The Building & Enhancing Bonding & Attachment (BEBA) Clinic Retrospective Study

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Abstract: In 2020, a retrospective study was conducted, examining 27 years of family sessions offered at the BEBA Family Clinic in California. Raymond Castellino, DC, and Tara Blasco, PhD, co-directors of the Building and Enhancing Bonding and Attachment (BEBA) program, assembled a team of researchers for the study. Fifty-four previous BEBA Clinic participants completed a quantitative survey and 12 participated in qualitative interviews. The data gathered are shared in this report, providing the BEBA organization with feedback corroborating the program's evolving principles and practices. The study and organization presents a model of child-centered family care to other professionals who are developing similar programs.

Keywords: bonding, attachment, child-centered therapy, early memory, trauma play therapy

The Building and Enhancing Bonding and Attachment (BEBA) Clinic was established in 1993 as a non-profit in Southern California to recognize babies and children as innately conscious beings, capable of remembering their experiences. The BEBA Clinic has continuously supported a holistic approach to healing early trauma that impacts the health of children, their parents, and entire families. Raymond Castellino, D.C. (retired), RPP, RPE, RCST® and Wendy Anne McCarty, PhD, RN, founded the BEBA Clinic, utilizing their years of research and practice in the field of health and wellbeing that honors both babies and children's experiences

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(Chamberlain, 1988; Cheek, 1986; Fraiberg, 1980; Noble, 1993; Verny, 1981). Castellino and McCarty maintained that they, and the families they served, could learn from babies and children by observing how babies communicate non-verbally through their movements, sounds, and interactions with their caregivers and the world. This recognition of both babies and children's innate consciousness could lead to the repair of challenging imprints and the restoration of the wellbeing of whole family systems.

The BEBA Clinic trained a group of facilitators who offered services to more than 250 families. From 2012 to 2020 the clinic was co-directed by Castellino and Tara Blasco, PhD, RCST®. After Castellino passed in December 2020, the BEBA Clinic has continued to operate in Ojai, California, as well as online under the directorship of Blasco. The clinic's mission remains the same: to support families in the resolution of prenatal, birth, and other early physical and emotional trauma, while facilitating the development of compassionate relationships, the healthy growth of children, and effective parenting. The BEBA Clinic promotes the art of addressing early trauma by working with the entire family system. BEBA families work with trained facilitators who utilize approaches that respect the innate wisdom of the child and seek to understand the child's perspective and experience. This model brings together the best of pre- and perinatal psychology and body-oriented therapies including craniosacral therapy, child-centered play, modeling, movement facilitation, and role-playing while focusing on pacing, tempo, and establishing harmonic resonance.

The BEBA Clinic's goal is to expand the understanding of the nature of early stress and trauma from conception through the first years of life, including their effects on human development and relationships. The BEBA Clinic supports the development of successful strategies and interventions to help babies, children, and their caregivers repattern and heal challenging and/or restrictive imprints from those early periods. While supporting families at the BEBA Clinic, Castellino wrote extensively about his work (Castellino, 1995a, 1995b/1996a, 1996b/1999/2002/2010, 1997/2001, 2000, 2004, 2010, 2014, 2020). What follows is a retrospective report to begin to determine how former participants found the BEBA Clinic's interventions. This study was comprised of mixed methods in which qualitative components asked participants both closed and open-ended questions. The results of the surveys and interviews are reported in Sections IV, V, and VI.

The BEBA Clinic's research, and research conducted in prenatal academic studies from the late 20th century, argue that if a baby is hurt, the whole family is hurt (Klaus & Kennell, 1976/1983; Levine, 1997b). Early trauma can occur anytime during conception, gestation, birth, the events following birth, and the bonding and attachment phases that follow. Trauma can leave restrictive imprints (memories) in the nervous

system and affect future behaviors, emotions, belief systems, psychological orientations, and physical health and wellbeing. Since the late 20th century, researchers have known that nicotine, alcohol, drug use, and poor nutrition have traumatic effects on prenates and babies (Chamberlain, 1988; Nathanielsz, 1999; Verny 1981). Stressful family events, emotional tension and intrusive routine medical procedures may also have long-lasting traumatic effects (Castellino, 1995a; Emerson, 1999; Sills, 1989/2002). Trauma can also develop due to premature birth or from a neonate losing a twin in the early stages of fetal development (Landy & Keith, 1998; Sampson & de Crespigny, 1992; Sulak & Dodson, 1986). Early prenatal experiences like a death in the family or not being wanted also can potentially contribute to the development of trauma (David et al., 1988). Routine separation of newborn from gestational parent after birth can be particularly traumatic, as can interventions like induced labor and birth by caesarian section (Arms, 1996; Buckley, 2003; Noble, 1993). The term "birth trauma" specifically refers to adverse experiences the gestational parent experiences during childbirth; however, any traumatic events that take place between conception and the age of three have particular significance in shaping an individual's life (Janov, 1983; Rank, 1929/1993).

