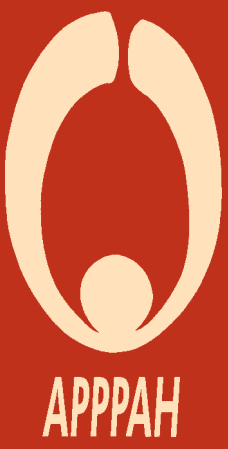
JOPPPAH 22(2) 79–146 (2007)
ISSN 1097-8003

JOURNAL of PRENATAL & PERINATAL PSYCHOLOGY & HEALTH



Published by the Association for Pre- and Perinatal Psychology and Health (APPPAH)
Editor: Bobbi Jo Lyman PhD

Volume 22, Number 2
Winter 2007

Journal of Prenatal and Perinatal Psychology and Health

Official Journal of the Association for Pre- and Perinatal Psychology and Health (APPPAH)

Published by

APPPAH
PO Box 1398, Forestville, CA 95436
apppah@aol.com www.birthpsychology.com

Journal of Prenatal and Perinatal Psychology and Health

Volume 22, Number 2, Winter 2007

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JOURNAL OF PRENATAL AND PERINATAL PSYCHOLOGY AND HEALTH publishes findings from the cutting edge of the rapidly growing science of prenatal and perinatal psychology and health. The journal, published quarterly since 1986, is dedicated to the in-depth exploration of the psychological dimension of human reproduction and pregnancy and the mental and emotional development of the unborn and newborn child. It is intended to provide a forum for the many disciplines involved such as psychology, psychiatry, midwifery, nursing, obstetrics, prenatal education, perinatology, pediatrics, law and ethology. The journal also deals with the numerous ethical and legal dilemmas which are emerging as society re-evaluates its attitudes toward adoption and abortion or strives to establish moral positions on hightech obstetrics and third-party conception. The opinions expressed in articles and claims made in advertisements are those of the authors and advertisers, respectively, and do not imply endorsements by APPPAH or the printer, Allen Press, Inc.

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INDEXED IN: American Psychological Association Abstracts, PsychInfo, and Health Instrument File.

 Journal of Prenatal and Perinatal Psychology and Health (ISSN 1097-8003) is published quarterly in the Fall, Winter, Spring and Summer by APPPAH, 8152 Grape Avenue, PO Box 1398, Forestville, California 95436-1398. Periodicals Postage Paid at Forestville, CA., and at additional mailing offices.

POSTMASTER: Send address changes to: PO Box 1398, Forestville, CA 95436-1938 USA.

ISSN 1097-8003 **JOPPPAH 22(2) 79–146 (2007)**

Journal of Prenatal and Perinatal Psychology and Health 22(2), Winter 2007

Editorial

In this winter issue of the *Journal of Prenatal and Perinatal Psychology and Health*, we offer three manuscripts on topics of interest to prenatal and perinatal psychology readers. One of these, an international submission, as would be expected, gives breadth to our unique perspective. This is the lead article by Dr. Gregg Lahood from Australasia, a region of Oceania (Australia, New Zealand, and neighboring islands in the Pacific Ocean). We also offer two contributions from writers who are new to our publishing program, Dr. Paulette Lucier and Ms. Lorna Millikin. These two student-scholars bring, what I have described in past editorials as, new voices to the choir. These fresh ways of looking at early human life always inspire me, and point to how broad the scope of our discipline is. I personally think of our perspective as touching the transpersonal side of ourselves on the one hand, while being grounded in the physical and psychological world during pregnancy, birth, infancy and early development on the other. Some of these themes can be found in the published articles in this issue of the journal.

As stated, the lead submission is by Dr. Gregg Lahood and is entitled, *From 'Bad' Ritual to 'Good' Ritual: Transmutations of Childbearing Trauma in Holotropic Ritual*. It is both a review of the traumatizing effects of Western medicalized birthing procedures on "birth-giving" mothers, and a need for therapeutic treatment following this event. It explores psychiatrist Stanislav Grof's and Christina Grof's holotropic breathwork in which 'good' transpersonal medicine can be utilized in healing.

Dr. Paulette Lucier's article, *The Skin as a Psychic Organ: The Use of Infant Massage as a Psychotherapeutic Tool in Infant-Parent Psychotherapy*, explores the use of touch, particularly infant-massage in infant-parent psychotherapy and the ways in which clinicians can utilize this intervention to strengthen infant-parent attachment. This topic is particularly important today when there is a heightened interest in treating the infant-parent dyad. Because prenatal and perinatal psychology covers this period (through the first year)—as influenced by events around the prenatal and perinatal periods—it is

important to publish articles of this kind. Lucier presents just such a manuscript with the integration of psychoanalytic principles in a skillful and scholarly way.

Cesarean Birth Stories is the third article of the winter journal that was part of Lorna D. Milliken's master's thesis research project. A phenomenological study, this research was performed to better understand the impact and implications of a cesarean birth on later adult behavior patterns. Ms. Milliken reports on three themes that emerged from the eight participants' interviewed: (a) interruption, (b) motivation to achieve, and (c) offering help even when it is not requested. Readers of the journal will enjoy this readable, yet important contribution toward understanding the effects of early experience on adult behaviors.

Putting aside the editorial summaries for a moment, I wish to let the journal readers know that there are fewer articles in this issue due to changes in the size requirements of the journal that the editorial staff needed to make. There are a number of excellent articles currently under review, so this smaller issue is not due to a lack of interest or submissions in our publishing program. And while our issues may be a bit smaller, what we offer between the pages are priceless glimpses into the foundations of humanity.

Bobbi Jo Lyman, PhD
Editor-in-Chief
Santa Barbara Graduate Institute

Errata

The book/video reviews of two works were inadvertently printed in two different issues of the journal. These were: 1) *Wisdom in the Body: The Craniosacral Approach to Essential Health*, and 2) *Lotus Birth*, which appeared both in Volumes 20(2) and 21(1).

Journal of Prenatal and Perinatal Psychology and Health 22(2), Winter 2007

From 'Bad' Ritual to 'Good' Ritual: Transmutations of Childbearing Trauma in Holotropic Ritual

Gregg Lahood, PhD

ABSTRACT: In this article a tentative and provisional theory is advanced on the treatment of birth-giving trauma. 'Birth-giving-trauma' here refers to women (and men) psychologically, physically or emotionally traumatized during birth-giving. In the first part of this article I outline anthropologist Robbie Davis-Floyd's argument that Western medicalized birthing can be constructed as a 'modern' rite of passage which can negatively imprint disempowering images into women's minds, reinforce messages of inferiority, and traumatise the birth-giving mothers. In the second half of the article I will argue that the trauma catalysed by the 'bad' ritual of technocratic birth may need to be therapeutically treated or rather 'ritually combated' with an equally powerful and reparative 'good' ritual. I will explore psychiatrist Stanislav Grof's and Christina Grof's holotropic breathwork as a pre-eminent contemporary ritual in which 'good' transpersonal medicine is ritually made.

KEY WORDS: Birth, childbearing trauma, transpersonal psychology, analytic psychology, holotropic breathwork, authoritative knowledge, non-ordinary states

> *Education for transcendence must deal directly with an experiential threshold. It must teach how one can cross the threshold of fear into a state of transcendence this education must also bring transcendence into ordinary life, and ordinary life into transcendence.*
>
> Anthropologist Richard Katz, 1976

> *For women, situations associated with motherhood can become another significant source of unitive experiences. By conceiving, carrying, and delivering a child, women directly participate in the process of cosmic creation. Under favourable circumstances,*

Gregg Lahood, PhD describes himself as an "anthropologist of consciousness at large" whose interests include contemporary rituals and childbirth. He is currently collecting narratives from women and men who have participated in extraordinary events in childbirth (sprirtual emergencies) for a book on the subject. Dr. Lahood gives workshops in Australasia and England. He may be contacted at: Gregg@gregglahood.com.

the sacred nature of these situations becomes apparent and is consciously experienced.

Psychiatrist Stanislav Grof, 1998

The sound that came out of my body was just awesome, utterly awesome. It was so primordial, primal, animal, I couldn't act it or make it again … it was as if my body and mind had become one, but it was not inside or outside, it was not named. My birth was fantastic. I suppose the best way to describe it was like an out-of-body-experience. But it wasn't quite that, it was like the categories of outside and inside got rearranged. It was like you 'be still and know'. It didn't matter what anyone else was saying my body just knew, call it what you like, waves; my body just went with it all.

Research Informant Trudy, 2006

It is equally outside and inside: therefore; it has transcended the geographical limitations of the self. Thus one begins to talk about transhumanistic [transpersonal] psychology.

Transpersonal psychologist Abraham Maslow, 1969

Introduction

Anthropologists have shown that birth in most cultures has been a "ritual event" (Kitzinger, 1978, p. 5) enveloped in protective rites of passage and spiritual procedures that lend emotional, 'supernatural' and charismatic support to birth-giving women. They argue that fertility and birth are in all cultures embedded is social, psychological, cosmological and spiritual systems (MacCormack, 1982, p. 10). Furthermore, the basic pattern of biological birth serves as a "model for structuring other rites of passage" (Davis-Floyd, 1994, p. 325) and ceremonial healing rituals (e.g., Turner, 1992). Traditional helpers at birth, midwives and shamans, operated as 'technicians' of the sacred (Potter, 1974; Paul and Paul, 1975; Kitzinger, 1982; Laderman, 1983) and it has also been noted that transpersonal visions may be part of a contemporary birth-giving woman's reality (Lahood, 2006a, 2006c) and the father's reality (Lahood, 2006a, 2006b). Grof writes for example:

> Delivering women and people participating in the delivery as assistants or observers can experience a powerful spiritual opening. This is particularly true if birth does not occur in the

> dehumanized context of a hospital, but under circumstances where it is possible to experience its full psychological and spiritual impact (1998, p. 135).

Unfortunately the Western biomedical approach to birth-giving does not value emotional or spiritual support nor does it value visionary states (c.f., Davis-Floyd, 1992; Klassen, 2001, p. 104; Sered, 1991, p.15) and many women are left traumatised by the dehumanized nature of 'technocratic' childbirth rituals. Moreover, in the Western world most births do not occur in domestic environments but in hospitals.

While there is an increasing literature on 'birth trauma' relating to the fetal person, less attention has been paid to the trauma of the birth-givers. 'Birth trauma' is a blanket term confusingly applied to the psychological and physical damage experienced by both women and neonates during the process of labor and childbirth. However some fathers can also suffer from 'birth-trauma' in the form of post traumatic stress disorder (PTSD) (Lahood, 2006b). I think it would be useful to delineate between 'women's birth-giving trauma', 'neonatal birth trauma' and 'partner's witness trauma' and the treatments for these divergent phenomena.

This paper will contrast two important contemporary 'rituals': modern childbirth and trans-modern holotropic breathwork.[1] I will suggest that while the former ritual system begets and amplifies birth-giving trauma (after Davis-Floyd, 1992) the later can be used to heal the trauma associated with birth-giving (e.g., Grof, 1985; Walden, 1993). Our aim here is to grasp the following nettle: *if it is in 'bad' ritual where harm is caused - it may well be that it is in'good' ritual where trauma could be negated and healing found*. The purpose of this paper then, is to offer those who suffer from birth-giving trauma; PTSD catalysed in childbirth, post-natal depression, grief and loss around miscarriage and abortion, those who feel emotionally, psychologically and spiritually impinged upon by the medical system, and those who work with traumatized persons a further treatment option … that of our species oldest healing system; ritual.

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[1]According to philosopher Richard Tarnas, Grof's work is "the most epistemologically significant development in the recent history of depth psychology, and indeed the most important advance in the field since Freud and Jung themselves (1991, p. 425).

Background

I came to study birth-giving through a long-time interest in contemporary transpersonal rituals (e.g., Heron & Lahood, 2007). My post-graduate and doctoral studies were focused on the ritual dynamics of birthing in New Zealand and the transpersonal events experienced around birthing-giving for contemporary women and men. I have described some of these research findings in several articles dealing with, for example, the encounter with death at birth (Lahood, 2006a, 2006b), the transpersonal dimensions of indigenous midwifery (Lahood, 2006a, 2006c) fathers near-death-experiences around child-birth (Lahood, 2006a), and women's transpersonal experience at birth-giving (Lahood, 2006c).

Another complementary strand to my research life is the role of a holotropic breath-work facilitator – a 'ritual specialist', so to speak.[2] I have been involved in broad holotropic breathing practice for almost two decades and this has given me an opportunity to gather data from a unique viewpoint; that of a participant/observer in the holotropic ritual itself (I also have modest roles as an antenatal educator and midwifery educator in New Zealand).

However there is another link between holotropic ritual and transpersonal events of consciousness among contemporary women I should outline. Some of the women (and men) I spoke to during my doctoral research had experienced 'non-ordinary states of consciousness' that bear a striking resemblance to what Grof calls 'holotropic consciousness' (1985). These are profound healing states of consciousness having to do with the experience of death and rebirth (Lahood, 2006a, 2006b). Let me give an example of this, not from one of my informants, but from Jungian analyst Jean Shinoda Bolen: who, in the film documentary *The Goddess Remembered* (1989) said this:

> My experience of a woman giving birth to a child put me in touch with the women's movement. Up until that time I was a

[2]Various anthropologists have explored non-ordinary-states-of-consciousness, Buddhist meditation techniques or shamanistic apprenticeships and some have gone on to teach their respective techniques i.e., Joan Halifax (shamanism and Zen Buddhism), Michael Harner, Felicitas Goodman (neoshamanism), Charles Laughlin (Tibetan Buddhism), Larry Peters (Nepalese shamanism) and Terrence McKenna (psychedelic shamanism) to name a few. My own trainings and 'apprenticeships' have been primarily with two Western transpersonal teachers Stanislav Grof (holotropic breathwork) and John Heron (charismatic co-operative inquiry).

> real medical student, intern, resident, kind of a person, who felt quite different from other women because my path was different from most women's. But once I was in labour and delivery and was experiencing at the deepest ritual level and at the deepest life level, what it is to be a woman and how it hurt … and how it was also a miracle and how none of my training prepared me for this and what I was doing at that moment was what every woman who had ever given birth to a child has been doing through all time. I felt linked horizontally and through time with every woman that ever was.

We might note the strong link between birth and "the deepest level of ritual" and then "ritual" with the transpersonal domain. Her sense of becoming continuous with all women through time and space (as a healing and empowering event) is a becoming beyond the Cartesian box of time and space, which means that she has stepped outside of Western medicine's 'body-as-a-machine' (e.g., Davis-Floyd, 1992) image, and the foundations of Western science in general. One of my informants said this at the birth of her daughter: "She was not breathing ... not energetically so I breathed into her energetically ... you are going to live! It's like I'm getting a vision … a sense of this line of women back through eons almost. It's like connecting in with a line of all women. It had to do with the family of women through time like a line". Such events are also a recurrent theme in holotropic research (Grof, 1988; Bache, 2000, Lahood 2006a).

