SHARING SPACE: A Bedtime Story: Sleeping Through the Night

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Full Text: INTRODUCTION I believe that patterns of behavior are based on the individual's process of primary bonding, or the way she learned to connect to her primary care giver (mother, guardian, etc), both prenatally and post birth. Healthy bonding creates a safe, functional, brave, and feeling individual. Some of these early life traumas occur not only in the first few weeks outside of the womb, but throughout the prenatal months as well. I believe that one of life's inevitable traumas is birth itself. A trauma which we will spend the rest of our lives attempting to incorporate both mentally and physically into our understanding of relating to self and other. Healing emotional and psychic pain requires experiencing (or reexperiencing in the case of older clients) the trauma in the presence of an empathie, compassionate, and understanding support system. For prenatal and perinatal bonding, this can be achieved in part by "mirroring" the child which suggests the caregiver validate the baby's experience by meeting her nonverbal demands, given the care giver has successfully interpreted them. Thanks to the Internet, I have been able to provide short-term therapy to distressed parents of troubled infants and toddlers such as in the case of the *Olafs, a couple in their thirties living in Arkansas, who sent me the following e-mail one year ago: Dear Dr. Rand: Please help. We have not slept for days because our 9-month-old daughter, Michelle, cries all night long. We hear of couples who sleep with their babies because it's the only place they will sleep, but we need our own bed for us! I replied: "I've done therapy by e-mail before, but never prenatal and perinatal work by e-mail! All the same, I think I can help you." In the case that follows, the speed of the Internet helped the Olafs understand their family system so they could at last sleep through the night. The Olafs are a middle-class Caucasian family living in Little Rock, Arkansas, having relocated there shortly after the birth of their first child, Jeremy, now age two. Many stressors occurred both prior to and following the time of the move, including Karen's resignation from a job she held for fifteen years, the death of her mother, and a host of complications with their first pregnancy. Following a miscarriage in 1998, Karen was put on Clomid and conceived her son two months later. Although there were few complications other than morning and day sickness, the labor was induced, which I think is always traumatic to both mother and child. Following his birth, Jeremy developed acid reflux and delayed gastric emptying as well as frequent crying spells which precluded him from sleeping through the night until he was six months old. Almost immediately following his first sound night's sleep, Karen discovered she was pregnant again which toppled the peaceful inner respite she thought she found with Jeremy. "I had mixed feelings about the pregnancy," Karen wrote. "I felt I couldn't handle two children so close in age. I wondered how my being pregnant would affect my care of Jeremy." These factors, combined with the inherent stress in a cross-country move, contributed to the disruption in the parentchild prenatal bonding between Karen and Michelle. A large percentage of primary bonding is non-verbal, which suggest that the Olafs aforementioned stress was undoubtedly passed on to the newborn (Jeremy) and to the fetus (Michelle). Immediately following Michelle's birth, the infant as well as her brother, developed digestive problems and severe allergy to formula. Two months into her life, Michelle was hospitalized for a week due to poor weight gain. During her hospital stay a nasogastric tube was inserted and its use continued for two more months at home. She was also on several medications to help with the caloric intake. In a nutshell, Michelle's first few months out of the womb amounted to many sleepless nights, repeated spitting up, and lots of crying. For everyone, this was a frustrating and trying experience. After seven months, Michelle began to show signs of improvement. She was spitting up less and maintaining a healthy weight. She was still on medication, but eating three meals and thriving in her exploration of her world via crawling, standing, and smiling. All the same, the