Babies and prenates routinely suffer traumatic experiences that negatively impact their development (Arms, 1996; Castellino, 1995; Janov, 1983). These experiences make it difficult for them to manage stress, deal with conflict, develop self-esteem, or even securely attach to their parents. Neurological research shows a direct link between individuals' experiences and the development of their nervous systems (Siegel, 1999). Our physiological response to stress is informed by this neurological development, which means that our adult stress responses are likely to be very similar to, and perhaps dependent upon, what we learned as prenates and infants (Siegel, 1999). In later life, unresolved early traumas affect personality, behavior, and relationship formation. They also impact physiological characteristics like balance and the ability to orient in space, and mental characteristics like the ability to focus attention and learn effectively from experience. In short, one's entire self-image and manner of responding to outside events is affected by early trauma (Emerson & Schorr-Kon, 1993; Janov, 1983).

An infant's ability to perceive their surroundings is truly remarkable. Babies and prenates will readily feel anything their mother, father, or sibling is undergoing. Daniel Siegel, author of *The Developing Mind* (1999), points out that prenates and babies learn how to respond to the world around them from their caregivers and are dependent on the caregiver's help to process trauma. Infants are still growing, not yet fully formed, and early experiences and responses are incorporated into their developing bodies and nervous systems. What a baby goes through, the

family goes through, and what a family goes through, the baby experiences as well. This gives family-wide importance to both the resolution of babies' early trauma as well as the resolution of conflict between (and within) other family members. The earlier these experiences are resolved, the quicker a family, and all its members, prevent the layering consequences of trauma and can regain or create anew the harmony and happiness they desire.

Repatterning and healing early trauma gives babies and their families tools to resource themselves and to find inner stability when events in the outside world are unsettled (Schore, 1994). Approaching imprinted trauma at their own pace and in an utterly safe, supportive environment allows the baby/child and family to make sense of their traumatic experience and gives them the opportunity to change how they respond to stressful situations. The nervous system's response to stress can be reordered: hormones are released differently, different parts of the brain are activated, and a difficult situation can be navigated with less stress (Levine, 1997b; Odent, 1999; Scaer, 2001; van der Kolk, 2014). Trauma resolution contributes to the health and well-being of an individual (Levine, 1997b; van der Kolk, 2005). Infants who have resolved their early trauma are often better able to sleep through the night, they are more alert, better able to self-attach (latch on) and nurse, and better able to perceive someone else's state of mind. Timely resolution of trauma and strong, loving familial bonds lead to healthy children and, in turn, healthy adults. Ultimately, and best of all, healing early trauma contributes to the health of the entire family and allows a family to bond much more closely.

Section II: Bonding, Attachment, & Trauma

The BEBA Clinic's ideas of bonding and attachment are heavily influenced by the work of psychologists and trauma specialists William Emerson and Peter Levine, Cranial Sacral Biodynamic pioneer Franklyn Sills, and physiotherapist Anna Chitty. Castellino's understanding of individuals and family interactions grew as he studied, conferred with colleagues, and worked closely with families at BEBA. Castellino (1996b/1999/2002/2010) narrowed down his ideas of bonding and attachment into several key concepts: 1) clinicians and caregivers can learn from babies, thus healing strategies should be infant-centered; 2) parents and caregivers connect with each other in specific ways that can be altered for the better or enhanced; 3) individuals in relationship have an ability to attune to one another—a connection he called "harmonic resonance," (p. 1); and, 4) there is consistency between how preverbal infants "express themselves and relate imprinted implicit memories and how verbal children and adults express imprints from preverbal time" (p. 1).

Castellino (1996b/1999/2002/2010) noted that some attachment researchers did not "make any distinction between attachment and bonding" (p. 2). In his paper titled *Bonding and Attachment with Treatment Strategies*, first written in 1996 and continually revised for application in his Castellino Foundation Training™, he expressed his view of the interaction of bonding and attachment:

> I like to use [the term] bonding for parents' connection with their babies. Babies [innately] attach to their parents, so together bonding and attachment means the glue or the substantive matrix for making healthy connection. Bonding and attachment then are the processes by which parents and babies come to love each other in ways that support optimal growth of the child and wellbeing of the parents. … In healthy bonding and attachment individuation is also supported. It's an exquisite state of merging and knowing your separateness at the same time. (p. 2-3)

In *Supporting Successful Breastfeeding and Attachment* (2004), Castellino promoted skin-to-skin contact immediately after birth to support both the gestational parent and baby "to self-regulate, [and] come into a more attuned space and ANS [autonomic nervous system] balance" (p. 9). He observed what other researchers such as Raylene Phillips, MD (2013), were finding as well about the value of this sacred hour immediately following childbirth.

Castellino expanded Erik Erikson's (1950) term mutual regulation, or co-regulation, which refers to parent-child emotional reciprocity and mutuality. Castellino argued for co-regulation, which implies that the gestational parent, in skin-to-skin contact with their newborn, is also affected by the emotional interaction with their baby. Castellino (2004) reported that, in his clinical experience at BEBA:

> We find that when we, including parents, actually meet a baby's internal rhythmic needs and attune ourselves to the baby's rhythm, it increases the likelihood that the baby will form secure attachments to her parents. A primary skill that caregivers (parents and practitioners) need to develop in order to do this with a baby is to be able to be authentic with their own feelings, state them, differentiate them and be with the baby. … The amazing thing is that when we attune to the baby's rhythmic needs, we function better and are more capable of making sense and integrating our own experience, moment to moment. We self-regulate and we become more coherent in ourselves. (p. 11)

Castellino recognized the important interaction between mother/primary caregiver and infant which necessitated parental involvement in the healthy development of a child—therefore, families, involving children *and* their parents, were at the heart of BEBA's principles and practices. Even more, he recognized the ability of facilitators in a clinical environment to co-regulate with parents and children as well. Whether co-regulation is spoken of in terms of physiological responses (Phillips, 2013), brain wave states, particularly calling upon the limbic/emotional brain (Tronick, 1989, 1998), or in the musical language of attunement and rhythm (Castellino, 2004), the connection between gestational parent and child is regarded as imperative for the development of a child's ability to self-regulate.