Rites of Passage

Rites of passage and their tripartite morphology were made famous by folklorist Arnold van Gennep (1960/1908). In his schemata a rite of passage process has three basic patterns (although a pre-initiatory phase must also be assumed e.g. the womb of childhood). They are 1) separation; the neophyte is removed from a previous social or cosmic world (1960, p.10), 2) transition; a magico-religious space in which the initiate "wavers between two worlds" (1960, p. 18) this *liminal* space was often a place of ordeal, chaos, and symbolic dismemberment, and 3) incorporation; a phase where the initiated is being absorbed or reintegrated into a new world.

Van Gennep also wrote that such rituals had a strong association with pregnancy and childbirth (1960, p. 41-64) and it is interesting to contemplate the relationship between van Gennep's *rite de passage* template and the basic morphology of the fetal person's journey

through the chaotic 'gauntlet' of the perinatal passage. The child is separated from the 'good womb' passing into a state of constriction, followed by an ordeal-like and laborious transition and finally emerges from the dangers associated with the birth passage into the world and a new social or cosmic status (see Grof, 1977, 1985). In Grof's schemata this perinatal process structures the psycho/spiritual experience of death and rebirth and the holotropic therapeutic ritual is geared to support this transformational process.

A 'Bad' Rite of Passage: Maternity in Modernity

Robbie Davis-Floyd's *Birth as an American Rite of Passage* (1992) is perhaps the most comprehensive study to date concerning ritual, cognition, and contemporary Western birth. She argues that contemporary hospital birthing can be constructed as a rite of passage operating tacitly within the medical birthing regimen. According to Davis-Floyd, in this context, the ritual process is deeply problematic because it is geared to indoctrinate women to its biomedical mythology by enacting its 'body as machine' system of authoritative knowledge in a ritualized technological apotheosis. From the medicalized position birth = medical/technical operation.

Renowned British anthropologist Shelia Kitzinger has also suggested that modern birthing rites of passage do not function to provide emotional support (as traditional rites of passage would have) but rather they *reinforce* the established (and patriarchal) social system (1982, p. 182). In the modern scenario women are routinely stripped of bodily knowing, authoritative knowledge, and the status and charisma associated with birth-givers. Birth-giving is treated as a routine medical crises indexed into a powerful structure of hierarchical power running on an 'assembly-line' system bent to capitalist clock-time (Davis-Floyd & Sergeant 1997, p. 8-11). Its rhythms do not sway easily to the rhythms of a female birthing body. Kitzinger writes:

> In achieving the depersonalization of childbirth and at the same time solving the problem of pain, our society may have lost more than it has gained. We are left with the physical husk; the *transcending significance* has been drained away. In doing so, we have reached the goal which is perhaps implicit in all highly developed technological cultures, mechanized control of the human body and the complete obliteration of all disturbing sensations [my emphasis] (1978, p. 133).

Using elements of biogenetic structuralism as a model (a model bound to transpersonalism e.g., Laughlin, 1988, 1994), Davis-Floyd's analysis suggests that women birthing can engage in the same neuro-cognitive processes that produce similar states to those found among ritual participants (1992, p. 7-19). She argues that the climaxes and peaks found in ritual and meditation (after neuro-theologist d'Aquili 1979, 1985) when neuro-physiological subsystems fire simultaneously in the autonomic nervous system, are also found among birthing women (1992, p. 11-15). Once these ritual dynamics are catalysed and 'kick-in' the human cognitive system can be rendered open to gestalt perception (d'Aquili 1979, p. 173-174), and what is called *symbolic penetration*, that is, the ingression of symbols in the environment and their meaning into the opened mind of the ritual participant (e.g., Laughlin 1994). The process moves toward a peak, climactic experience resulting in the long term memory storage of symbolic messages (Davis-Floyd 1992, p. 15).

Davis-Floyd argues convincingly that it is the symbols of the Western technocratic medical system in all its hegemonic and patriarchal glory that are impressed into women's minds at childbirth serving to reinforce its power and status over women. In other words; contemporary medicalized birthing rituals oppress women at a societal level through the use of a series of rituals that can be thought of as a dynamic rite of passage—a conversion process—it is a compelling argument. The price Western women pay for the belief in the Western hospital system's ability to control childbirth outcomes, its routine technological wizardry, its hierarchy of charisma, its body as a machine mythology, and its efficiency in saving lives and reducing pain; is a reduction in participation, a reduction in emotional and spiritual life, the loss of personal autonomy and authoritative knowledge, and at worst, psychological, physical, emotional, and spiritual traumatization.

The Problem with Birth

I will not attempt an exhaustive account of the trauma of birth-giving here but touch on a few key points beginning with a definition from Cheryl Beck:

> Birth trauma is an event during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing women experiences intense fear, helplessness, loss of control and horror (2004, p. 28).

Simkin and Klaus list the following: "a sudden emergency caesarean perhaps with inadequate anaesthesia; shoulder dystocia; severe perineal damage; fetal asphyxia; vacuum extractor or forceps injuries; severe hemorrhage; newborn disabilities or death (2004, p. 92). We could add the following for the child: prolonged labour, decelerations of heart beat, anoxia and hypoxia (diminishing oxygen supply), and meconium in the amniotic fluid. For the mother: prolonged labour, severe constriction, miscarriage, spontaneous abortion and eclampsia. Birth trauma then is physically damaging, psychologically damaging, and may result in, or at least threaten, neonates and birth-givers with death. Research shows that Post Traumatic Stress Disorder (PTSD) as outlined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV; 1994) can also be catalysed through birthing among mothers (Beck, 2004) and among fathers as witnesses to life-threatening events (Lahood, 2006b).

Explicit in Davis-Floyd's account is a strong correspondence between modern technocratic ritual childbirth, patriarchal oppression, and women's birth-giving trauma. She refers to a process of "compartmentalization" by "the ones who were most totally effaced during their hospital births" (1992, p. 242). Often those anaesthetized had placed their birth completely outside of their lives. Others awake and aware, but in "extreme terror and pain" also used this compartmentalizing defense to divorce themselves from the traumatic experience. Some of Davis-Floyd's participants refused to even talk about the subject because it had been so traumatic (1992, p. 242). Other women drive miles out of their way to avoid going near the hospital where the trauma occurred (Simkin & Klaus 2004, p. 93); these dissociating behaviors are also symptomatic of PTSD. However, psychological defense mechanisms have psychotherapeutic problems since, as Davis-Floyd rightly points out (and as people-workers well understand), "unresolved traumas tend to resurface in various ways" (1992, p. 242).

So how to resolve the trauma caused by perinatal complications or technocratic rituals or a complex combination of both? Meaning-making verbal therapies, such as narrative therapy (White, 1980), might well be the first level of ameliorating this trauma as Davis-Floyd suggests (1992, p. 242). However, talk therapies might not be enough because as cognitive anthropologist Douglas Hollan points out many of our engagements in the world remain "unconceptualized, unverbalized, and outside of conscious awareness until they gain conscious representation through complex symbolic processes" (2000, p. 539) and that certain experiences can be so overwhelming and

shattering of our normal everyday expectations, that they "never become cognitively and linguistically processed and represented at all" (2000, p. 540). Furthermore, as Grof writes:

> In the case of major traumas, particularly situations threatening the survival and body integrity of the individual [e.g., birth-giving women]. It is very likely that in situations of this kind, the original traumatic event was not really fully experienced at the time it was happening. [This] can lead to a situation where the experience is shut out partially rather than completely. As a result of it, the event cannot be psychologically 'digested' and integrated and remains in the psyche as a dissociated foreign element (Grof, 1988, p. 225).

Therefore, just as the birth-giving trauma began with a whole person, bodily, social, political, psychological, sexual, existential, and transpersonal wounding—in a ritual context—healing may *need to be attended to in a counter-ritual* and counter symbolic/therapeutic social milieu.[3] This should be a ritual in which the creative healing potential of the woman's own psyche and soma are brought strongly to bear on the healing process; a process that restores her personal authoritative knowledge by engaging her intentional, volitional, bodily, emotional, intellectual and transpersonal knowing. A 'good' ritual should have the ability to bring the unprocessed and undigested material back into consciousness in a creative and emotionally intelligent environment (a set and setting) that is symbolically optimal for such a recovery.

In many rituals the human body and nervous systems are 'heated' through dancing, exertion, breathing, or emotional catharsis. An example would be the prolonged dancing and the !Kai trance of the Ju/'oansi (the !Kung Bushmen) of the Kalahari Desert:

> !Kia can be considered a state of transcendence because during !kia, a !Kung experiences himself as existing beyond his ordinary level of existence. !Kia itself is a very intense physical state. The body is straining against fatigue and struggling with

[3]According to Hollan, recent anthropological inquiry into spirit-possession rituals show that possession idioms are a means "by which otherwise unknowable, suppressed or repressed knowledge … is directly or indirectly expressed" (2000, p. 539). This is similar to Lévi-Strauss's argument that the Cuna shaman in their childbirth ritual was expressing 'otherwise inexpressible psychic states' (Levi-Strauss, 1963).

> convulsion-like tremors and heavy breathing. The emotions are aroused to an extraordinary level, whether they be fear, or exhilaration, or fervour (Katz, 1976, p. 287).

Heightened motor activity, bodily postures and metaphors, gestures, vocalizations, and enactments including a fully embodied re-performance of the vital energies of birth-giving might need to be enacted to shift through a sense of constriction or 'blockage' into a sense of 'openness'. Here the same neuro-cognitive subsystems of the central nervous system can be harnessed in the healing ritual process. In a reparative ritual process, as the autonomic sub-systems fire and open to gestalt perception (holistic grasping), a new set of symbolic impressions, post-conceptual cognitions or transpersonal events, could ameliorate or replace the traumatic imprint of the 'bad' ritual. This can be conceptualized as *ritual inversion*: replacing the hierarchy and hegemony of the traumatic "governing system" in the psyche to a position in which it is experienced as ultimately transitory and partial in an unfolding dialectical process (see Tarnas, 1991, p. 429-31; Walden, 1993; and below). A dynamic shift in "governing system" (Grof, 1988, p. 227) can move the participant through the negative system and attune her to more positive, nurturing and healthy constellations.

The Problem with Sexuality

It is a strange situation where birth activists have to argue that birth-giving is an extension of normal female sexuality, nevertheless, due to the over-medicalization of birth, they must (e.g., Davis-Floyd, 1992, p.69; Klassen, 2001, p.181). Davis-Floyd sees "obstetrical rituals" as having developed in tandem with a medicalizing program to "desexualize" and render the mother's sexuality around birth-giving "tabu" and "defective" (1992, p. 69). She writes "So effective are hospital routines at masking the intense sexuality of birth that most women today are not aware of birth's sexual nature" (1992, p. 69). We should also mention the father's recent presence at birth in Western cultures as symbolic of the couple's sexual power. Brian Bates and Allison Turner say that many "childbirth rituals found throughout the world appear to be of a sexual nature" (2003, p. 88)

> The stimuli used in such practices are symbolic of the man who fathered the child and, in particular, of his sexuality. They may thus inculcate some form of sexual imagery in the woman, albeit at the preconscious level, which then stimulates the

> physiological responses normally elicited by sexual stimuli—the release of hormones and contractions of the uterus which serve to aid the birth process (Bates & Turner, 2003, p, 89).[4]

One of my informants spoke of her homebirth as intensely sexual, although it was a sexuality that incorporated a cosmic dimension. Frieda put it like this: "carrying a baby is such a deeply spiritual experience and giving birth is the ultimate spiritual orgasm … you tap into that greater energy, that greater consciousness", clearly a statement reflecting transpersonal dimensions of sexuality. Nevertheless the vast amount of Western births occurs in the hospital system, a system which, according to Davis-Floyd and others, has robbed women of a vital and integral birthing energy.

However there is another serious problem to take into account when addressing sexuality and birth: the complications of childhood sexual abuse. It was matter-of-fact among some of my midwife informants that childhood sexual abuse can seriously impact birth-giving women protracting her labour and making it more exhausting and dangerous. Penny Simkin and Phyllis Klaus in their recent book *When Survivors Give Birth* (2004) write that some women can experience prolonged non-progressing labor and "extreme pelvic tension" (2004, p. 71) due to childhood sexual abuse. They speak of a woman whose "greatest fear was that something in labor would trigger 'body memories' or feelings of victimization" (2004, p. 68). Fear releases hormones (catecholamines) that are known to slow labor (2004, p. 80). Thus childhood and adult sexual abuse can become a vicious and problem laden cycle at the level of birth-giving because it can further constrict the women's laboring which can then call forth further biomedical interventions. In the light of this situation it is little wonder that in some circles women are beginning to talk about "birth rape".

Neva Walden's exploration of the relationship between holotropic breathwork and healing: *Contributors of Transpersonal Perspectives to Understanding Sexual Abuse* (1993) gives several examples of the relationship between sexual abuse, birth-giving, and holotropic consciousness. The women here are reporting on their participation in holotropic sessions:

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[4]Kitzinger notes that a man's sweaty shirt was brought to obstructed Jamaican woman in labor - human sweat contains prostaglandins which can stimulate uterine inertia (1982:192). Prostaglandins were originally thought to reside in human semen and the prostate gland.

> I felt a strong build up of tension in my genitals and bladder area. As it built I got extremely angry and sexually frustrated. My body was filled with it. First it was my rage and frustration. Then my body was filled with my mother's as well. Then, my grandmother's and finally that of all womanhood throughout time (1993, p. 173).
>
> Opening to feel the pain and suffering of that little girl within, I cry. As I cry, I fully feel the cry of a wounded animal, and also the cry of all children being raped and abused. I feel the cry of all women in childbirth. (1993, p. 170).

Walden suggests that abuse victims (like victims of birth-giving trauma) are locked into the second phase of something like the ritual dialectic and that holotropic ritual can move her through process much like completing a gestalt:

> Unfortunately, many sexual abuse survivors are still living the experiences of stage two of the initiation process. They are left in the turmoil of the separation, humiliation, shame, and death portions of the passage. With healing, however, the survivor can move into the integration phase. Experiencing the full range of emotions and physical feelings of sexual energy in [holotropic] states … brings the integration that is a result of any successful initiation. It produces a profound shift in their sense of themselves.[5]

In the same way it could be argued that women traumatised by technocratic birth rituals or birth trauma and the frightening encounter with death are in a similar phase in the ritual process, she is 'betwixt and between' the traumatic situation and with successful integration. The trauma, largely unrecognized, is compartmentalized and isolated but at the same time unconsciously (psycho-dynamically) structuring her relationship with the world which is often experienced as threatening and dangerous.