crying spells continued throughout the night, which both frightened and provoked her older brother, Jeremy, with whom she was sharing a room. "We had to just let her cry it out," typed Karen, "but after two and a half hours, we couldn't take it." Karen also reported that around this time, Michelle became very clingy to her mother and that Jeremy began to feel dethroned. His behavior reflected as much in his "me me" language and the taking of his sister's toys with the occasional swat to the head. "I am constantly rescuing her," typed the exhausted Karen. This is when Karen first contacted me and asked for help. At the time I was living in Los Angeles and working intensely both at home and abroad with clients and trainees. Unable to travel to Little Rock, my heart went out to the Olafs and I agreed to help by corresponding via e-mail. For the next few months, the Olafs communicated with me about their problem and were ultimately able to see marked changes in the family. In fact, once they began to use mirroring, Karen sent an enthusiastic message to me, the first of many: "Michelle is doing very well. She cried at about 11 pm for five minutes and then nothing until 7 am! We are delighted." This e-mail arrived only three days following the Olaf's initial contact with me. CORRESPONDENCE The following will reflect the key correspondence between us, emphasizing the importance of mirroring in this process. To explain this I need to briefly define the fundamental ideas I use in working with parents and infants. What is trauma? In this case, trauma refers to anything that disrupts the patterns of energy flow and movement in the body, a process which begins at a cellular level even before the child is born. That blockage is then manifest in how well the individual functions, behaves, emotes, and thrives. For example, if the infant was "traumatized" either prior to or following birth, evidence of trauma could include neglect, abuse, illness, birth trauma, or abandonment. On the other hand, trauma can also be defined as something as simple as an awkward or surprising exchange with a peer or family member-essentially anything that might instill fear in the infant. Sometimes trauma results from events that cannot be helped or changed (lack of breastfeeding, for example). The goal is to help the infant or individual safely work through the trauma by re-patterning the body's memory in order to prevent reactivation of the trauma and ultimately provide a secure and connected sense of self. What is mirroring? Mirroring is a form of empathy which provides safe presence, boundaries, and honoring of the infant's experience. Essentially, it is the practice of putting words to feelings which helps the infant identify his or her feelings. Because a large part of early bonding is preverbal, mirroring is achieved through tone, presence, and positive energy of the care giver and/or therapist. What is bonding? I assume that early bonding becomes the blue-print for all future relationships to self, others, and the environment. An unempathic bond will likely lead to an apathetic attitude toward work, love, and goals. On the other hand, a healthy bond with accurate mirroring will lead to a thriving and curious individual. Bonding occurs before birth and continues until the infant is at least 3 months old. THE BEGINNING The first e-mail arrived in April, presenting the family problem and asking me if I might be able to help. I followed up immediately by asking Karen about specific details in order to assess the presenting problem and rule out birth trauma or other diagnoses. Dear Karen, I have done email therapy before, but never attempted pre and perinatal. It will be important for me to know the symptoms of your daughter's sleep disorder and your family's emotional reaction to it. Tell me about the conception, the pregnancy and any complications with the birth. Finally, tell me what you can about your own births and overall emotional behavior toward the child. Here, I am gathering information about the pre- and post-natal bonding between Karen and her daughter, Michelle, emphasizing that Karen's feelings would affect the fetus, as would Mark's, her dad. Karen responds almost right away. In addition to the facts stated in the introduction, she reports that Michelle's sleeping disorder has nearly turned the family upside down. "We have become frustrated and impatient. Michelle can cry up to three hours which is scary for Jeremy." She goes on to describe how the crux of the sleeping disorder lay in getting Michelle to stay asleep, describing how the typical pattern involves her waking at least 5 times per night and crying until one of her parents would comfort her. "We are concerned that we are creating more dependency by going in and rescuing her." Essentially, she says they are concerned, sleep deprived, and running out of answers. "Once Michelle begins to cry, Jeremy will, too, and become hysterical. He will go back to sleep if the crying stops shortly, but she will be at it for hours. We thought he should be with us

until Michelle is sleeping through. After that, they would have to work it out alone. This is the part that I have never seen in any articles dealing with the effects of such a young sibling. What is your advice?" I assure Karen that most of this is normal. "I can't imagine what it's like to have interrupted sleep for 8 months and also to have a 2 year old," I type, empathizing with the anxiety the Olaf's are clearly experiencing. "However," I write, "I suspect you may not have as big a problem as you think." I assure her that many of these sibling behaviors are indeed typical, especially given the age differential, separation anxiety, and overall chaotic energy surrounding the stress. "Sleep disorders often have as much to do with the anxiety of the parents as with the infant," I remind Karen, indicating the crucial role of parent self care to enhance bonding in the infant stage of life. In fact, the sleep disorder would be improved in no time; all it required was empathy, awareness, emotional support, and patience. In a matter of weeks, I was confident that the Olaf household would go from counting sheep to snoring lullabies. "Once you learn to mirror, most of this will go away," I wrote. I felt that instilling confidence in the parents was essential. Karen was optimistic: "I am confident that you will help us get through this. We have a lot of emotional support from friends and relatives, but things still go on as they are." She agreed to maintain contact with me until results were seen. Anxious to get started, Karen inquired, "What is mirroring?" PROGRESS In the following series of e-mails, I attempt to show the Olafs how to apply mirroring while explaining its connection to bonding. I emphasize that it is not so much about being in the same room with the infant, as it is being present with her. The difference between being present and just being a body is huge. I also emphasize how important it is for the parents to remain emotionally supported and stable themselves, taking care of themselves and seeking out time for themselves in order to pass on positive energy to the infants. To begin, I ask Karen to describe her and her husband's response to the nightly commotion in order to assess the influence of their own anxiety on the situation. Karen replies: "We usually run in right away so as not to wake Jeremy. We know she is looking for comfort. She cannot fall back to sleep on her own." Sometimes, Karen added, they would simply give in and let Michelle sleep in their bed. From this, I conclude that the Olafs are adding to the anxiety by going immediately to Michelle when she cries. "You should not go in to her when she cries, but wait until she falls asleep. While 2 hours is too long to wait, I suggest you add five minutes to the usual time you wait, and then go in." I think waiting allows time for the Olafs to gather composure and confidence in order to be present with Michelle. Once the waiting is over, the Olafs take action: "At first, I would try to reassure her of your presence," I type, "but not pick her up, all the time mirroring her feelings. If you must pick her up, then do, but I would try gradually withdrawing the positive reinforcers. You can try increasing the time by five minutes each day. At the end of five days, that will be 25 minutes and I would expect that she would stop crying and go to sleep by herself before then." Additionally, I suggest that her husband, Mark, remain in the other room with Jeremy while the crying is going on. I also suggest an over the counter mild herbal sedative (Valerian) to aid the process. Finally, I suggest that both Karen and Mark spend time with each child during the day, describing to them the difficult conditions of their births in order to communicate calmly empathy and hope. I type, "If parents feel bad about a difficult beginning, this will be communicated to the children." By applying these changes, I believe this will help to meet the physical and emotional needs of each member of the family. "I know this will be difficult, but rushing in each time to stop Michelle from crying is not a long-term solution for her nor you. Nor is having her sleep with you. After a few months, the goal is for the infant to adjust to her own world, which will serve her well in life in terms of self sufficiency. At that point she should be sleeping at least 6 hours per night with only one waking period earlier in the evening." First Night Karen was willing to give it a try. That night she and Mark read over my advice and remained hopeful. The next morning, they had good news to report. "Hooray," Karen wrote, "Yesterday I spent the day talking to Michelle about her conception and birth. It felt very cleansing and put a positive spin on the day. She seemed content and happy. The same for Jeremy. I got to retell our story which is so much a part of who we are. Mark and I also spent time talking about it which seemed to give us new energy." She then describes how Michelle only woke up 3 times and was able to get back to sleep within five minutes. As told, the Olafs waited the extra time, giving time for themselves to be