At the BEBA Clinic, Castellino and his facilitators were seeing secure and insecure attachment styles of interacting in the dynamics of the families they were assisting. Insecure attachment is not a diagnosis—it is a pattern of strategies employed by an individual in relationship with others. Merging the terms bonding and attachment, which are reciprocating processes that reinforce one another, Castellino (1996b/1999/2002/2010) wrote "attachment and bonding may occur out of love and nurturement or as a result of trauma" (p. 2). Drawing upon earlier bonding and attachment research and his clinical experience at BEBA, Castellino, (1996b/1999/2002/2010) argued:

> . . . prenatal and birth trauma imprinting interferes with the healthy bonding and attachment processes between baby and loved ones. The completion of the traumatic experience, especially integrating the experience consciously, leads to healthy bonding and attachment. When traumatic experience is not completed or integrated, something must be done to bring that about. Otherwise the compensation, survival and dysfunctional behaviors left over from the trauma will be repeated and recapitulated over and over again. The resolution of traumatic imprints from prenatal and birth experience allows healthy bonding and attachment to happen. (p. 2)

Although Castellino's collaborators agreed that bonding and attachment could be interrupted by birth trauma and early separation, the experience at the BEBA Clinic demonstrated time and again that the connection between parent/caregiver and child could be reestablished at any time, particularly once the traumatic birth experience was processed and integrated. The child is wired to attach to their primary caregiver; if that sequence of attachment is interrupted because of trauma and/or separation, it can be reestablished later (Blasco, 2003).

It was in the treatment of "interruptions and insults" (Castellino, 1996b/1999/2002/2010, p. 3) to the essential processes of bonding and

attachment that Castellino distinguished himself, stating that there is a "need for babies and moms to have the sanctity of their connection respected. Misattunements interrupt the rhythmic integrity and harmonic resonance necessary for healthy resonance for healthy bonding and attachment" (p. 3). Castellino was able to identify troubling patterns of behavior in children and adults that arose from prenatal and birth interruptions, circumstances that interrupted the process of bonding, attachment, or both. Together with colleagues William Emerson and Franklyn Sills, Castellino developed an Energetic and Somatic Prenatal and Birth Model which he presented in *Being with Newborns: An Introduction to Somatotropic Therapy*; this model incorporated "new tools for assessing and treating prenatal and birth trauma" (Castellino, 1995b/1996a, p. 3).

Castellino (1995b/1996a) described the biological mechanism by which traumatic experiences are recorded, or imprinted, in our bodies, minds, and emotions through the rise of catecholamine hormones in our bodies. Castellino was exceptionally attuned to infants and respected their inherent capacity to communicate their needs to caregivers. He explained how infants convey imprinted trauma residing in their nervous systems:

> Every expression and movement a newborn makes has purpose. Babies do not do anything without purpose. Breaks in the continuity of movement patterns are obvious and easy to identify. An obvious movement pattern which demonstrates breaks in the neonate's integral continuity is jerky movements. The baby's nervous system is unable to deliver an integrated motor signal in a consistent even flow from their neocortex. Non-traumatized babies, including neonates, are observed to move their limbs and body in even continuous patterns. (p. 10)

The earlier the event in prenatal life, the deeper, he believed, the imprinting.

Castellino (1995b/1996a) emphasized that "parents, care givers and healthcare providers are supposed to be trustworthy … Without trust, our children are left betrayed" (p. 18). Describing how feelings of betrayal are generated prenatally (gestational parent alcohol or drug use, or abortion ideation), during birth (birth interventions from providers), or just after birth (rough handling of, or tests on the baby) Castellino (1995b/1996a) wrote:

> Betrayal feelings can easily be recapitulated by parents just by telling the birth story without including the baby in the conversation. Parents, caregivers, and healthcare professionals often do not understand, nor acknowledge protests and tears that babies express while experiencing procedures or while someone is talking about them without including them. Research has shown that babies do experience

> perceptions and express feelings in direct response to what is happening to them. These unresolved betrayal feelings undermine the primary trust the neonate has of his parents. Without trust firmly in place, parenting and being parented is unnecessarily encumbered. Unresolved betrayal inhibits the child parent relationship and, more often than not, results in power struggles between the child and his parents. (p. 18-19)

He noted that interruptions, insults, and interventions of all types during birth can be interpreted as betrayals—traumatic events—that lead to distress being experienced by the infant. Further, these experiences are recorded in the child's body and mind, later recapitulated, and ultimately become patterns which are played out over the course of their entire lives.