Let me give an example: Anna (25-years-old) came to a holotropic session in New Zealand 5 years ago in which she replayed her birth-giving. Anna had been expecting a water birth with her partner and

[5]This is not to suggest that sexual abuse can, in any way, be seen as any kind of initiation process. Only that the healing process, like the ritual process, can follow a dialectical pattern based on the pattern of birthing.

their friends. Unfortunately this did not happen and her dreams were dashed when her birthing became a highly medicalized event. She had also lost meaningful contact with her male partner during her birth crises. While grateful for the intervention, she said ever since she had experienced high levels of distress, anxiety and nightmares that she strongly related to the birth of her child. It was as if, she said, there was an energetic, emotional, and spiritual aspect of her experience that was not brought into consciousness and this charge had been lying dormant ever since "just below the surface". Anna went through a very cathartic session, involving a wide range of emotions, bodily movements (very obviously linked her labor pains and her own birth) oscillating with states of deep blissful relaxation and bouts of ecstatic communion with a spiritual force. What was most remarkable was her conviction afterwards that she had moved into a state of transpersonal consciousness where she somehow not only birthed all the babies in the world but all the creatures in the world and even all the *forms* in the world.

The Problem with Death

Some women's birth-giving narratives also point to a frightening encounter with death during parturition. Certainly among the women (and men) I interviewed in New Zealand this was a common factor (Lahood, 2006a, 2006c). The two following narratives disclose just how potent but also how unrecognized this feature of birthing is:

> I was terrified when my daughter was born. I just knew I was going to split open and *bleed to death* right there on the table, but she was coming so fast, they didn't have any time to do anything to me [my emphasis] (Davis-Floyd, 1994, p. 331).

> During the delivery process, some women were shaken to the core by feeling abandoned and alone, as illustrated by the following quote: 'I had a major bleed and started shaking involuntarily all over. Even my jaw shook and I couldn't stop. I heard the specialist say he was having trouble stopping the bleeding. I was very frightened, and then it hit me. *I might not make it!* I can still recall the sick dread of real fear. I needed urgent reassurance, but none was offered' [my emphasis] (Beck, 2004, p. 22).

There is a serious knowledge gap surrounding birth-giving women

and the impact of the potential psychological encounter with death during parturition. Davis-Floyd, for example, does not seem to acknowledge the encounter with death as a central aspect of the ritual process for contemporary women in her study. Furthermore, I believe Beck is in fact naming two traumas here. First the 'primary': an acute and dreadful encounter with death, and then a 'secondary' trauma occurs when this experience is not offered much needed social support, empathy, or understanding and is left isolated. Was she shaken to the core because she was 'abandoned' as Beck suggests or was it because she feels she is really dying?

According to some anthropologists fear of death (like sexual abuse) plays a crucial role in reproductive crises. Carol Laderman, writes that "The prolongation of labor because of fear is associated with much higher than normal perinatal mortality rates" (1987, p. 300). James McClenon notes that, "Fear results in muscle tension, which inhibits the normal dilation of the cervix" (2002, p. 53). He also suggests that fear and stress can increase the likelihood of childbirth complications, psychosomatic infertility, spontaneous abortion and miscarriage, post-partum haemorrhage, and obstructed labor (2002, p. 46-57).

It is important to note, however, that the human encounter with death, is not always necessarily a negative experience (perhaps in the same way that losing control is not always a negative experience and one often mandatory for birth giving), it can also become a part of the ritual process and a doorway into transpersonal consciousness (Grof, 1985, Lahood 2006a). Kitzinger, following Levi-Strauss, writes that "birth and death are rich with meanings which have penetrated the whole of social life. But in the West, as part of a process of 'scientific praxis' we have emptied birth and death of everything not corresponding to mere physiological processes (Kitzinger, 1982, p. 195). For example, anthropologist Megan Biesele in her study of birth and trance dancing among the Ju/'oansi of Africa's Kalahari Desert writes:

> Daring death seems to be part of cultural maturation for the Ju/'hoansi, as it is in fact for many other groups of people. Both the men's and the women's daring—in trance and in giving birth—seem to function as transformational rites of passage in Ju/'hoan society (1997, p. 476).

Indeed Grof and anthropologist Joan Halifax wrote that an encounter with death is at the very core of rites of passage: "profound experiences of symbolic death result not only in an overwhelming realisation of the impermanence of biological existence but also in an

illuminating insight into the transcendent and eternal spiritual nature intrinsic to human consciousness" (1977, p. 5). Women in the Kalahari have access to ritual status through the processes of transformation and self-actualization by giving birth and encountering death (Biesele, 1997). This ritual or *charismatic status* is denied in the Western birthing system. Good ritual, then, must be potent enough to rework the encounter with death at the somatic and symbolic level and restore ritual status and charisma to women.

Midwives and birthing women categorically encounter new life and the potential of death everyday. I would like now to introduce a story from a midwife who has participated in a dozen holotropic rituals and recently participated in a still-birth. The following process of skeletonization (returning to bone) and transformation is a classic feature of psycho-spiritual death-rebirth initiations and shamanistic practices of many cultures:

> Breathing deep into myself another path was to be explored. As previously experienced in holotropic breathing, I feel I am often taken into the darkest aspects of my soul. I have learnt to trust this journey and surrender once again having acknowledgement from my guides.
>
> This day I had a golden *deva*, of feminine form and energy from what felt to be a heavenly realm. As I was being drawn deeper into what I experienced as a dark spiralling tunnel I remember looking back, perhaps over my shoulder, and feeling the reassurance of my golden heavenly *deva* encouraging me forward. Breathing deeper into these dark surrounds, encapsulating me in its spiral design, fears began to rise, descending upon me rapidly, accumulating within me so quickly.
>
> Confronting so many fears at such speed. Beginning to feel a nausea rise from within my belly, running out of breath. The taste of fear rising from out of my belly now into my throat, a few coughs to try and clear this muck, some gagging, having difficulty breathing as my body fills up with fears needing to expel somehow. Then the sense of just opening my mouth as this black dust sprayed from my mouth, a thick stream of black fear broken down into little bits exiting my body. My mouth is wide open as if in a yawn with some sound being emitted. Time was lost as my body purged this accumulation of dark fears from my body. When I was empty of the fears and darkness I find myself

breathing again and still, bit only for a moment.

As I journey on to explore other aspects of myself as Midwife. I began to experience the birthing of all the Mothers and Babies I have been witness to. I began to birth them myself, I birthed them, their histories, all their ancestors and beyond. Giving birth to the earth in its entirety itself. Yet there was still more.

My physical body begins to leave behind all of its layers to expose only my skeleton self. Beginning to shake and rattle I slowly begin to crumble and disintegrate into the earth, there is nothing left of me. I have stripped myself bare to the bone and completely undone myself. Having completely lost every layer of myself I am lost in the awe of transformation as slowly I resurrect myself into physical form once more. Here I am held in a pink loving womb, rocking to and fro slowly coming into a new consciousness.

Here I am, heavenly being. Here I am, alive and breathing again.

Ritually Combating the Spirit of Alienation

In the intersection between the three biological powers of birth, sex and death, (outlined above) with Western culture – it is *isolation* in its various guises (compartmentalization, separation, solitude, alienation, and obstructed relations) that are critical. As we saw each of these biological categories can be highly constricted and hegemonically controlled by Western biomedicine: women until very recently were routinely *separated* from their families, their husbands and lovers, even her newborn, the psychological encounter with death largely ignored or denied, sexual relationships obliterated, sexual-abuse isolated or even amplified.

According to Jeanne Archterberg this sense of "alienation" from "family, community, the environment, the self, and the spirit world" (1992, p. 159) is axiomatic with illness in many tribal societies and requires transpersonal rituals for its amelioration. Yet, as anthropologist Jurgen Kremmer points out, these are the very relational fields severed by the march of Western progress (including Western biomedicine). The Eurocentric ego is "constructed dissociativly from nature, community, ancestors" (Kremmer 1996, p. 46). Indeed the categories equating with *alienation* are the very ones

associated with the *demonic* in many traditional societies. Furthermore it is often in her dangerous travail that a woman is attacked by demonic forces (e.g., Laderman 1983). For example, anthropologist Bruce Kapferer says of Buddhist exorcism:

> In Sinhalese cultural understandings a demonic victim approximates what I refer to as an existential state of solitude in the world. The demonic as conceptualized by the Sinhalese is similar to that which Goethe recognized from within the worldview of European culture as ultimately everything that is individual and separates one from others. Demons attack individuals who are understood to be in a state of physical and mental aloneness. Solitude and its correlate, fear, are among the key essences of the demonic (Kapferer, 1986, p. 195).

We have seen already how fear plays an important part in obstructing a woman's labor. Kapferer writes, "At the paradigmatic level and in accordance with Buddhist cosmological view and worldview, demons are at the base of a hierarchy dominated by the Buddha along with a host of major and lesser deities"[similar to Christian hierarchies of angels] (1986, p. 193). Kapferer, arrestingly, links Buddhist thought to Goethe's Romantic, participatory thought - both of which are *seminal* ancestors of the transpersonal movement (McDermott, 1993).

Here is the crux of the matter; the modern European worldview as spelled out by Richard Tarnas (1991) is very much an ego-centric one and therefore according to Kapferer's Buddhist/Goethe formulation; categorically 'demonic'. The picture Tarnas paints of the Western ego - is one of absolute solitude, solipsistic, alone, and isolated. Our "cosmological estrangement … ontological estrangement [and] epistemological estrangement [results in] "a threefold mutually enforced prison of modern alienation" (Tarnas 1991, p. 419). Seen from the Buddhist/Goethe/transpersonal standpoint the European mind is cathected to a flawed image of the universe. The mystery of nature is demystified through 'objectivity' and we are severed from participation in the sacred worlds of our ancestors. But perhaps more importantly for this article, the dualistic Cartesian-mechanistic worldview is the running system on which the Western birthing system operates (see Davis-Floyd, 1992; Lahood, 2006b). Thus birthing women and their partners are participants in a ritual process that can amplify isolation, alienation, and fear.

By way of an example of the demonic spirit of alienation promoted

in technocratic rituals, I would like to use the following statement from Robbie Davis-Floyd:

> The Cesarean itself felt like somebody stepping on my stomach with a boot, and pulling up the skin for laces. It was cold in the room, and the table was cold, and that cold penetrated my opened in–sides till I felt cold throughout my entire being - lonely-cold, as if I were floating naked on an iceberg. And my mouth was dry as sand, and I asked for ice chips, but the anesthesiologist just shook his head. So this is how I felt during the Cesarean - stepped on like the floor, laced up like a boot, cold as the Arctic, dry as the desert, and just as alienated from my experience as if I had been on another planet (2002, p. 10-11).

'Good' Ritual

The antidote to the demon of isolation from a transpersonal participatory worldview would be what Tarnas calls "radical kinship with the universe" (1991, p. 437) brought about by 'good' ritual. Or, to follow Kapferer, "the languages of ritual contain varying potential for bringing together the Particular and the Universal" (1986, p. 191). If ritual is the "foundation for transpersonal medicine" as Jeanne Achterberg (1992) claims, then holotropic breathwork is transpersonal ritual medicine-making *par-excellence* and one geared for our participatory times (see Tarnas, 1991, p.425-445). While the method is used for healing psycho-trauma, an approach in transpersonal research, and self exploration (Grof, 1998; Bache, 2000), it *can* also be conceived as a ritual and rite of passage and, for the purpose of this article, I will conceive it so.

In holotropic ritual participants can organically retrieve and 'relive' traumatic events, abuses, accidents, birth and birth-giving (wounds that compound a person's sense of alienation) while in what is called a 'holotropic state of consciousness'. These are non-ordinary states of consciousness moving toward greater sense of wholeness. This sense of wholeness is often accentuated in transpersonal events of consciousness accompanied by a shift in *meaning* of the traumatic experience.

The approach has been compared with other cross-cultural rituals in a growing body of literature. In the epilogue to *The Passion of the Western Mind* (1991) Tarnas, working from Grof's experiential research wrote that the process of holotropic ritual and its engagement with the 'perinatal' level of the psyche "appeared to be essentially

identical to—the death-rebirth initiation of the ancient mystery religions" (1991, p. 440). Psychoanalytic anthropologist Larry Peters writes in "The Contribution of Anthropology to Transpersonal Psychiatry" (1996) that:

> The Tamang healing rite reveals transpersonal elements that are present in the healing systems of many cultures and that may be useful in psychiatry … [the rite brings the patients condition to a painful crisis that is cathartic and healing. The release from social etiquette allows the free expression of emotion that may resolve interpersonal conflicts … [the healing rites involve partial or full dissociation. The therapeutic effects of dissociation in ceremonial contexts have been described in relation to numerous indigenous cultures ... [these intense experiences are given structure and meaning through the use of potent spiritual symbols, rituals and myth … [there is an alteration in the patient's relationship to community and cosmos. The Tamang ritual not only creates social support, but also generates what Stanislav and Christina Grof call a "*spiritual emergency*." This is an intense emotional crisis that often includes themes of death and renewal but presents opportunities for healing through a deeper connection to nature, divinity and other people. A structured ritual crisis, therefore, gives the patient access to the transpersonal healing forces of community and spirit (1996, p. 208-209).

During my time facilitating holotropic rituals I have observed several thousand individual holotropic sessions in group settings in several countries around the world. Certainly the holotropic approach creates Peter's 'structured ritual crisis', however, for the purpose of this paper some of these healing crises were specifically linked to an expressive re-ritualization of birth from the standpoint of the birth-giving mother. This is to say that during holotropic breathing sessions some women seem to 'relive' their birth-giving experience. The unconscious material coupled with the dynamic urge to re-enact birth-giving seemed to arise naturally from the women's psyche when placed in the therapeutic holotropic environment. As Grof wrote 30 years ago:

> It was frequently observed that female subjects reliving their own birth re-experienced [in holotropic sessions] the delivery of their own children. Both experiences were usually relived simultaneously, so that these women often could not tell

> whether they were giving birth or being born themselves (Grof, 1977, p. 167).

The following statement is from a woman Doreen, who participated in a holotropic setting in England last year:

> Then I carried on sharing around my own birthing experience and the only way I could describe it, was as if my spirit had been born again and again and again, it was like I was giving birth, I was birthing my own children and I was my children in the birthing process, and I was aborting and I was being born, it was like I was coming down through the birth canal.

It is well known language can fail to convey the essence of the post-conceptual nature of the transpersonal condition and the lived experience of healing, no less difficult to convey are the exact healing mechanisms of the holotropic breathing ritual. Something that I *hear* time and time again from participants is that a shift in consciousness happens somewhere during the process and people feel themselves cradled by a deeper wisdom, or higher power, a sacred mind, or a Great Mother and as they entrust themselves to that wisdom a profound emotional, somatic, and transpersonal unfolding can begin which seems to have its own therapeutic genius. Once 'held' by this intelligence the process is often likened to a 'purification' which is to say that anything felt by this intelligence to be inorganic or not healthy begins to emerge into consciousness and moves toward "a climax of expression" (Bache, 2000, p. 9) which then allows for the unconscious material to be re-evaluated and integrated in a therapeutic/symbolic social milieu.

