) experiences within which resonance, synchrony and genuine empathy arise. This fosters greater unconscious safety and allows the patient to go more deeply into their experience.

Here you may slow the pace a bit more, lower your voice slightly, wait for an impulse inside the patient. Watch for and work with non-verbal cues, "I notice when you say that your posture changes." Wait, stay with what emerges. As you delve more deeply into the felt sense of the story, you might ask, "Is this feeling familiar? Is this the first time you've ever felt that tightness in your belly?" Pause. The patient will most often say: "Yes. This is pretty familiar. I've had this sort-of anxious feeling since I can remember." Pause. Invite the story of what happened *then*; slowly invoke images and memories.

As the process unfolds we name, monitor, and support felt experience, for both clinician and patient. Here we use fewer words, slow the pace even more as needed and track somatic experience, the clinician's and the client's. As this happens we move more into the earliest memories and experiences.

Phase 4: Regression into an Earlier Experience

As the patient is moving more deeply into the experience you may find yourself slowing the pace and lowering the tone of voice even more, as appropriate. As you track voice and body response, one cue that you have entered this phase is that the patient is going more inward, eyes may close, patient may seem "younger."

Here we monitor and track the experience of resources. Is the patient still regulated, "in the room," and connected to the experience? If not, the top priority is to regain self-regulation and bring the patient back into her body and into the relationship. "Just now, can you hear my voice?" or "Can you feel my hand on your shoulder?" This is maintaining connected catharsis as mentioned earlier. Be sure the patient stays present, even in the face of big feelings. If the patient seems to "disappear", hold a

place for the child in the early experience and the adult who is having the experience in the present moment. "Just now, are you aware that I'm right here with you?" We want to prevent dissociation or immobilization if at all possible. It is beyond the scope of this paper to fully address dissociation and immobilization. Our goal is to move slowly enough, being sure the patient is connected and resourced to prevent dissociation. If you sense that the patient has dissociated, stay with her, let her know you are there, and especially that you are with the "little one" and the unbearable experience, *then*. Ask for eye contact if appropriate, if not ask for focus on something external. Name where you are and what is happening right now. "You just touched into that very frightening place and I want you to know I am here with you. *Then* you were all alone and didn't know what to do. *Now*, you are safe. Can you feel your feet on the floor just now?" Stay with it, gently bring the patient back into her body, into the room, the present moment and into the relationship.

Next we watch for a shift in the experience and the energy of the process. The patient may move through some tears, shift positions, and/or have some eye contact. There may be a few words. Something will happen that tells you that this portion is complete and you are moving from the pre-verbal or early developmental realm into a more "grown-up" place.

Phase 5: Beginning the Journey Back

As the energy shifts, catharsis subsides and a different kind of contact is made. Staying very much within the relational dance, the patient begins to find words to describe the experience, and you can feel the return and the beginning of integration.

As words come back we may differentiate "*then* from *now*." "Yes, when you were little you were helpless in the face of what happened *then*. *Now* you can see that you're okay." You may also work with double binds or paradoxes. "When you were small it seemed that your life depended on you protecting your mom from your dad's rage. But you were too small. That wasn't your job. The double bind was, "If I don't take care of mom 'I'll die'; if I do take care of mom and not myself, 'I'll die.'" This type of paradox is common in early experience. As we integrate the experience we are able to hold two equal and opposite things to be true at the same time. "I love my dad and I'm angry that he didn't protect me." You might ask, "What is your experience of that

now? What do you notice? How does that feel holding both of those now?"

It is also important to bring it into the relationship, as it feels right: "How is it for you to share this with me now?" And, share your experience as clinician, as appropriate. "It touched me when you talked about your adoption experience." "I really respect that you were able to stay with that just now."

As there are more words, you will know that you are beginning to move into an integration of the experience.

Phase 6: Integration into Current Experience

As we return to the linguistic processes, we look at patterns, mental models and perceptual biases. Working with the following questions help ascertain early belief systems that resulted from pre- and perinatal experiences and help the patient gain an understanding of what has been running her life as well as a new lens through which to view herself and the world:

- What did the Little One begin to believe about her/himself in that situation?
- What did the Little One begin to believe about "the other" or the world?
- What did the Little One begin to believe she/he had to do or be in order to survive?
- How did the Little One begin to expect to be treated by others?
- What did the Little One begin to look for and/or avoid in order to stay safe?
- What is really *true* about the Little One? For example, she is smart, precious, creative, etc.
- What do you know as a result of this experience? For example, I am strong; or I'm okay now; or I'm a good person.
- How can you bring this back into your life now? For example, "When I experience this again, I can remind myself of what is really true about me and what I know now (I am good, lovable, capable, etc.)."
- What resources do you have, or can you create, to assist in sustaining this experience, this new knowing? For example: "I can take a breath, remind myself I'm safe,

remember the experience of love from my grandmother and/or repeat my affirmation."

Once you ascertain the early beliefs or mental models and the current *truths,* you have a foundation for the new neural nets that have been opened in the experience. The new nets begin to contain new mental models and healthy perceptual biases. These can become touchstones to be revisited regularly and begin to change the patient's experience of themselves and their relationships. For example, the new truths might be something like: "I am competent. I deserve love. I am safe."

It is important here to have eye contact. Be sure your patient is grounded, back in the room with you, in his "thinking" brain, ready to be an adult, at least enough to do what is needed next, like get himself home safely. If this has been a particularly emotional, difficult, or revealing session it is sometimes helpful to acknowledge that and add that you don't expect to do this every time. In fact, after "deep" work, patients often think about not showing for the next appointment. If you name that ahead of time and reassure her that she may need time to integrate this experience, she will be more comfortable and more likely to return.

Summary

The evolving research in attachment theory and affective neuroscience has given us new directions in how we practice our art and craft in prenatal and perinatal psychology. We now understand that with early trauma there is often loss and a disruption in the attachment relationship. With the advent of modern technology we now have a greater understanding of neurophysiology and tangible evidence for what we see clinically, that healing is possible at anytime within the life span. Repair and an "earned secure" attachment happens best in the context of experience, in the body and within an attuned relationship. Given that the clinician is half of that relationship, we have focused on ourselves as healing instrument. Within this new paradigm we in prenatal psychology have a unique opening to offer our perspective to our patients, their families and to others within the helping professions.

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