Section III: Practices Offered to Participants at the BEBA Clinic

Prenatal and Perinatal (PPN) Therapy

Prenatal and perinatal therapy is based on the understanding that our earliest experiences of conception, gestation, birth, and throughout infancy have an ongoing and cascading effect on shaping who we are and who we become later in life. Basic premises of PPN therapy are that babies and prenates are conscious, sentient beings, capable of remembering their experiences implicitly and communicating them. PPN therapy emphasizes that what happens during this period of life has a profound influence on our physical, emotional, intellectual, and spiritual wellbeing later in life and on what we believe about ourselves and the world.

PPN therapy supports families to revisit their early experiences and wounds with the intention of acknowledging what happened and creating space for each member of the family (including the baby) to tell and show their story so that it can be processed and integrated. Although babies don't communicate their stories with words, they can show their stories through movement, facial expressions, vocalizations, and crying. Later on, children will add creative and symbolic play as a way to communicate and integrate their experiences. While these experiences are happening, the PPN practitioner makes sure there are enough resources, support, and contact in the room so that several things can occur: A new imprint of connection is made; feelings of being welcomed and accepted are created; and prior traumatic experiences are no longer overwhelming. It is an ongoing process until the experience feels complete, which often requires repetition.

Part of the healing process is to create a bridge to understand and integrate our painful emotions and uncomfortable sensations. We do that by creating a coherent narrative about our experiences, and by providing our babies and children with a coherent narrative about their experiences. Thus, they can acknowledge and understand that their body sensations

are connected to what has happened to them and have an experience in present time that offers what was missing in the past.

Working with Babies: Facilitated Movement, Supported-Attachment, and Co-Regulation

A prenate or a birthing baby who has been traumatized develops stress responses and/or reactive patterns that are repeated and reinforced later in life unless the trauma is addressed and resolved. At the BEBA Clinic, babies with their families have the opportunity to resolve these traumatic imprints, using an infant-centered approach: All the interactions are done with the baby's permission and the parent's protection of the baby. The practitioner acknowledges that all behaviors exhibited by the baby have purpose and knows that negotiating distance and boundaries is essential during sessions.

Facilitated Movement

Facilitated Movement is used in order to establish near or hands-on contact with the baby, which the practitioner needs to create rapport, forewarn the infant of any therapeutic intervention, and negotiate the contact offering choice to the baby. In facilitated movement, the baby takes the lead, and the practitioner follows. When a child is re-experiencing the movements they made during their birth, and right after birth, facilitated movement can be very useful to support this process. Often the facilitator might offer some resistance at the baby's feet so that they can move through space, sometimes moving to the mother's breast to engage in an attachment sequence.

Supported-Attachment (SA)© and Co-regulation

There is a sensitive period just after birth during which a baby first rests and integrates their experiences, then, left to respond to their own instincts, will begin to move toward the breast. Castellino and midwife Mary Jackson felt this is a crucial period and that every effort should be made to support the gestational parent and baby in this journey of bonding and attaching (also called latching on), naming it Supported-Attachment©. From observing babies right after birth, they concluded that part of what babies were doing in their journey to the breast was actually showing and reproducing the movements they completed while being born.

During BEBA Clinic sessions, parents and babies have a chance to revisit the birth; Supported-Attachment© is used to facilitate movement for the baby by offering gentle support at the soles of their feet so that

they can move in the direction they want to move, often showing their birth journey and their journey to the breast. Baby and parent are engaged in a process of *co-regulation* to stay attuned, soothe, and manage emotions and sensations in relationship to each other. It is not just the parent offering regulation to the baby, but the baby also taking an active role inviting social engagement and regulation with the parent. Supported-Attachment© is a process that promotes co-regulation and social engagement in the family.

Child-Centered Play

Children communicate through play. In this way, they process their day and show current and past experiences. During child-centered play, children can play out their feelings and challenges. Child-centered play is an excellent way to integrate overwhelming events that otherwise would get acted out on other children, pets, or adults, at home or at school. Child-centered play helps the child come back to a state of regulation and helps them process overwhelm, fears, anger, loneliness, and feelings of being misunderstood or inadequate. In this way, play helps reestablish a sense of wellbeing and balance, increasing the perception of self-worth and self-esteem.

At the BEBA Clinic, play is supported and parents are encouraged to let their child(ren) initiate what happens in the time they are together with a facilitator in a session. Adults follow the child's lead. Children seldom have this opportunity in their daily lives. During sessions, the child, parents, and facilitators all play together. Practitioners pay attention to the toys that are selected and hold an attitude of curiosity to assess if the child is trying to communicate some part of current or past stories by choosing these particular toys. The practitioner sets time aside to have sessions or phone calls with parents to talk about the sessions. The facilitator offers insights and supports parents to find meaning in what the child might be trying to communicate. During these calls, practitioners coach parents, offering parenting tools as well as providing space for parents to explore their own activations and differentiate their own early history of how they were parented so that they can be fully present when interacting with their children.

Biodynamic Craniosacral Therapy (BCST)

This form of gentle and non-invasive touch, both physical and energetic, plays an important role in the therapies offered at the BEBA Clinic. This approach is based on the osteopathic principles founded by William Sutherland (Kern, 2001; Sills, 2011, 2012). To restore the health in the body, and in the family system, practitioners seek to connect with the *Breath of Life* (or intelligent life force) as it distributes and manifests

in different rhythms in the body. Craniosacral therapists refer to these rhythms as *the three tides*, the slowest of which is the *long tide* (Kern, 2001; Sills, 2011, 2012). Facilitators at the BEBA Clinic are taught to generate the long tide space that helps slow down the rhythm in the room, creating a centered feeling and allowing the nervous system to reorient and the natural health of the body to arise. Babies thrive in the slow rhythm of the long tide as it supports them to stay connected to themselves and show their story.