Healing a Traumatic Birth

Let me give a typical example: Beth, a woman of about 55 years, came to the breathing ritual. Although this occurred some ten years ago I remember her well because I was so struck by her story. During her breathing session she became extremely primitive and (as she told us later) gave birth to all her five children again. Beth told us that she had been brought up a Catholic and that 'down there' meaning her reproductive organs and genitals were never talked about in any positive way. Beth said she felt strong injunctions about living 'in her body' and in particular 'down there'. Thus with the onset of her first labor she had been extremely overwhelmed and shocked by the depth

of her biological power and process but had struggled to keep herself from occupying her lower body because of the shameful associations from her upbringing. In her words she had felt 'split off' from herself. Beth had not come to the workshop with any agenda about replaying her birth-giving but this was where her process took her. She also had to deal with admonitions from hospital staff not to make any sound when giving birth. Indeed she was told to 'shut up' when she swore with pain. She described her anguish of giving birth from a body that was held to be shameful, surrounded by strangers who were reinforcing the denial of her physiology and her need to express pain and outrage.

During the breathwork ritual she actually relived the birth of all her five children and made a point of bringing her awareness into her birthing body as a sacred vehicle and with each birth she roared, swore, and labored and roared some more. At one stage I remember her powerfully discharging her anger, frustration, disbelief, and fear at the medical staff, her parents, and the Catholic Church, for the ways they had negatively contributed to her birth-giving. Thus in the course of her breathing she revisited the archaeology of her traumatic or oppressive birth-giving history and re-enacted her births with deeper awareness, with vocal expressions fitting her needs, greater sense of autonomy and power in the situation and freed-up emotional and motor responses. In my opinion, and most certainly in Beth's, she had transformed herself by re-birthing her children and claimed for herself some of the charisma and status that she believed were rightfully hers. But more importantly, she felt she had finally struggled against these internalized oppressions and allowed her emotional body to finally go through the process of birth; an 'act hunger' she had held back ever since then.

Jungian Edward Whitmont in *Return of the Goddess* (1983) said that, "differentiation from others, and hence self-definition occurs through struggle" and then this:

> Grof has described the close association of birth and rebirth experiences with violence, upheaval, and death as they emerged in [holotropic] research. He describes the arousal of feelings and urges of violence during the passage through the birth canal. The subject experiences overcoming a state of deadlock and inertia, of feeling oppressed and hemmed in. Subsequently, urges of violence and aggression are likely to be aroused by any stagnating or deadlocked life situation which calls for the need for regeneration, a *new birth*. This is true collectively as well as

individually (Whitmont, 1983, p. 17-18).

Another woman, Karen, 35 years of age, came to a group in Australia and relived her birth in a most extraordinary way. During her session she was lying very still on her mat and I motioned my co-facilitator over and said to her that I had sense she was conceiving. This intuition seemed to be more-or-less correct because during the course of her 4 hour session we watched her become pregnant and then gave birth. What I remember most about Karen's session is that she had turned her sitter (her assistant during her breathing) into her husband. She appeared to be deeply engaged in birth-giving and he with her process. She was sitting, sometimes squatting or standing, other times on her hands and knees, her 'husband' was holding her, encouraging her and breathing with her. Sweat was pouring off both of them. It was a most remarkable thing, the magic of it tangible, and many of the other sitters in the room were drawn to their performance.

Later she told us that the birth of her son had hurt them both and that their relationship had suffered from the trauma they had caused each other as if there had always been a very primitive and intimate anger between them from that primal moment. She said that the breathing had enabled her to go right back to conception and replay somehow the whole reproductive cycle. But this time she said it was like doing it all with a deeper wisdom that she felt pervading the ritual space. She said she was not hampered by fears, embarrassment, and the directives of the hospital staff (or lying on her back in stirrups) but was able to return to this defining moment in her life with the wisdom of the group and a healing intention and that somehow she had found herself re-doing her birth giving. It was her belief afterward that she had changed a major unconscious distress pattern and that it was her hope that this would have a healthy effect on her relationship with her now teenage son.

Not Altogether Sure How It Works

Because of limited space I will devote another article to the *ritual* mechanisms in holotropic breathwork. However, I should say from the outset that since the healing is orchestrated by the breather and her integral wisdom, and is deeply idiosyncratic and unique, then I can't ethically offer an authoritative meta-narrative about what it is that heals – other than this one. Secondly anthropologists are well aware that ritual has an uncanny way of doing magical things, this is to say that there are big question-marks about how ritual *really* works also

how the human psyche *really* operates (e.g., Elkin, 1945; Turner, 1992). However as a ritual facilitator and an anthropologist I have observed *some* things and I offer these thoughts, however modest.

I can say that if the transpersonal container is co-created by the ritual participants, in an atmosphere of positive regard and the 'inner healer' is evoked, then healing seems to happen, but again, not necessarily in quantifiable ways. Preliminary discussions (re-mythologizing the human body and psyche) with participants describes and negotiates a broad map of possible perinatal and transpersonal experiences. Thus at the beginning of a breath-work group a contemporary 'myth or map' of the universe is offered which embeds the participant in an ever-widening non-Cartesian worldview and participatory paradigm. Holotropic breathers take it in turns to breathe while evocative music is played over several hours. Each 'breather' has a 'sitter' a personal guardian who behaves (a bit like a midwife) supporting and not interfering in the unfolding process. Ritual participants move into a 'liminal' stage (after Turner, 1969) as they enter into 'holotropic consciousness' and participate in what amounts to a self-generating healing ceremony. At the same time we see people often discharging very primitive levels of pain, anger, grief and fear. This appears to be similar to Victor Turner's description of ritual:

> Powerful drives and emotions associated with human physiology, especially the physiology of reproduction, are divested in the ritual process of their antisocial quality and attached to components of the normative order, energizing the latter with a borrowed vitality (1969, p. 52-53).

This to say that 'negative' perinatal energies may be in some way transmuted by the group structure and container itself. During the liminal phase 'breathers' can enter into a healing crisis which can include re-connecting or bonding (writ large) with the wider universe, nature, society/group and something like a sacred-mind such events are experienced as numinous and often self and world-transfiguring (e.g., Grof, 1998; Bache, 2000).

As participants emerge from the holotropic state they pass into a post-liminal stage. Here they make artwork of their experience and present their lived-knowledge to their co-ritual participants. This 'presentational knowledge' (Heron, 1998), I suggest, becomes part of the symbol system of the group and helps to canalize the psychodynamic, perinatal, and transpersonal energies into each

person's unique idiosyncratic symbol system. This gives the energies unleashed in the healing crisis an artistic, embodied and communal container around which meaning-making and self-reflection coalesce. During the sharing circle, or 'reflection phase' of the inquiry, participants are now seen, heard, and acknowledged as being at the crest of their own transpersonal being and becoming, and importantly, the ritual charisma or 'mana' (power accrued through ritual means) is associated with the breathers and is not appropriated by the ritual specialist (thus a restoration of spiritual authority).

On occasion I have been present with women working through elective abortion, miscarriage, spontaneous abortion, unwanted caesarean section, loss of fertility, the frightening encounter with death at birth, and the traumatic sense of abandonment that can occur when a woman looses contact with her partner, or when her desire or expectation of a natural birth is obliterated during medical interventions. The following three stories are from women who have experienced various reproductive crises and then relived those experiences as part of their healing in the holotropic ritual. Holotropic sessions are generally serial, and, in terms of depth, cumulative. Usually after several sessions, when the traumatic material is well managed and integrated, the 'gestalt' finds 'closure' in a full-blown transpersonal experience and initiation. Each of the following sessions can be seen as 'a work in process' with the final session (Jeni's) an example of the movement toward integration.

Imam's Story

My daughter's birth was very long. I had had a pause in the middle where I had been sent home and felt frustrated. I had felt embarrassed when a group of medical students had come to watch, I hadn't been asked if that was ok, they asked my husband who said yes. I also tore the ligaments at the front of my pelvis on delivery.

Imam's 3rd holotropic session: I started this session again with extreme heat in my body and lots of pain. There was intense pain in my womb, the front of my pelvis and lower back. I felt myself go rigid. Then I was visited by my mischievous man. He has appeared to me several times before. We dance together and he has dragged me out of my body before [in an NDE experience during child-birth]. Although he is mischievous and fun there is also a deep side to him and an immense feeling of power, so he deserves great respect. This time I was rigid and he danced around me rattling his red rattles, his blue eyes glinting with mischief. He gave me a song to sing. When I sung it, it

came straight from my womb. I was under my blanket for this. I then had to leave the room for a toilet break. When I returned I still had the pain in my back and womb and couldn't get back into it. I felt extremely frustrated.

Then Gregg came over and asked to check in with me about what was happening. I realised that these pains related to my daughters birth. It felt like I was going through a birthing process. I wanted to go under my blanket again but talking with Gregg I realised that this shame related to the feelings I had had at the birth with the medical students. Gregg suggested I chant powerfully as a way of deliberately releasing the distress. I chanted the song given to me by the mischievous man as I pushed and sang the pain began to subside. I had another go and the pain from the womb went but some of the pain remained in my back. When I rested Gregg made a comment about having felt like rattling or drumming around me. [Gregg: I had heard from midwives that sounding during birth, especially powerful sounds were useful. They had told me that fearful sounds release hormones that can slow things up so I suggested this to her to discharge by chanting. I also had a very strong urge to grab my red rattle or a small drum and play for Imam, something I would not do during a session, and had suggested to her that I would be willing to rattle for her - but only if she thought it would support her in her birth-giving. I was not aware that in her transpersonal world she had been visited by a bearded figure who had given her a song to chant and was rattling and dancing around her. Her vision had occurred prior to my engagement with her].

Imam: The following morning I felt faint and nauseous again and went to my bed. I came round from what felt like an anaesthetic by a friend calling my name and it took a while for my body to regain feeling. We shared the mandalas from the session. I talked about my session and how I had felt strange this morning. I realised there were threads of all my experiences in my mothers, her mother's, my fathers mother's, my husband's mothers', and even my ex-husbands mother's biographies. I also felt the abuse of the hospital system as well. It seemed to link all three sessions together, like a deepening and interconnecting. The birth experiences, rejections and abuse all interwoven together in some way.

Emma's Story: a Preterm Miscarriage

The following narrative comes from Emma a woman of about 30 years of age.

Emma: Last year in September I had a miscarriage. I knew I was pregnant only three days, but felt very excited about the pregnancy. Later in October I had a spontaneous healing experience which began with a scream that ripped out of my body and through my throat leaving me hoarse. I knew it was not pain from my own life but from some other place. The point at which my holotropic breathing experience changed from personal to that of feeling the pain of others began also with such a scream. I cannot view life in the same way anymore. It has a different meaning. That feeling of others' pain is still with me, though not acutely, just an awareness.

Emma's 1st holotropic experience: Skin alive, fingers rigid and contracting back, hands and arms following, foetal comfort. Moving to music, loving the feel of my body in dance, moving, writhing, laughing, playing – with music and movement. Loving that place of dance and play, singing and laughing at myself to hear my singing, short breath followed by long, long notes held for what felt like forever. Feeling snake twisting and dancing, swan flying, graceful. But while swan-flying my arms suddenly are held back, restricted, stopped. Horror at this restriction, disbelief and confusion, why would anyone stop me, this dancing, singing woman? If you take my life, how can I breathe? If you take my breath, how can I sing? More dancing but each time back to locked arms. Caged and restricted, held down, controlled, stopped. Arms tied behind me, trying and trying to untie them but never trying hard enough, always knowing I could move when I wanted to but staying tied. Fierce pride and strength and horror and pain as memories of control, violence, restriction pass through my vision and my body feels the force of each strike, each violation. Gradually beaten down to despair and exhaustion till finally giving up, no fight left, no pride. Watching my daughter still dancing, unable to stop those moving to stop her also, then her begging me to fight, to resist, break free, my total inability to do so. Despair as exhaustion and resignation immobilise me completely. Aware suddenly that even now, in this life, I am still tied but it is now only me that keeps me so. Immobility, apathy, pointless, seeing this cycle repeated over and over.

At this point following pressure on my neck on an area of pain… Screaming, screaming, screaming just like the scream that ripped from me last year preceding the passing on of spirits of my ancestors, then uncontrollable weeping for the despair as I see children taken from me over and over. My child ripped away from my arms, my womb, my heart. Watching helpless as they are taken, die, are killed, leave home. Pain of mothers through time losing their children, pain unbearable, irresolvable. The certainty that it will continue, each life, each time,

children will be lost and that pain is so strong, so acute, so all encompassing. A well of pain and grief, blue, deep, circling, tangible, despair. Birthing more, only to watch them too be lost. How do I stop this? I cannot. But yet more are born, more new life flows from me, from woman, life ever flowing, unstoppable, womb giving new life, no way this can be stopped. And this bringing hope, light, peace.

Slowly quietening, slowly lessening, fear of more grief but slowly it ebbs away. Realising this dancing woman is there, seeing her in my ancestors, seeing myself in her. Quiet, quiet, sweetness, tiredness but life back. Life back!

Finally, left with images – a woman stood facing away with her hands tied behind her back, but her hands are now two doves. And a dancing woman, hair flowing back as she spins, arms outstretched. Restriction and hope, freedom and expression.

Jeni's Story: A Spontaneous Abortion

The following is from Jeni, a Scottish woman who attended a workshop this year in North England:

The peace of being pregnant settled within as I took every precaution to nourish my growing bundle. I sang my songs, made plans, paid close attention to the doctor's advice and attended the scans. I smiled, seeing the fetus develop into a recognisable form my pleasure and expectation mirroring the growth. The magical nature of the following months heightened my sensitivity to the wonder of creation. I occupied a space which held my baby and me in an inviolable bond.

Disaster struck just before my sixth month as I stood in the bathroom one morning. I blacked out. Coming round I crawled to the bedroom followed by my youngest daughter whose face was streaked with tears. Her distress was palpable and I was caught between trying to comfort her and the pain in my belly. My husband called the doctor who came sometime later. When he examined me he told me I was miscarrying. The bed was soaked with blood and the contractions strengthened doubling my body with pain, the weakened womb pacing my mounting distress joining with the stark realisation that my baby's life was transformed into death's dark and still hand. My son was stillborn, my grief overwhelming as I held his small, formed lifeless body, the doctor gently mouthing his sorry. Time stood still.