present for her. Although Mark had to pull her from the crib, the crying stopped once she was settled. "We were pleased with the first night, but worried it may not go as smoothly tonight. We are not sure about mirroring. Would that help?" Second Night I was not surprised by the progress. I decided to instruct the Olafs to go further into mirroring that evening. I tell Karen that sometimes it will be hard to tell if Michelle is crying because she is angry or because she is afraid and that understandably, she will feel both. "The important thing is that you let her know you are there and understand and name what she is feeling. The same for Jeremy. He will need to be comforted and told that this is not about him when she is crying; this will help him and Michelle in their differentiation." I also clarified that many forms of crying communicate different needs and that comforting an angry baby is not advisable. "This teaches us that anger is not okay," I write. "Instead mirror her by letting her know seriously that you see that she is angry. Tell her how much you can tell she is mad. You will be surprised at how much this matching will communicate to her that you understand her feelings, and then the crying (communication) will stop. But you must not speak in a sing-song voice," I warn, "but mirror the emotion in a matching tone." I then describe how other forms of crying can communicate hunger, being cold or hot, tired, or attention seeking and that by learning to match those sentiments, she will help Michelle teach herself how to increase her frustration tolerance and learn to soothe herself. "As long as you communicate your presence, the crying will stop and she will calm down." I instruct the Olafs to utilize this right away. "Tonight wait 10 minutes before you go in and don't pick her up right away. Let her really feel your presence." The next day Karen sends further good news. She reports that Michelle woke up three times, but fell back to sleep without them needing to go into her bedroom. She also informed me that they all spent time together during the day watching videos of each of the children's births. Karen confessed to fearing they may take a step back, but was grateful for the sudden changes. "On to night three," she wrote. Naturally, I was thrilled. I reassured them that this would be a work in progress and to expect setbacks. "Don't be discouraged if it doesn't work instantly. Please enjoy your success and try not to be too nervous. If you are anxious, you will convey it and they will sense it. You can also tell the stories about their births as many times as you want to. They may not understand the words, but they will hear the music, and this strengthens their bond to you, which is what they are asking for and need." For the next few nights, the Olafs kept in contact with me, reporting increased progress. They shared that Michelle has been consistently sleeping though the night, both with and without the support of them mirroring her behavior. I wrote, "You were just so anxious about Jeremy waking, or that something was wrong, that you actually reinforced the behavior! But Michelle is a smart baby and she learns fast. Congratulations!" CONCLUSION By watching two partners dancing, one can observe how it is the give and take of each dancer that keeps the routine thriving. The rhythm and trust inherent in that bond will create a fun, risk taking, and confident relationship. By the same token, child rearing requires that the parent be attuned with the child in order to produce a confident individual. While trauma can lead to a disruption in the parent/ infant bonding and consequent family progression, this model has often proven successful in correcting early life disturbances. Furthermore, just as the dancer's coach wouldn't add more anxiety to the situation by scolding the dancer or taking blame for the dancer's effort to master a routine, a caregiver should not bring his or her assumptions and failures to the infant. In other words, as I said to the Olafs, "let's separate what belongs to the parent and what belongs to the child." Footnote * Author notes that written permission was obtained from client prior to the publication of this case history and that all names and geographical locations have been changed to protect confidentiality. Marjorie L. Rand, Ph.D., www.drrandbodymindtherapy.com, may be reached at Ph/fax: 310-937-0053. AuthorAffiliation Marjorie L. Rand, Ph.D.

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