The craniosacral work at the BEBA Clinic is done in relationship, including the entire family. It can manifest by practitioners treating parents first, and then coaching parents to give treatments to children. Other times children are open to receiving craniosacral contact from the practitioner as well. With the support of craniosacral therapy, the family can re-experience the same patterns, movements and positions that happened during the birth of the child, only this time with resources, contact and support using facilitated movement and cranial touch. BCST is very useful as well in processing falls and blows in the current life of the child. This work can be done hands-on or with no touch involved and is different depending on the age of the child or baby and the need of the family.

Somatic Integrative Approach Developed at BEBA

A somatic integrative approach takes into consideration the emotions, narrative, and somatic experiences of everyone in the family while paying attention to the energy in the relationship itself. This approach includes the use of trauma resolution skills (Castellino, 1996b/1999/2002/2010, 2000; Levine, 1997a) especially for the processing and integration of early prenatal, birth, and perinatal trauma. Castellino emphasized the need to pay attention to resources while working with early imprints and trauma, as well as the wisdom of the body that is taught in Biodynamic Craniosacral Therapy.

Castellino developed a structure for the flow of sessions using his somatic integrative approach that he called The Form. The Form has five phases. Phase one is intention, including parents' explicit intentions and children's movements, expressions, or play. Phase two is relevant history of the family system. Phase three is movement/somatic process, including expressions, symbolic play, and connection between family members as well as facilitators. As the session evolves, families often come into a state of flow and attunement with each other that Castellino called *Harmonic Resonance*. Harmonic Resonance is necessary to stay connected and to share fun, experience pleasure, and be able to process challenging feelings without losing contact with oneself and others. Phase four is completion of the session. Phase five is integration and happens after the session and when families return to their daily lives. Occasionally, BEBA Clinic

facilitators invite parents to debrief sessions by phone to share insights and support them in processing their activations and develop new strategies for parenting.

The following sections of this paper include the quantitative and qualitative retrospective research conducted with families using the principles applied during the BEBA Clinic sessions.

Section IV: Quantitative Research

In performing a retrospective study of the BEBA Clinic's quarter century of work, the researchers decided a mixed methods study, including both quantitative and qualitative data, would best explore and evaluate how clients viewed the short- and long-term effects of having participated in sessions at the BEBA Clinic. An online survey was designed to assess BEBA clients' attitudes. The families were those who had received services from the BEBA Clinic from its inception in 1993. Two hundred sixty- two families were in the database; 233 emails were sent to known email addresses. Seventy-eight of those emails were opened; 54 families agreed to fill out the survey, and, of those, 12 individuals or families agreed to be interviewed. Initially, families were contacted by an email, composed as an introductory letter stating BEBA's plan to conduct a retrospective study and inviting families to participate. After allowing a one-to-two-week period for receipt of the email/letter, personal phone calls were made to each family. Two team members called and/or texted everyone listed in the BEBA data bank. According to researchers, the biggest challenge was reaching the families whose contact information was outdated.

If an individual or family agreed to participate, they were provided with an Informed Consent Form and given a link to the online survey. The data distilled from that survey are reported in the following charts. Individuals who agreed to participate in a personal interview were given instructions regarding how to schedule an appointment at a convenient time so they could share more detailed perspectives about their experiences at the BEBA Clinic. The qualitative data including transcribed quotations from one of the interviews are presented in Section V.

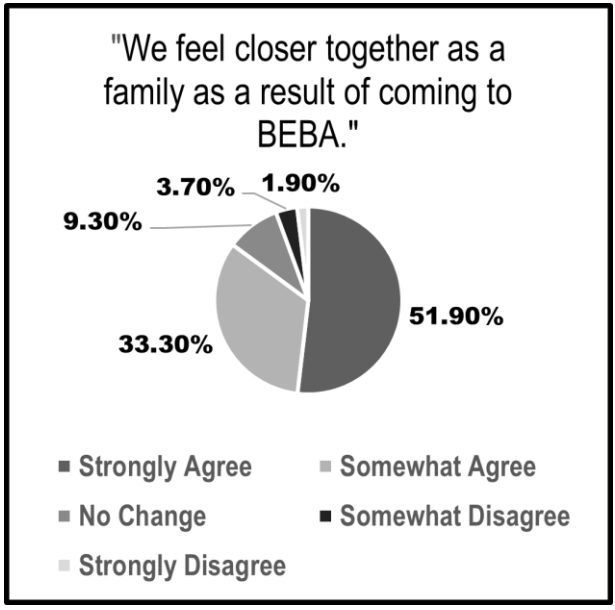
The online survey was designed to ask questions of those who had utilized the services of the BEBA Clinic over the 27 years that it had been supporting families. Questions were asked that would give BEBA families an opportunity to share how they perceived the value they received. Responses to eight questions were scaled from strongly disagree to strongly agree; a ninth question was comprised of 20 items that could be rated on a scale of 0—10 with zero representing no benefit and 10 representing the greatest possible benefit. One other choice was offered to

this series of ratings: prefer not to answer. Each question with the collective responses is presented graphically. The quantitative data was compared with qualitative statements, which were added at the end of the survey.