Jeni's 4th holotropic session: I remember entering the coldest blackest space I have ever encountered. My whole self shivers to the

bone and beyond, as chilly fingers flex their ice laden grip stilling all hope. I curve my body as tightly as it will allow; fear transplanting the warm blood in my veins. I descend into the agony of loss, seeing my broken baby, dead in my womb. My son, his lifeless body held gently in the weakening womb, is small, formed and silent. Holding him with my mother's love, I struggle to rise for him, for me. I am caught in a density, which threatens to overwhelm me. Pinioned by strong hands, I smell the maleness of raging desire assaulting my nostrils and stare desolation in the face [Jeni is re-experiencing a sexually abusive episode]. I flee to that place of non-identity. I know not how long I wander desolate or how I find myself again. My broken baby is no more and my womb is no longer with me.

I hear my name being called softly, it is whispering still on the wind, warming my limbs, bidding me rise. I feel a powerful presence - primal in nature. A huge yellow and black cat softly pads across my path - sinuous, lithe and, familiar. Mouth open, enormous yellow sabre teeth displayed, ears sifting meaning, tail long and gently flicking side to side. Cat stops and gazes in my direction, slanted eyes focussing. Without warning we merge and, I become Cat - savage, ancient and flushed with natural instinct. My cub has been killed and I hunt his slayer. My humanness sits inside quiescent and accepting. Tears flow inside as I roar 'you killed my baby'. The force of my distress marked by a loss of control, warm urine rushes down my legs. I feel no shame. Our flattened tight body hugs the grass, eyes centred on my prey. A thrust of speed and claws and teeth fasten; rending, tearing, cracking muscle, sinew and bone. Life's blood spurts, spills, soaking fur teeth and tongue. My hunger sated, I curl my body into contentment's shape and rest. Fat Cat.

A huge deep orange sun hangs just above the horizon. Seven tall, tall dark men, twig thin, stand in front of this sun; their bodies glistening with effort. Startled by this image, I come to a standstill. They are moving in unison, to an internal rhythm, spears held in hands as brown as the soil they dance upon. Their heads are each decorated with four points floating just above. Fascinated by this and their primordial ways, it takes time to realise they are dancing for me, and for him - the broken woman and the broken baby. A sense of awe and a feeling of pure connection spirals within.

Summary and Conclusion

Holotropic ritual can break through the hegemony imposed on the psyche by a traumatic birth, reworking the traumatic event until a

new sense of self is born. The 'data' these women gather in transpersonal states of consciousness generated in holotropic rituals suggests that the frozen energy bound up in blocked emotional or psychosomatic symptoms is converted "into a stream of experience" (Grof, 1988, p. 166) coupled with a sense of "flow" after Turner (1979, p. 154). This ritual process has been likened to the death and rebirth mysteries of many cultures, it is a process that seems to be a universal one naturally occurring when the psyche seeks to rebalance and re-tune to its integral healthiness. The experience is also educative, after the climax of the session and the breakthrough into transpersonal consciousness, "The remainder of the session will be spent in these spaces as one's education continues against an often ecstatic background" (Bache, 2000, p. 13). There is a feeling of community and cooperative endeavour that pervades the ritual process, which when heightened to its zenith, bears fruit as *communitas* - a sense of deep psycho-spiritual bonding with the universe and its particulars beyond *all* hierarchies. It is in the state of communitas where further transpersonal potentials open and flower.

A last (but by no means final) word on authoritative knowledge: in holotropic ritual authoritative knowledge rests with the ritual participants. While the map and model (or myth) of the holotropic cosmology is given as *authoritative* and *warranted* - it is nevertheless a *provisional* map. Indeed because Grof's transpersonal paradigm is perpetually open to revision (Bache, 2000, p. 30; Ferrer, 2002, p. 149) ritual participants can contribute to this revision (as my participants have), therefore Grof's transpersonal cosmogony is in creative flux and is not only *demonstrated* or *legitimated* in holotropic rituals but potentially *extended*. Therefore holotropic breathers can participate in, and share in, the construction and production of transpersonal authoritative knowledge.

As Anthropologist Richard Katz put it in relation to healing in non-ordinary states, "During the experience itself, cultural concepts and descriptions are not available. *So, while there is conceptual clarity, there is experiential mystery* [my emphasis] (1976, p. 290). Grof's model has conceptual clarity yet the ritual's 'experiential mystery' leaves the door open for idiosyncratic healing events (Grof, 1988, p. 207). That is to say that ultimate authoritative knowledge rests in the hands of the protagonist and his or her 'inner healer'— this is a very important for persons who have been ritually robbed of their spiritual authority (in any environment).

I have presented here the tentative foundations of a theory suggesting that the traumas accrued in modern technocratic birthing

rituals, and reproductive crises in general, could be healed in holotropic rituals. I have offered several examples pointing in this direction that further women's "epistemic exploration through narratives" (Davis-Floyd, 1992, p. 245) of their birth-giving and ritual healing experiences.

To some this might suggest an ambulance at the bottom of the cliff scenario. Ideally the original ritual where the birth-giving trauma was maximized would be changed; however, attempts to re-ritualize hospital birth beginning in the mid 1960s seemed to have (debatably) failed. Nevertheless as our exploration into childbirth and healing expands into the 21st century new possibilities and paradigms open and older ones will slowly disappear (Davis-Floyd 1992). The transpersonal movement, among other *perspectives, such as those of prenatal and perinatal psychology*, will continue to offer alternatives to the dominant system in the hope changing those structures for the better, or until the alternates become main-stream.

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Journal of Prenatal and Perinatal Psychology and Health 22(2), Winter 2007

The Skin as a Psychic Organ: The Use of Infant Massage as a Psychotherapeutic Tool in Infant-Parent Psychotherapy

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ABSTRACT: This paper explores the use of touch, particularly infant-massage in infant-parent psychotherapy and the ways in which clinicians can utilize this intervention to strengthen infant-parent attachment. Touch as a taboo in psychotherapy, and the paradigmatic shifts that are occurring to allow for a reconsideration of the value of touch in psychotherapy is considered. Theories on touch and development from a depth-oriented perspective are presented, including related concepts such as: psychic skin, skin ego, and Winnicott's holding environment or handling.

KEY WORDS: Infant development, infant, massage, infant massage therapy, infant-parent bonding, mother infant relations, psychoanalysis, object relations, psychic skin, skin ego, holding environment and handling, touch.

INTRODUCTION

The infant's development of differentiation of the senses through the use of touch, smell, taste, sight, and sound and the infants' experience of their skin as a defining boundary between internal space as opposed to that which is external to the self greatly impacts psychological development. These encounters set the foundation for our experience of self and identity. In addition, this early sensorial foundation frames our capacity for attachment and individuation. The skin is the largest human sensory organ, and touch, the first

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This paper is based, in part, on Paulette Lucier's doctoral dissertation entitled: *The Role of Touch in Early Development: the Use of Infant Massage as a Psychotherapeutic Tool in Infant-Parent Psychotherapy* (2006). Dr. Lucier received her PhD in Clinical Psychology from Pacifica Graduate Institute. Her dissertation committee members included: Christine Lewis, PhD, Allen Bishop, PhD, and Wendy Anne McCarty, PhD. Dr. Lucier founded The Little Village, a specialized counseling center for children and families, located in Santa Maria, California. She is also a certified infant massage instructor (CIMI). Contact information: Website: www.thelittlevillagecc.com; email: paulette@thelittlevillagecc.com

sense, is in itself a language, setting the stage for symbolic communication beginning in the womb (Montagu, 1971). Since the skin is the first sense to develop, it seems reasonable to assume that the somesthetic system (kinesthetic and cutaneous processes) plays a fundamental role in development.

This paper will explore the following topics: (a) Touch in the practice of psychotherapy, particularly psychoanalysis, and the longstanding debate against the use of touch in psychotherapy, (b) changing paradigm shifts within the field of psychology that allow for a reconsideration of the value of touch within psychotherapy, (c) the skin as a psychic organ based on psychoanalytic theory and practice highlighting the importance of holding the infant through empathic mental containment as well as through physical holding, and (d) touch therapies, particularly infant massage, as a psychotherapeutic tool in infant-parent psychotherapy.

Touch in Psychotherapy

The idea of introducing touch into the practice of psychotherapy is not new. Ferenczi (1953) felt that nurturing touch could facilitate analysis by assisting the patient to tolerate pain that was characterologically defended against. However, Freud strongly held onto the belief that touch could lead to sexual enactments (Rachman, 1989). James Fosshage (2000) outlined a review and assessment of the classical theoretical basis for the exclusion of touch in psychoanalysis and found that most analysts restrained from touching their patients due to the assumption that physical touch gratifies (allows for energy discharge of) the patient's infantile sexual longings and, thereby, fixates the patient at an infantile level.

It is understandable that under the classical model, touch was strictly prohibited. However, it was still hotly debated despite popular assumptions about its non facilitative function. Winnicott (1954-1955) suggested that "*therapeutic changes can only be brought about by new instinctual experiences*" (p. 273) as they occurred in the transference of patient to analyst. This statement highlights Winnicott's belief that psychoanalysis can provide an alternative experience and education for the patient, including techniques outside of the realm of language.

Winnicott (1969) compared the work of the analyst to that of a physiotherapist. In cases of disturbances in early care, such as inadequate *holding*, which may lead to unthinkable anxiety, physiotherapy was warranted to repair damage to the infantile ego and the injury to the sense of self. Winnicott held the belief that

physiotherapy provided a means to address the lack of ego cohesion which manifested as unintegrated states. In addition, he felt that physiotherapy could restore the relationship to the body and create an awareness of the skin as a limiting membrane. Winnicott did allow for touch and physical contact in play as did Klein when working with children. In his work he observed that the body had a certain intelligence that defied containment in words. Winnicott also used touch with adults, similar to his work with children, which would not have been indorsed by Klein or Freud. Margaret Little (1990), an analyst, wrote of her personal analysis with Winnicott between 1949 and 1957 in *Psychotic Anxieties and Containment*. Little (1990) writes of her first-hand experience of her analysis with Winnicott, shedding light on such concepts as *holding, holding environment, facilitating environment*, and *containment*. In a session early in the analysis, Little described having intense spasms that would build and reach a climax and then subside, and then once again build. Winnicott interpreted Little's physical reaction as a reliving of the birth process and the experience of being born, and then he held Little's head for a while and said, "that immediately after birth an infant's head could ache and feel heavy for a time" (Bass, 1992). Little (1990) described in detail Winnicott's metaphorical holding as well as his literal holding: "Literally through many hours he held my hands, clasped between his, almost like an umbilical cord, while I lay, often hidden beneath the blanket, silent, withdrawn, inert, in panic, rage, or tears, asleep, sometimes dreaming" (p. 44). Winnicott strongly believed, as illustrated in Little's account, that psychoanalysis should in part gratify the patient and provide an alternative experience through education and new instinctual experiences, such as touch.

Dworsky (2001) outlined in her dissertation "the implications of repression of physical expression in western psychotherapeutic practice" highlighting how classical analytic techniques encompass the Cartesian mind/body split and often sequester the body's expressiveness in favor of persistent reliance on intellectual understanding. She further outlines the longstanding taboo of touch in analytic work due to its association with unnecessary gratification or sexuality, which contaminates pure understanding of the patient's unconscious thoughts and motivations. The literature emerging in support of the reintroduction of touch in psychotherapy often includes theoretical justifications for the use of touch, research findings that support the use of touch in psychotherapy, and ethical guidelines which include recommendations against the use of touch with certain clients (Maroda, 1999).

A Shifting Paradigm

Psychoanalysis has undergone two major paradigmatic shifts that allow for a reconsideration of the value and use of touch within psychoanalysis. First, it has shifted from being considered a positivistic to a relativistic science, and second, it has moved from an intrapsychic to an intersubjective approach or relational paradigm. This shift involves a new understanding of the analytic relationship to include the concept of an intersubjective (Stolorow, Brandchaft, & Atwood, 1987) or relational (Mitchell, 1988) field where there is a mutual bidirectional interactive influence (Beebe, Jaffee, & Lachmann, 1994). This paradigm shift recognizes that action or lack of action on the analyst's behalf affects the relational field and, therefore, the patient's experience of the relationship. This being said, the new model is in contrast to the classical or displacement model of transference where transference is seen as being an intrapsychic process (Fosshage, 1994). Understanding that the analyst contributes to the patient's transferential experience makes us far more aware of the subtle, intricate verbal and nonverbal communications that take place in analysis or psychotherapy. Therefore, it allows us to consider the multitude of interventions available that can be introduced into the therapy process, including touch therapies such as infant massage.

The Skin as a Psychic Organ

Esther Bick has been credited with being the first to do an in-depth study of the psychological function of the skin (Feldman, 2004). Bick, a Kleinian analyst, wrote a small number of articles that explored the personality-containing functions of the skin. In addition, Bick originated the infant observation model at the Tavistock Clinic, which has had a tremendous impact on the training of psychotherapists and psychoanalysts worldwide (Davison, 1994). Bick in *The Experience of the Skin in Early Object Relations* (1968), indicates that the primal psychic function of the skin is to bind and hold together parts of the infant's personality, which the infant has not been able to distinguish from parts of the body. The infant lacks a binding force to hold parts of the personality together, so the skin functions as a concrete boundary:

> The need for a containing object would seem, in the infantile unintegrated state, to produce a frantic search for an object—a light, a voice, a smell, or other sensual object—which can hold the attention and thereby be experienced, momentarily at least, as holding the parts of the personality together. (p. 484)

The internal function of containing the parts of the self relies on the initial introjection of an external object, optimally the nipple in the mouth, in conjunction with mother's familiar smell, voice, and holding. Furthermore, Bick asserts that the containing object is experienced by the infant concretely as the skin. It is only after this first skin integration that identification with this function of the object surpasses the unintegrated state and "gives rise to the fantasy of internal and external spaces" (p. 484). Bick indicates that a failure of introjection would result in the baby functioning primarily through projective identifications and identity confusion. According to Bick, successful introjection of the containing maternal function is needed for the concept of a space within the self to occur, where symbolization and thought transpire. This may lead to the development of a second-skin formation, where dependence on the object is replaced with precocious development, early muscular development in the child, or a pseudo-independence. Second skin formation is similar to Klein's (1930) belief that excessive anxiety often resulted in the premature development of language and or motor skills. Bick's theory also resembles Winnicott's theories regarding the development of a *false self*. A defensive pattern can develop along the lines of language skills and early development of talking where the infant uses the sound of their own voice for self-soothing purposes.

Anzieu's Contribution of the Skin-Ego

The concept of the *skin ego* was well established by 1974 by the Freudian French analyst Didier Anzieu. Anzieu in *The Skin Ego*, (1985/1989) originally published in French in 1985, further developed Bick's (1968) concepts, particularly the primal psychic skin. Anzieu begins by explaining that mental processes are supported by both the biological body and by the social body. He defines the *skin ego* as:

> A mental image of which the Ego of the child makes use during the early phases of its development to represent itself as an Ego containing psychical contents, on the basis of its experience of the surface of the body. This corresponds to the moment at which the psychical Ego differentiates itself from the bodily Ego at the operative level while remaining confused with it at the figurative level. (1989, p. 40)

Anzieu explains that the primary function of the skin ego is to support the various functions of the skin: containment of the inside with a boundary, and the exclusion of the outside; communication with

the Other; and inscription of sensory traces. Anzieu stresses the role of the external environment in containing the individual psyche over the function of the primal psychic skin in creating a sense of internal space. Anzieu (1985/1989) explained that phantasy was both a "bridge and intermediary screen between the psyche and the body, the world, and other psyches" (p. 4). He postulated that the skin ego was a phantasied reality and an intermediate psychic structure.