The demographic data provided by respondents to the survey yielded the following: the mean age of participants in the survey was 50 years; 91% of respondents were female; 66% were married, 19.1% were divorced, 6.4% were engaged or in a serious relationship, 4.3 % were single, and 4.3% were widowed; some of those who responded had no children, but most had one, two or three; the average family income was $75,000. Visits to the BEBA Clinic began as early as 1994 and the last visits reported ended during 2020, the year of the study. The time dedicated to attending BEBA sessions varied widely: 25% of the respondents attended sessions from less than one month to six months with some attending only one BEBA session; 10.4% attended from six to 12 months; 43.8% attended from one to two years; and 20.8% attended sessions for two years or more.

Fifty-four people responded to all eight questions, which were posed as statements. Three respondents preferred not to answer four of the questions/statements. The responses on a Likert scale from strongly agree to strongly disagree are reported graphically; percentages are rounded to the nearest tenth of one percent. Answering questions one through eight, participants predominantly somewhat or strongly agreed with each of the statements. See pie charts of questions one through eight.

Question 1



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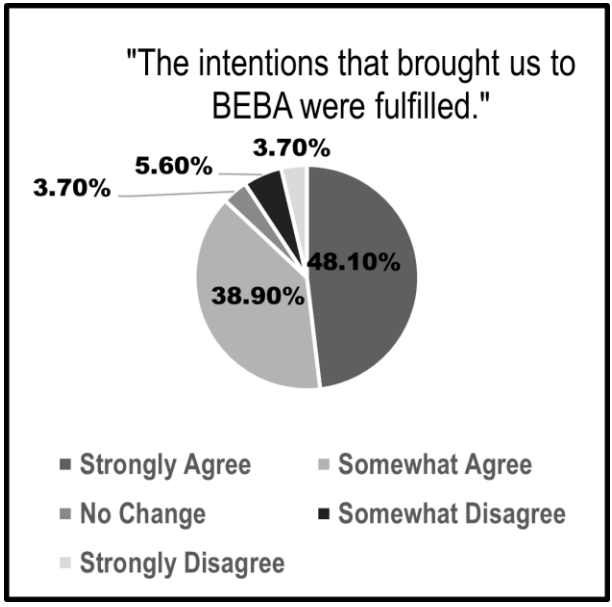

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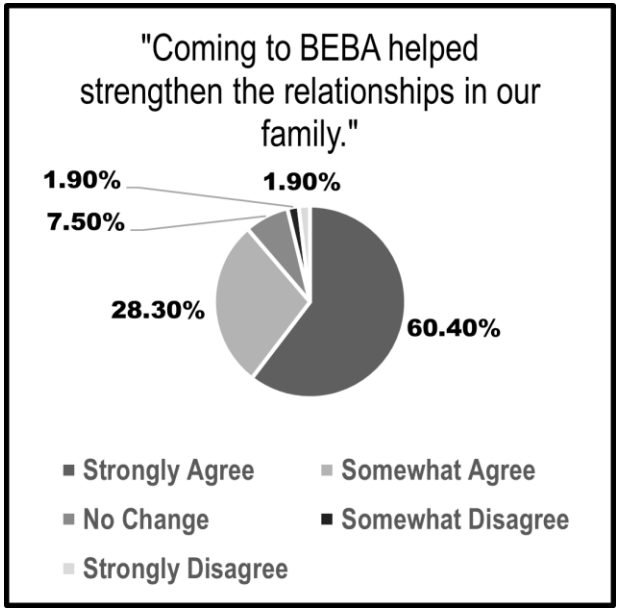

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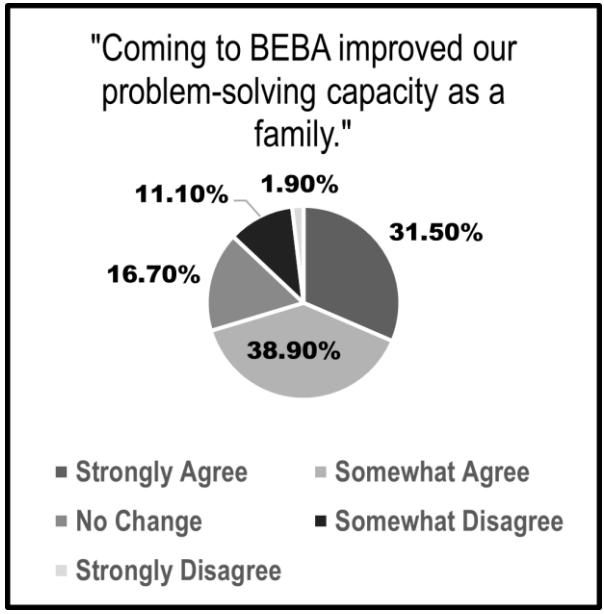