Anzieu (1985/1989) held that the skin ego was developed through the experience of touch. The skin ego is essentially an image used for ego-representation in infancy. This ego-representation was built on psychic elements resulting from sensory experience on the body's surface, the skin. Anzieu critiqued Klein for not acknowledging the essential role of the skin in defining a boundary between inside and outside worlds making introjection and projection possible. Anzieu indicates that it is the initial skin-to-skin contact between mother and infant that defines communication and the foundation of language. The infant first experiences touch as sensation or stimulation then as communication, the "massage becomes the message" (p.39). Anzieu emphasized that the way the infant was held, rocked, and attended to provides clues into the emotional state of the caregivers and external reality. The skin ego emerges as a mental representation through the exchange between the mother's body and the infant's body.

The skin supports the skeleton and muscles, whereas the skin ego has the function of maintaining the psyche. When this interchange is successful, the containing function (similar to Winnicott's holding) is introjected and the infant is able to develop a sense of space within the self, which leads to the conceptualization that both the mother and the infant are respectively contained within their own skins. The skin covers the entire body surface, yet the skin ego performs a containing function which envelopes the psychic apparatus.

Anzieu presented many psychic functions of the skin ego, which corresponded to the physiological functions of the skin. For example, the skin ego was formed through the baby from the mother's secure support of the infant's entire skin and muscles while she cared for the infant through her holding and feeding. Supportive holding, in turn, reduced the infant's anxiety about her lack of control over bodily orifices related to the feeding and digestive process. The mother then served as a reliable receptacle of the infant's sensations and emotions, both good and bad. Maternal reliability is then internalized by the infant and serves the function of reducing and managing the infant's internal anxieties. When the containing function is unsuccessful the infant develops a *secondary skin function* defense to guard against the

experience of having a fragile skin ego, or a leaking colander skin that allows for psychic content to leak or spill out causing distortions of reality testing and interpersonal relationships. In addition, Anzieu related skin conditions to stress and deficient ego structure, which can be linked back to unsatisfactory skin-ego formation. Skin ailments like dermatitis may worsen over time with the compulsion to scratch, which is difficult to discontinue. Anzieu related this symptom to an inability to discriminate between body and psyche and a confusion of epidermal irritation with psychic irritation, and this was referred to as a primary *skin language* which is used to transform discomfort into pleasure.

In therapy, the strengthening of the primary skin function comes from the secure holding environment that the analyst provides. Despite Anzieu's recognition of the primal affiliation of the skin and touch to language, he rejected the use of touch in the practice of psychoanalysis. Anzieu (1985/1989) outlined several theoretical considerations in relation to a *double prohibition* on touching in psychoanalysis and held strong in his belief, as did Freud, that it is symbolization through language that allows for an effective psychoanalytic cure. Anzieu's prohibition on touch in psychoanalysis creates a paradox. On the one hand, Anzieu's theories relied on touch and on the physiological structure and functions of the skin; yet, his theoretical position may very well have missed the challenges of patients experiencing unintegrated preverbal states of mind reflected in embodied feeling states.

Winnicott on Holding, Handling, and Indwelling

Winnicott held that emotional development is a process of maturation and that growth is based on the accumulation of experiences, and he referred to this as the maturational process (1989a). The *maturational process* is inherited and does not become real unless the infant is in a *facilitating environment* (1989a). The facilitating environment can be explored in relation to the details of the *maturational process*, which includes integration in its various forms, such as "the indwelling of the psyche in the soma, object relating, and the interaction of the intellectual processes with psycho-somatic experience" (1989a). Interconnected to these and other fundamentals of the *facilitating environment* are "Holding, Handling, and Realising" (1989a).

Winnicott addressed in his theory and practice the infant's extreme dependency needs and his or her non-negotiable need for holding,

which includes both the *holding* of the baby in mind and empathic identification with his or her state of mind, as well as his or her need for physical holding. Winnicott refers to this empathic identification as the mother's "*primary maternal preoccupation*" with her baby, which includes subtle unconscious adjustments to various infant sensitivities. *Primary maternal preoccupation* allows the infant, early in development, to maintain an illusion of omnipotence, and to feel that he or she creates the breast. For example, when he or she is hungry food appears. The infant is not aware of external care, but experiences it as a continuity of *going-on-being* within his or her own body. As the infant gets older, he or she is better able to recognize the mother as a separate being, with her own needs which are separate from the infant's control. This is where a transitional object, which is both "me" and "not-me," comes into use by the infant as a partial substitute for the mother. This object is often a soft blanket or teddy bear with obvious tactile qualities that allow the infant to self-soothe. The infant however, cannot make use of a *transitional object* in the first few months of life and is dependent on physical holding.

The physical holding of the infant allows the mother to show her love; however, Winnicott (1965b) also adds that there are those that can hold and those who cannot. To instruct a mother to be *good-enough* is not sufficient if she does not have it in her, but if she has the potential to be *good-enough* in her mothering it is extra support and care that acknowledges the essential nature of the mothering task that can allow her to do better. Holding:

> Protects from physiological insult . . . Takes account of the infant's skin sensitivity-touch, temperature, auditory sensitivity, visual sensitivity, sensitivity of falling (action of gravity) and of the infant's lack of knowledge of the existence of anything other than the self. It includes the whole routine of care throughout the day and night, and it is not the same with any two infants because it is part of the infant, and no two infants are alike. Also it follows the minute day-to-day changes belonging to the infant's growth and development, both physical and psychological. (Winnicott, 1965b, p. 49)

Winnicott coined a separate term *handling* and this is linked particularly to the establishment of indwelling, defined as the dwelling of the psyche in the personal soma or vice versa:

> A subsidiary task in infant development is that of

> psychosomatic indwelling (leaving the intellect out for the moment). Much of the physical part of infant care—holding, handling, bathing, feeding, and so on—is designed to facilitate the baby's achievement of a psyche-soma that lives and works in harmony with itself. (Winnicott, 1986, p. 29)

Winnicott held that there is an inherited tendency in each individual to achieve a unity of psyche and soma, and that the experiential identity of the spirit or psyche as well as the totality of physical functioning are all linked by our early experiences of *psychosomatic indwelling* (1966), which, when positively achieved, involves responsive touch or *handling*. Winnicott views these experiences as a critical aspect of maternal care, with far reaching implications for infant and adult adjustment and health. Winnicott's term *holding* covers similar ground as Bion's (1962) use of *containment*, which refers to all the ways in which maternal care helps or hinders an infant to take in and manage his or her experiences.

Winnicott adds the concept of *handling*, which relates to the actual physical aspects of infant care, and to the associated frame of mind of the maternal figure. Handling is related to the way in which the mother handles her infant in all the day-to-day details of maternal care, including her ability to enjoy her baby and the associated tasks and routines required of motherhood. Winnicott (1989b) contends that in healthy development body function reinforces ego development and ego development, reinforces body functioning (influences muscle tone, coordination, adaptation to temperature change, etc.). Winnicott also contends that touch qualifies as good-enough handling only when it is reliant upon and responsive to the needs of a particular infant at a particular time.

Infant Massage

Touch therapies, particularly infant massage, can be used with parents to sensitize them to the need for touch between infant and caregiver by providing them a new technique, philosophy, and way of being with their infants. When parents are instructed in infant massage techniques, bonding and attachment may be enhanced, leading to increased parental efficacy and infant emotional well-being. A review of the literature suggests benefits for the dyad, including: increased mother-infant bonding (Field, 1995; Heart, 2003; Heller, 1997), increased pleasurable interactions on the part of mothers who have massaged their children (Field, et al., 1987), improved mood of

depressed mothers engaging in an infant massage program (Field, 2003), increased parenting skills (Szyndler & Bell, 1992), and increased sensitivity to behavioral cues.

When the psychotherapist instructs parents in infant massage, not only can the experiential component of sentient touch between parent and infant begin to occur, but an opportunity for deeper understanding to emerge through the use of contextual transference directed at the therapist as the provider of a *holding environment* (Winnicott, 1986) for parent and infant. A model baby is used in infant massage, so the therapist literally models for the parent a contextual holding of the baby analogous to the mother's holding and protecting of the baby. The infant massage instruction is geared towards the nurturing and supporting containment of both mother and infant. The therapist models nurturing using the model doll, and comments on the parent's massaging of the infant such as: "she is really enjoying your touch," or "notice how you and your baby are making such great eye contact with one another, or "she really seems relaxed today in your presence."

Attachment and Bonding

Infant massage can play a significant role in the enhancement of bonding and attachment. Infant massage provides the infant and caregiver an experience that includes eye contact, skin contact, the caregiver's voice and the infant's response to it, and rhythms of communication. Touch is also a powerful element in bonding, and through infant massage the caregiver learns to enjoy and engage with his or her infant. Vocalizations are utilized in infant massage, and soft vocalization and singing can also be used to enhance the massage. Massage is a great form of intimacy, communication, play, and caregiving.

Early parenting behaviors that are known to affect the parent-infant attachment and bond during the first year of life are highlighted during the instruction of infant massage, for example the learning of vocal cues and body language of the newborn. When the new parents become more familiar and confident in their ability to read and respond to these cues, they feel more relaxed and self-assured in their parenting tasks, and in turn become more sensitive to their infant's needs. In addition, the new mother is particularly sensitive to a re-experiencing of her own infancy through the stimulation of her own unmet infant needs, which come to surface within the context of the infant-mother relationship. Here is where a therapist working with the dyad can make a critical difference by

utilizing infant-parent psychotherapy in conjunction with infant massage instruction.

Infant-Parent Therapeutic Intervention Models and Programs

Currently several established methods of intervention and program models are being utilized, which treat infants and their parents, such as infant-parent psychotherapy, interaction guidance, watch-wait-wonder, short-term treatment, prenatal and birth therapy, relationship-based prevention and the infant in context. The relationship between therapist and parent(s) serves as the primary catalyst for change and for the integration of the intervention modalities mentioned (Heffron, 2000).

Infant-parent interventions often incorporate the goal of altering the interactional styles and behaviors to improve and enhance parent-infant relationships, and to help the infant achieve mastery or to develop new abilities. There are many commonalities between the treatment goals and the purpose of infant-parent interventions and infant massage instruction. The main difference, of course, is that infant massage instruction introduces the body into treatment, whereas other treatments may have an inherent taboo related to touch, as mentioned earlier in the paper.

Conclusion

It was Freud (1940) who referred to the mother's bond as "unique, without parallel," and who has asserted that the mother is "established unalterably for a whole lifetime as our first and strongest love object . . . the prototype of all later love relations." It is the trust created within the mother-baby bond that sets the stage for the adult's later relationships. At core, this trust comes from the most basic level of relating, touch, which is central to the success or failure of the mother-baby bond. As I mentioned earlier, touch can be felt both literally and symbolically. It is the mother's task to contain her baby in both mind and body. Successful relating comes from the mother's ability to connect with her baby from one mind to another, as associated to holding of the baby in mind and empathic identification with his or her state of mind, as in Winnicott's *primary preoccupation*. It is also important that the mother connects to her infant from one body to another through the utilization of the senses of touch, smell, taste, sight, and sound, creating, through the skin, the defining boundary between internal and external space, forever impacting

psychological development. These early sensorial encounters then become the basis for our experience of self and identity. When it goes well, development is set on course for love of self and others to transpire. It becomes more likely that one will bring forth positive feelings from others, and to develop resiliency in the face of adversity. When the mother-baby bond goes awry the stage is set for faulty development, for cruelty to self and others, weakened relationships, provocation of anger, and poor coping skills (Heller, 1997).

The use of infant massage instruction in clinical practice allows touch to be introduced into psychotherapy without the therapist ever touching the infant. It is the mother who is instructed to do all of the touching. The inclusion of infant massage instruction in conjunction with infant-parent psychotherapy provides the therapist an avenue for exploring the benefits of touch between infants and parents by providing them with a primary learning experience. The use of infant massage allows learning to occur naturally through the use of *modeling*. The parent is then allowed an *actual* experience with the infant instead of an intellectual understanding of the benefits of physical contact.

It has been my experience in teaching infant massage, as an adjunct to psychotherapy, that when a parent can experience an actual positive experience with his or her infant, which is witnessed and encouraged by the therapist, true learning occurs. Sir Richard Bowlby (2003) really seems to understand this concept, emphasizing that words are not necessary to communicate feelings and develop relationships, a valid experience affects change more than intellectual understanding, and positive messages are easier to communicate to the average parent than negative ones.

This paper has highlighted both the importance of holding the infant through empathic mental containment, which relates to all the ways in which maternal care helps an infant absorb and process her experiences of the maternal figure and the actual holding tasks of motherhood as highlighted by Winnicott (1957) and referred to as *handling*, which includes both the holding of the baby in the mother's mind and her empathic identification with the infant's state of mind as well as the infant's need for physical holding.

It was suggested that the use of infant massage as a psychotherapeutic tool allows for the infant to develop sensory distinction through the use of touch, smell, taste, sight, and sound. Furthermore, infant massage can be used in conjunction with most infant-parent intervention models and programs. Many of the treatment options available for infants and parents dovetail with the

purpose and goals of infant massage instruction. Therapists treating infants and parents have a unique opportunity at hand when utilizing the instruction of infant massage as a psychotherapeutic tool, which allows and enhances both touch as a sentient experience for the parent-infant dyad and as a model of containment or "holding" (Winnicott, 1986) for the parent.

Opening up the Dialogue

At the very least, this project opens up an understanding of how infant massage can be of benefit for the infant-parent dyad. In turn, it is my hope that more psychotherapists will support the instruction of infant massage in their prospective communities. This may take the form of referring clients out to an infant massage group. It is my hope that this project will open up a dialogue on the significance of touch in early development and will allow therapist to assist clients in connecting with their infants in a new, or should I say *ancient* and effective, manner. This study has provided a bridge between a depth-oriented approach of understanding the developing infant and the use of infant massage as an adjunct to psychotherapy.

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Journal of Prenatal and Perinatal Psychology and Health 22(2), Winter 2007

Cesarean Birth Stories

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ABSTRACT: The purpose of this phenomenological study is to better understand the impact and implications of a cesarean birth on later adult behavior patterns. A written survey was designed using Dr. William R. Emerson's questionnaire *The Evaluation of Obstetrical Trauma: A Questionnaire* (1997). Forty statements were developed to represent behaviors believed to relate to birth via cesarean section. Four cesarean-born women participated in the study. Each completed the questionnaire and was interviewed by telephone about the statements she thought best applied to her experience. Three themes emerged: (a) interruption, (b) motivation to achieve, and (c) offering help even when it is not requested. This study supports research suggesting that (a) people remember birth implicitly and (b) persons born by c-section share attitudes, behaviors, and other characteristics.