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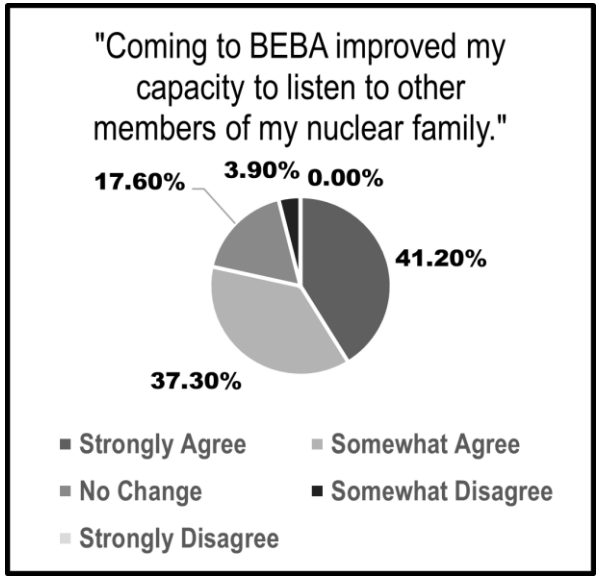

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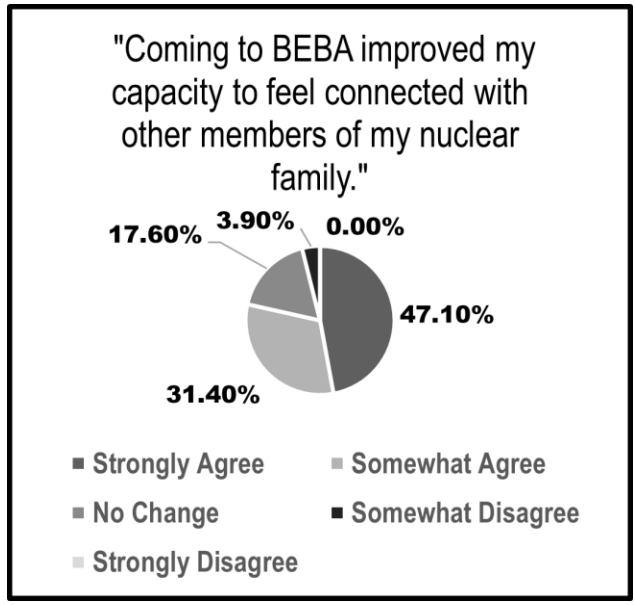

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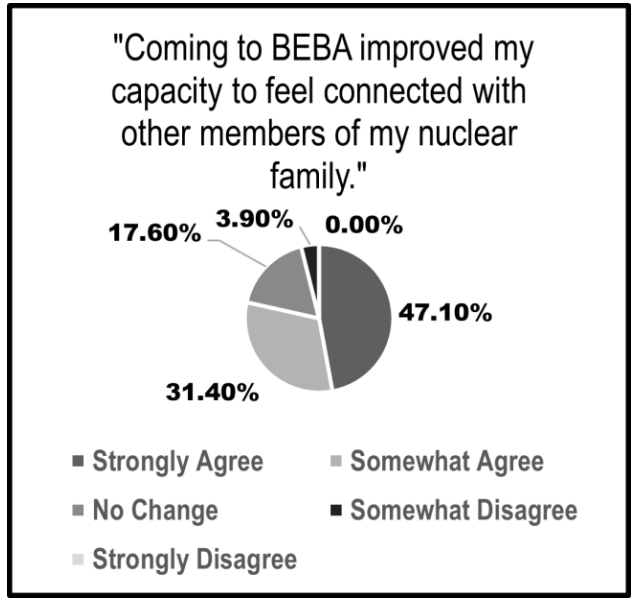
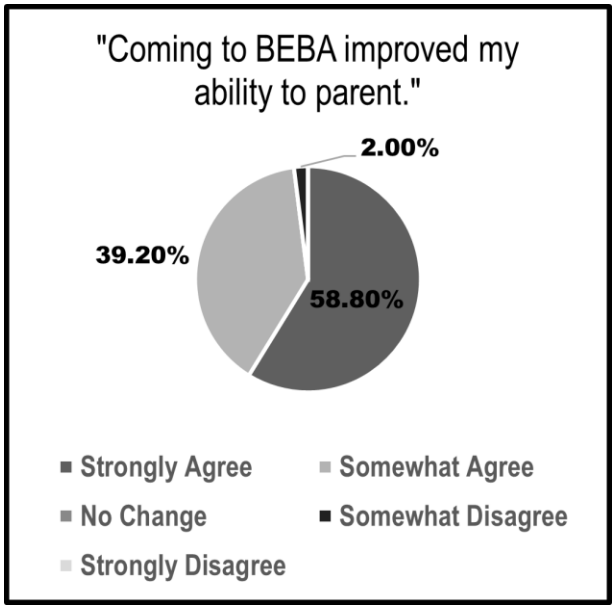
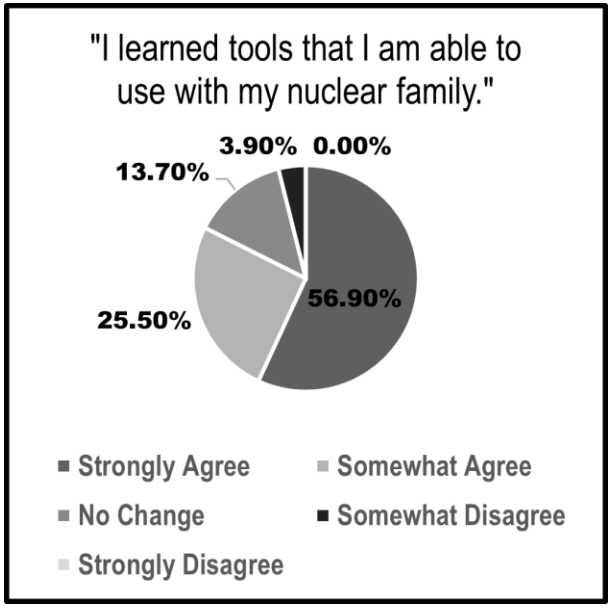