KEY WORDS: Cesarean birth, birth trauma, birth patterns

Personal Statement

When my mother told me the story of how I was born, I became fascinated with the impact my method of birth seemed to have on my life. She showed me a very large scar on her stomach and told me, "This is where you came out." I was born by cesarean section.

I discovered more about my birth in a very safe group environment at my first prenatal and birth process workshop, which was conducted by Ray Castellino, D.C. At this workshop I began to re-experience my birth at a visceral level. My body began wedging itself into a wall, a position that put pressure on my head, neck, and right shoulder. I felt

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as if something within me was pushing me tighter and tighter against the wall. I became acutely aware of this innate memory that was driving me into what I thought of as an uncomfortable “stuck place." I later learned that a study of birth memory had been conducted in which each participant was hypnotized and was asked to describe the position of his or her head and shoulders at birth. Subsequent review of medical birth records confirmed the reported positions as accurate (Verny & Kelly, 1981).

As a result of these experiences and my own birth memories, I decided to continue my studies with Castellino by taking his two-year Pre and Perinatal Somatic Training. In this training I gained deeper insights surrounding my own birth experience and how others experience their circumstances of birth. My personal discoveries have allowed me to better understand myself and my life patterns, such as why I “cut to the chase” and tend stay in uncomfortable situations, waiting for someone to rescue me.

When I was a young child I also had a recurring dream in which I was falling next to the sharp edge of a very large razor blade. As I pulled my body away from the razor's edge to avoid being cut, I would awaken abruptly. Chamberlain (1988) pointed out that dreams and subconscious feelings may reveal hidden birth memories. As I learned more about birth trauma, I began to suspect that this dream might be connected to my cesarean birth.

In my profession as a craniosacral therapist, I do what I call “listening with my hands” to the fluid motions in my clients’ cerebrospinal systems, using touch to palpably sense restrictions that may be the result of injury or dysfunction in various parts of the body. I have also learned to sit with my clients with an attitude of curious exploration. With this supportive attitude and in this safe environment, a client often finds that a surprising insight or memory surfaces. Clients have reported to me that these sessions yield insights into their birth stories and that these insights give them better understanding of their present lives. These memories are visceral in the sense that they are often experienced as bodily, sometimes muscular or skeletal, sensations. Because I have often witnessed this type of unfolding, I am convinced that the human mind has an innate capacity to recall memories that normally remain subconscious. After more than 15 years of professional experience and personal work, I have come to believe, along with McCarty (2002) and Emerson (2001), that our bodies do remember the birth experience, even if we do not. I also suspect that these memories can shape our self-images and how we see the world. For these reasons and because I was cesarean born,

I have a particular interest in the impact of cesarean birth and how others born by cesarean section experience the world. Therefore I chose to study the characteristics of persons who have entered the world via cesarean section.

Problem Statement

Only during the last 100–120 years have surgical interventions been used as a method of childbirth. The first cesarean deliveries were performed in an effort to save a baby's life after the mother had died. Later cesarean deliveries were attempted when childbirth was not progressing well, in an effort to save both mother and baby; however, infection often led to the mother's death. With advancements in medical technology the survival rate has increased significantly, and doctors and mothers now consider cesarean surgery to be a safe and in some cases even an elective method of childbirth.

English (1994) pointed out that "the subject of caesarean birth is of concern to all of us…We all have close contact with caesarean-born people" (p. 215). According to the National Center for Health Statistics, in the period 1996–2004 the rate of cesarean birth rose from 21% to an all-time high of 29% (Martin et al., 2006, p. 3). The reasons for the increasing use of this surgery include the medical profession's desire to avoid lawsuits, mothers' requests (termed c-section on demand), convenience, the practice of delivering a mother's subsequent babies by c-section after she has delivered one baby by this method, and the general increase in medical interventions during labor (Goer, 1995).

The full impacts of cesarean birth for baby and mother are unknown, but research shows that there are physical effects and symptoms present in cesarean-born babies that do not appear in vaginally delivered babies. For example, cesarean birth deprives a baby of descent through the birth canal, the pressure of which stimulates the baby's lungs and central nervous system (Arms, 1994); and Emerson (2001) noted that cesarean-born children display particular attitudes and personality traits that vaginally born children are less likely to have: low self-esteem, difficulties with task completion, tactile defensiveness, feelings of getting "stuck," and rescue complexes.

Purpose

The primary focus of this research was to examine the influence that being born by cesarean section may have over a person's life span.

The prevailing thinking about birth does not associate the birth experience with later non medical life events. However, findings from the field of pre- and perinatal psychology suggest that an important relationship exists between birth events and adult psychological characteristics. This study of women who have been born by either planned or unplanned cesarean section was designed to explore the possible connection of this method of birthing with the women's overall life patterns.

Literature Review

The Birth Experience

Dr. Thomas Verny is a founder of the field of pre- and perinatal psychology. In the book *The Secret Life of the Unborn Child*, Verny and Kelly (1981) stated, "The unborn child is a feeling, remembering, aware being, and because he is, what happens to him…in the nine months between conception and birth molds and shapes personality, drives and ambitions in very important ways" (p. 15). Birth is often the first physical and emotional shock a baby encounters, and it is never quite forgotten. According to Verny and Kelly, birth by cesarean section is a further shock, a deprivation of the physical and psychological stimulations associated with vaginal birth:

> Removed from his mother's uterus in an operating room, [the baby] gets no massaging or caressing. The feelings birth stirs in him often sound a discordant note. Physically, the Cesarean has trouble with the concept of space. Knowledge of his body proportions does not come naturally to him. He does not seem to know where he begins or ends physically. (p. 121)

In the article "Treating Cesarean Birth Trauma During Infancy and Childhood," Emerson (2001) argued, based on 20 years of clinical and behavioral observations, that cesarean births can cause babies considerable trauma, both physically and psychologically. The traumatic effects are subtle and powerful, occurring at the unconscious level of the infant psyche. Emerson further argued that perceived success or failure during birth underlies important attitudes people have about life. Cesarean-born babies exhibit symptoms that sometimes mirror what happened during labor and birth. Emerson reported observing particular attitudes and personality traits in cesarean-born children that vaginally born children are less likely to

have. The effects of a cesarean delivery are exemplified in the following description, obtained from an 85-year-old woman who remembered her cesarean birth during an Emerson workshop:

> Well, it came to me as clear as a bell. My blessed mother, bless her heart, was cut open and they yanked me out, and hard at that. I didn't know I was born that way. But I checked my mother's diary, and sure enough I was. Now I know why I've been so afraid of people my whole life and why I've never been a touchy person. Don't like to be touched at all. My first touch by humans was utterly shocking, just disgusting. It wasn't right. And I've been mighty frightened of people and particular about touching ever since. I never realized I could learn such things about my birth. It feels much better now, though, thanks to you. I even took a hug from Rev. Parsons the other day. Imagine that. He was as shocked as I was. (Emerson, 2001, p. 192)

In the article "Being Born Caesarean: Physical and Psychosocial Aspects," English (1994) pointed out that cesarean birth is not better or worse than vaginal birth, just different. However, because the majority of babies are born vaginally, English considered that there is value in knowing what the differences are for both the cesarean-born and for persons who deal with them.

Dr. Wendy Anne McCarty (2002) is the founding chair of the Pre- and Perinatal Psychology Program at the Santa Barbara Graduate Institute in Santa Barbara, California. She wrote that for over three decades the field of pre-and perinatal psychology has been mapping out what life in the womb is like and how prenatal experiences and birth impact development and personal life patterns across the life span. Pre and perinatal psychology and therapeutic work suggest that a human fetus is a conscious, aware being and that prenatal and birth experiences often entail stress or trauma:

> Our earliest experiences are embedded in our being and act as a natural filter of our perceptions and interpretations of situations, people, events and our sense of self …. We know that when a person has experienced something traumatic or disturbing, one of the most healing experiences can be to have another person hold presence, listen and acknowledge what happened and our experience of it. It is also known that denial, discounting, or not believing something happened or could be remembered can exponentially complicate and strengthen the

> destructive impact of the original trauma. … Often babies have foundational trauma because we haven't known … how much they could be impacted by what happens so early in the pregnancy and during birth …. We don't always have explicit, conscious memory of our earliest experience, but the impact has shaped us and implicitly pervades our lives. Some part of us knows. (McCarty, 2002, p. 9)

Method

Participants

To locate participants for this study, initially I contacted by word of mouth several groups of students at Pacific Oaks College in Pasadena, California, and asked them whether they had been born by cesarean section. Eight students answered yes and were invited to participate in this study. The first four to volunteer were recruited. Each of the four participants was asked to complete a written questionnaire and a scheduled telephone interview to discuss the statements that the participant thought best applied to her experience.

Instrument

The questionnaire used in this study (Appendix A) was based on Dr. William R. Emerson's (1997) questionnaire *The Evaluation of Obstetrical Trauma: A Questionnaire*. Forty questions in Emerson's questionnaire were selected and reformatted as first-person statements, and the participants were asked to mark all statements that apply to them. The statements concerned attitudes, behaviors, and other characteristics identified in the literature and by Emerson as potentially influenced by cesarean birth.

Interviews

After the written surveys were returned, a telephone interview was scheduled with each participant. These interviews were audio taped and transcribed. Each interview began by asking the participant to "tell me about your birth." Then the participant was asked to discuss five or six of the statements on the questionnaire that seemed most significant for her. Finally, each was asked, "What are your thoughts about cesarean birth?"

Data Analysis

A master tally was designed and the statements selected by the participants were documented. Distinction was made between general statements selected and those which the participants considered most significant. The participants were given the option to select as many statements as applied.

Results

Of the 40 statements on the questionnaire, 13 were selected by none of the participants. Of the remaining 27 statements, one participant selected 18, another selected 15, another 8, and another 6. The two participants who selected 18 or 15 statements were born by emergency c-section. The two who selected 8 or 6 statements were born by planned c-section without complications.

Three of the participants marked as significant the following items: (a) interruption, (b) having a strong motivation to achieve, and (c) offering help even when it is not requested. Two participants selected two matching answers on the survey: (a) childhood fantasies of being rescued and (b) having recurring dreams. Two participants considered each of the following statements significant: (a) "I can trust higher forces to direct me and/or assist me in my life," (b) "I like isolation and quiet," (c) "I change my heart and/or mind readily," and (d) "It is sometimes difficult for me to mobilize effort to start something."

The following sections report verbatim the answers each participant gave during their telephone interviews to the questions "Tell me about your birth" and "What are your thoughts about cesarean birth?"

Elizabeth's Story

Interviewer: Tell me about your birth.

Elizabeth: I have three older brothers, and my mother had a miscarriage before she became pregnant with me. I think the doctors were concerned that my mom might miscarry again, so they gave her a drug called diethylstilbestrol (DES), which was very popular in the '50s and '60s and was used to prevent miscarriage. She was ordered to bed in the second month of the pregnancy. My mom was extremely frustrated because she wanted to participate in family life, so she had

a lot of resentment about having to be bedridden. My due date was in early September, but on the third of July my mother started to bleed just a little bit, so her doctor admitted her to the hospital. Again my mother had a lot of resentment about being in the hospital on the fourth of July when her husband and sons were out enjoying the traditional fourth of July without her. I was born on July 10th. The night before, my mother started bleeding pretty badly. My mother didn't call anyone because she did not want to disturb them. Can you imagine that? Not wanting to disturb the nurses or the wonderful doctor! I am not sure if she called the nurse, or if they discovered her, but she was bleeding so badly that it was becoming an emergency. They called the doctor, and when he arrived he *berated* [interviewee's emphasis] my mother: "How could you have done this? How could you have waited so long? This baby may not make it, and we have no time to spare! How could you have done this!" They gave her anesthesia—I do not know what kind. But there was no time for it to take effect, and the doctor began the c-section while she was not completely anesthetized. To this day, when mom hears the gardener's clipping sound, it floods her memory with that experience of being cut open. (*sighing*) It was pretty traumatic. I was born via c-section two months early. I weighed two and a half pounds, which in 1956 was pretty tenuous. They placed me in an incubator immediately, and I was there for four to six weeks. My mom said it was a terrible feeling to have to leave the hospital without her baby. I'm sure it has played out in my character, and probably in the way I relate to people to some degree: being rather independent and closed off. I looked at the world as if I was alone in it. I was responsible for myself, and basically no one else was going to take care of me. I think that's mostly how it has played out. My mother and I never emotionally connected. I don't think we ever bonded because, as soon as I got home from the hospital, she handed me over to a baby nurse, which I think was the custom of people with means in the '50's. I had pretty severe colic when I arrived home from the hospital, causing my mother and the baby nurse a lot of stress and anxiety. That is the story that my mother tells. I can visualize what the experience was when my mom tells the story.

Interviewer: What are your thoughts about cesarean birth?

Elizabeth: I have some pretty strong thoughts about cesarean birth, having been a mother myself going through two pregnancies. The first one was very much by the book, and when I went into labor my water broke just as the textbook said. The doctor said, "Come on in," and I

spent about 12 hours in labor. I was in a birthing room with a woman doctor, which was what I wanted. At one point, she said: "Elizabeth, you have to deliver this baby now, or I'm going to have to give you a c-section. We are out of time here." Man, did I kick myself into high gear, and my daughter was born within 20 minutes. I so did not want a c-section birth, and that was probably my own innate, inner subconscious experience and some conscious knowledge of my mother's trauma. I grew up being the c-section, feeling separate and apart. The birth of my second daughter had a similar outcome. I showed up at the hospital, and the doctor said: "The baby is flipped the wrong way, she is facing down. I don't think you are going to be able to deliver this baby vaginally. I think we are going to have to do a c-section." It is rare that women can do this because there is too much risk involved, along with the tearing, and I said, "No way! This baby is coming now!" Again, I delivered the baby without the need for a c-section. I did suffer a terrific tear from vagina to rectum. Years afterwards, seeing my doctor, he would comment that this birth went on the record book for doing the impossible out of sheer determination and will: My child was going to be born vaginally!

Ellen's Story

Interviewer: Tell me about your birth.

Ellen: I was a big fat healthy baby. My mom almost died from toxemia 13 months before I was born while giving birth to my sister. It was one of those situations where the doctors thought my mom was going to die. She was actually given her Last Rights, and the doctors thought they might be able to save the baby. The doctors told my mother not to get pregnant again, but since she was a good Catholic, 13 months later she was delivering me. I don't imagine they let her go into labor, and I'm sure as soon as it looked as if things were ready they just went in and took me. Back in those days, they didn't believe that a woman could actually deliver vaginally after having had a c-section. The nurses in the nursery gave me the nicknames of "Butterball" and "Tiger." [The interviewee stated this twice in the interview.] I was a big fat healthy baby, not a puny little thing like my sister. As far as I know, my birth was a perfectly normal one. I'm sure they used drugs, but I do not know what kind. I am not aware of any complications. I was just a big fat healthy baby. Because of the nurses' nicknames, I think obviously I was quite a happy healthy baby. I guess they gave me these nicknames because I was feisty and I weighed eight pounds something

that was a good sized baby. I was born on October 9, 1951.

Interviewer: What are your thoughts about cesarean birth?

Ellen: I had never thought about my birth until you brought it up. I guess I saw being born by cesarean as another way to get here. I see how there could be a difference with a cesarean birth because sometimes it is a medical emergency. The babies have to be put in incubators and have no immediate contact with their mothers. I guess these things could have some kind of an effect on us, even though we don't remember. I think the earliest memory I have is at age three or four, but that doesn't mean it did not have some kind of an impression on me just because I don't remember it. This is an interesting study and I think you have hit on an interesting topic. It will be interesting to see what kind of trends you see, if any at all. I find things about people interesting and I think the more you know about people the more you realize that we're all the same, but all so different. Back when I used to think about having children, I thought about having them naturally—vaginally—although the pain aspect didn't thrill me. I don't think I ever thought anyone would opt to have cesarean. I thought one only had cesarean if things didn't work out the other way or, like with myself, because they thought they had to. I just figured the only reason you would have a cesarean birth is if there was a medical reason for it. Not ever having been pregnant, I never had to consider the aspect of what would be best for the baby. Maybe I would have given it more thought. I'm the kind of person that doesn't think about things unless I have to. I would have thought cesarean would be a lot less trouble for the baby—not having to be squeezed out. When I look at a baby that has been born vaginally, they are all squeezed and wrinkled, and their head is out of shape. The baby having been born cesarean is all pink and healthy, and their head looks good because they have not been through that trauma. I would have thought that the baby would be happier being born cesarean. What is interesting with me is that I never would have thought this was something to know, and that's why I am so interested in the whole premise of the idea that caesarian birth could impact us throughout our lives. I guess it is a totally different experience for the kid, and I can see it is a totally different experience; but I would have never even thought that.

Alice's Story

Interviewer: Tell me about your birth.

Alice: I was born cesarean on August 27, 1979. My due date was the 14th of August, but I wasn't ready, so they changed the date of the surgery. They decided I needed to be born cesarean because my mom's tailbone was in the way and they thought that I would not be able to come out. My mom called the doctor when she was in labor, and the doctor told her it was not her due date, so she could not be in labor. But she kept insisting, "No, no, no! It's ready to come out, I can feel it." She was alone at home and decided to call an abortion clinic because she thought they knew all about birthing rights and could help her. She told them she was in labor but the doctor would not let her have her baby. Someone picked her up and took her to the hospital. When she got there, this person told the hospital, "This woman deserves to have her baby, and you can't refuse her." When the doctor arrived, he said to my mom, "You were right, you were in labor. I'm sorry." I've seen pictures of me in the little thing where they place the baby. I was five pounds nine ounces at birth. My mom told me I was such a small little thing that my head would fit in her hand and my feet would reach her elbow, and that is how she would carry me around. My parents had married in June, and by November my mom was pregnant with me. I think my dad would like to have waited, but they went ahead and had me because they were married. They were happy and as such were very good parents. I have pictures that show it. I don't remember all the stuff when I was younger, but you know they would spend a lot of time with me. Just after I was born, my mother had a full-time job during the day and was going to night school to get her master's degree. I spent a lot of time with people other than my parents because they worked a lot. I guess they were having financial difficulties because sometimes they would have to choose between buying diapers or milk. They had bought a house, and my dad worked two to three jobs, so he would be up and gone by four o'clock in the morning and wouldn't be home until late at night. My parents told me they spent a lot of quality time with me. From the pictures I can see this, even though I don't remember any of it. My mother tells me that it was "misery" and that she didn't want to go to school or go to work, she just wanted to be with me. I was their first child, and after me she had seven miscarriages before my brother arrived. I kind of felt a little bit like I put them through a lot of stuff. I know I didn't; they were the ones who decided to have sex and have a baby. It was my existence that

probably made it harder for them, although they would never say that. I don't think they were financially prepared because they were only married six months when she got pregnant with me. They were prepared emotionally, but they hadn't had married life for long. I know they don't regret it. They love me very much, and they loved me then too, but I'm sure things would have been different if they would have waited.

Interviewer: What are your thoughts about cesarean birth?

Alice: People have no choice but to do cesarean birth like my mother did. My brother was cesarean too because of my mother's tail bone. It was broken and cracked in the wrong place. I really have no thoughts, and sometimes I think I'm going to have cesarean births because I know my tail bone is broken too. I'm wondering if I'm going to have cesarean births. I know that my cousin, who just recently had a baby several months ago, had her baby cesarean, although it was not planned as the baby was breech. So she had to have the cesarean birth at the last minute. I know that sometimes it's a choice and sometimes it's not. The ones that I've heard of where it's not a choice, but you have to do it if you want the baby to survive. If you compare it to natural birth—except for afterwards, the pain and the cutting up—I guess it is relatively painless. You don't feel the pain of the baby coming out of your vagina, so it seems like it would be a nicer choice. I know a lot of people who have had it the natural way say it's worth it the natural way because you feel more connected, maybe, to your child—although my mom would strongly go against it because she feels very connected to me, and I am connected to her. But we worked really hard at it; so every minute that she had she spent with me. Whatever spare moment she had was spent with me and she made up for it in a lot of different ways. She said she played with me, but I don't remember her playing with me. In fact, I really don't remember my life too much before my brother was born. I remember everything after my brother was born. I have very distinct memories when I look at the pictures. I remember—but I really don't know if I do or if I have conjured up an image. I have a picture at age three or four of me on my mom's back, and we are on the lawn in the back yard of the house. We are playing, and we're happy. And there is a picture of me and my dad, and we are playing too. I don't remember the actual moment, but I do remember the back yard and I do remember the house. I spent a lot of time there. I remember my brother coming home, and holding him in my lap; and I have that picture and I remember that moment. I really recall my life

after he was born.

Mary's Story

Interviewer: Tell me about your birth.

Mary: All I know is that I was born cesarean. I don't remember asking my mom too much about it. All I know is she had trouble with my brother. She had lost him at birth, so she had to have me cesarean. His cord was around his neck, and she had a hard time during the delivery. When I came along five years later, they decided to do cesarean. My mother and dad wanted to have a child for the longest time, and then I came along. They didn't have any more children because she had a hard time holding the babies. When I use the term she couldn't "hold" them that was the term my mother used. I assumed it meant that she had lost another one before my brother. She said she couldn't hold them and was not able to carry a baby through the nine months. I was a wanted baby; I was the only one she could hold on to. She held on to me throughout my life. She was afraid to let go of me, and we were always very close. I remember vividly when she was in the hospital after she had a heart attack. As they were taking her off for some tests, she was calling out my name. She was semi-conscious but making sure I was there. I remember my mother saying I slept and was a good eater. There was a lot of fuss around me because I was the new baby at the time. I had many older cousins so everyone always crowded around me because I was such a happy baby. I guess they used the mask and gassed my mom, so she was completely out. I was born on March 7, 1946 weighing six pounds nine ounces. Nobody mentioned there being any complications. I have no idea how they decided the delivery date.

Interviewer: What are your thoughts about cesarean birth?

Mary: I don't know; that's really a hard question. I had never really thought about it. I guess I would have to say that if someone is born cesarean, I feel that they would be fine. For me it's fine if you have to have cesarean. I think there still can be closeness between mother and child even though they don't go through that birth canal. I think there are a lot of cesareans born these days for different reasons. My daughters were not cesarean. The first one was normal. Labor was 12 hours, so it was long; I was very tired. I was afraid if everything would be OK. I was concerned about what they were going to give me and if

I could handle the pain. I was tense, so I had a lot of labor. My first daughter weighed seven pounds two ounces. I was nauseated for almost the whole nine months with both of my daughters. During the second pregnancy, I took a pill for nausea because I could not hold anything down. I can't remember the name of it. With my second daughter I also had a long labor, but there were no complications at birth. I didn't notice until I brought her home that she was born with her thumb on her right hand not developed and it was very tiny. It didn't look like a thumb, it looked like a regular finger, a pointer finger. And then her chest was indented, and so naturally one shoulder was higher than the other. They gave her a test and claimed that maybe that pill was responsible for her little thumb. The doctor said there were other women that took this pill, and their children were born with the same symptoms. Other than that, she is fine. With both births I did not have complications, and they were both delivered vaginally. I have a child in my class whose mother just had a baby by cesarean surgery. You know that I'm going to ask to see how she feels because her three other children she had vaginally. I'm going to ask her.

Analysis and Discussion

Initially, for all the women there was no indication of conscious recollection of birth; rather they relied on the stories of others to describe the experience. However, as Verny and Kelly (1981) said, "Our inability to remember specific events or situations does not mean those experiences and the feelings that color them have been irretrievably lost. Even deeply buried memories remain emotionally resonant" (p. 186). There are indications that the birth experience is retained at an implicit level: "We don't always have explicit, conscious memory of our earliest experience, but the impact has shaped us and implicitly pervades our lives. Some part of us knows" (McCarty, 2002, p. 9)

Each participant, after considering her current behavior and attitudes in the light of her birth story, began to see that there may be a connection between her birth and her adult behavior. Each said she had never thought about her birth as having connection to her adult behavior, yet each recognized birth as an important, physically challenging, and often traumatic event. As McCarty (2002) said, "Our earliest experiences are embedded in our being and act as a natural filter of our perceptions and interpretations of situations, people, and even sense of self" (p. 9).

After the interviews were completed, the questionnaires and interviews were reviewed to identify any themes and potentially

meaningful connections between the participants' life patterns and birth experiences. Three main themes emerged: (a) interruption, (b) motivation to achieve, and (c) offering help even when it is not requested. These themes are congruent with themes reported in the literature as being associated with cesarean birth experiences. In addition, two of the participants reported having recurring dreams.

Interruption

The pattern of interruption came up for all four women in one form or another. This pattern is often seen in persons born by cesarean surgery. C-section babies exhibit symptoms that sometimes mirror what happens during labor and birth (Emerson, 2001), which suggests that the abrupt nature of the surgery can be perceived by the baby as an intrusion.

Motivation to Achieve

The motivation to achieve surfaced for three of the women. This achievement theme may be a way for these women to compensate for not successfully initiating or being an active participant in their births. Similarly, Emerson (1998) talked about recapitulation styles, in which one might choose to confront behaviors to resolve them.

Offering Help Even When It Is Not Requested

Another remarkable theme for three of the women was that of offering help even when it is not requested. The literature suggests this has some connection to being born cesarean if the baby perceives the intervention as a way of helping the baby to enter the world. English (1994) identified what may be a related pattern of some cesarean-born persons: trusting that help will always be there without one having to ask for it.

Dream Themes

Two of the participants reported experiencing recurring dreams. One of them dreamed of being chased by someone and being saved by another person. Emerson (2001) noted that a small percentage of adults who had difficulty during birth report that the cesarean procedure was a relief; these same adults also report having fantasies of rescue during childhood daydreams and having nocturnal dreams of wishing someone would save them. For the other participant who reported a recurring dream, the dream was of being chased in slow

motion and of barely being able to escape. She stated that when she gained control in her life as an adolescent, she stopped having this dream.

Other Items

The two participants whose c-section births were planned selected the statement "I can trust higher forces to direct me and/or assist me in my life." This result supports an observation of Emerson, who stated that "those born by planned cesarean without complications tend to trust in higher power or forces and appear more able to believe" (personal communication, April 5, 2007).

Implications

This phenomenological study provides qualitative narratives drawn from the lives of four women born by cesarean section. Because of the small sample size, the findings cannot be generalized, yet they are of value in being considered along with other works cited in the literature concerning specific themes and behaviors that may be part of the legacy of being born via cesarean surgery.

The potential long-term ramifications of a baby's experience at birth have not been clearly identified or appreciated in traditional views of early development. The current study's findings, along with clinical findings from pre- and perinatal psychology, suggest that birth is remembered at an implicit level throughout the life span. Because one cannot consciously recall birth does not mean that birth does not have significant longitudinal influences on one's life. The experience of birth is unique to every one of us. This study suggests that those born by cesarean section carry the influences and "stories" of this surgery throughout their lives.

Babies born by cesarean section now are over 30% of the population being born in the United States. Cesarean surgeries are being provided more frequently on an elective basis. It is therefore important that parents and parents-to-be have information concerning this birth method's potential lifelong influences, such as the ones reported in this study, so that they can make informed decisions based on the needs of mother and baby.

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Study Questionnaire

Please respond to the following statements by marking any that seem to apply to you.

1. I sometimes notice that others interrupt me.
2. I interrupt others from time to time.
3. I feel, in a subtle way, that others can rob me of my power.
4. When I am going good at something, I seem to run into unforeseen interruptions.
5. Things seem to be more of a struggle than they should be.
6. Things seem to come very easy to me.
7. I find it difficult to be corrected.

8. I find it difficult to be told what to do.
9. I seem to get stuck very often.
10. I have or have had significant pain in my neck.
11. I enjoy being the one in charge.
12. I get pleasure from imposing my point of view on others, or out of winning an argument.
13. I change my heart and/or mind readily.
14. Others change their hearts and / or minds around me.
15. When others offer help I have difficulty accepting it.
16. Help sometimes seem like opposition.
17. I am fiercely independent.
18. When I was a child I had fantasies about being rescued.
19. When I was a child I had fantasies of rescuing others.
20. I seek pressure to function.
21. It is easy for me to find the simplest way of doing things.
22. It is sometimes difficult for me to mobilize effort to start something.
23. When I do get started I find that I need help to get through.
24. I sometimes believe that I have got it too easy.
25. I sometimes offer help even when it is not requested.
26. I have trouble claiming my space.
27. I have or had a strong motivation to achieve.
28. I have or have had fears of our country being invaded, or strong feeling that we should invade another country.
29. I feel undeserving of what I have.
30. I can trust higher forces to direct me and/or assist me in my life.
31. I long for protection and safety.
32. I am disappointed that others have not protected me enough.
33. I like isolation and quiet.
34. I anticipate or fear emergencies in life.
35. I initiate sudden or drastic changes as a way of dealing with stress or conflicts.
36. When I was a child I said, "I can't" a lot.
37. I sometimes believe that I cannot do things right.
38. I resent others making suggestions to me about how to do things.
39. I find it difficult to complete tasks on my own.
40. I have or had recurring dreams.

Note. This questionnaire was developed using Dr. William Emerson's (1997) *The Evaluation of Obstetrical Trauma: A Questionnaire*.

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