Question 8

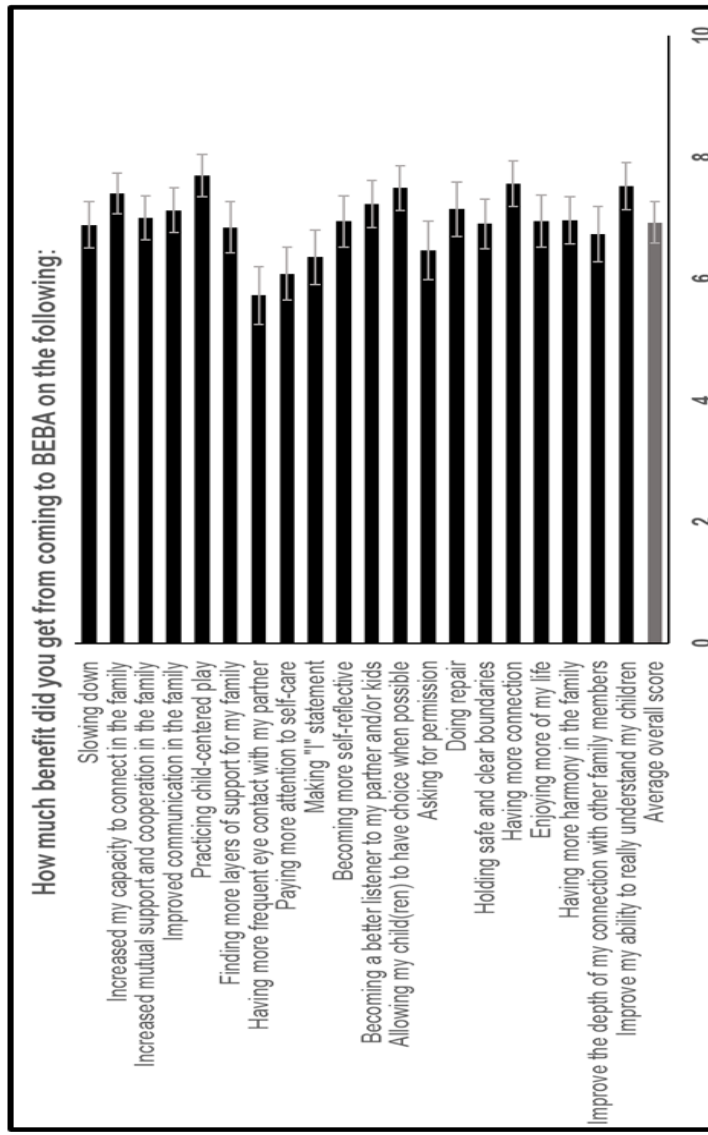


Question 9



In question 10, those surveyed were asked to rate 20 items on a scale of 0—10. Zero (0) signified no benefit while 10 signified the greatest possible benefit. Each question asked how much benefit in a particular area a client of the BEBA Clinic received and valued over time. The Bar Graph of Mean Scores depicts the mean score for each of the questions as well as the average overall mean score. Each mean score represents the mathematical average of the set of ratings recorded for a particular item.

Bar Graph of Mean Scores



Two questions were asked at the end of the quantitative survey that were more qualitative in nature: 1) Is there something else you would like us to know about your unique experience as a parent/family coming to the BEBA Clinic? and 2) Is there anything you would like to tell us about how your children are doing now that has been influenced by your family's experience at the BEBA Clinic? The answers to the two questions were qualitatively reviewed and two themes identified. The first theme communicated by numerous respondents was that coming to the BEBA Clinic was a positive experience: words used to describe the BEBA Clinic were "helpful" and "supportive." One respondent said:

> We came to BEBA for a brief period 17 years ago when we were expecting our second child. It's hard for us to remember what we specifically learned there, but our hope was to create a safe space for our older child to welcome the younger. In this regard BEBA was immensely *helpful* and our two daughters have been fast friends from day one.

The second theme was praise for BEBA's "child-centered approach" and the "therapeutic effects of play." One participant remembered,

> We treasured our time both in the *play sessions* and the Zoom parent-only sessions. The play sessions were always amazing about how things really were processed by our child through the tools/toys there.

Conclusions drawn from all the quantitative and qualitative information gathered are shared in Section VI (Conclusions) of this report.

Section V: Qualitative Interviews

This retrospective study investigated what clients of the BEBA Clinic thought, felt, and remembered about their experiences during sessions with founder Castellino and other facilitators. More than 200 clients were identified; 54 completed an online survey which predominantly gathered quantitative data, and a dozen of those individuals or couples took part in a Zoom interview with one researcher, Susan Highsmith. These respondents' interviews were considered "information rich and illuminative" sources of data (Patton, 2002, p. 40).

The qualitative study focused on asking questions of respondents, observing behaviors, gathering information from relevant documents, or interviews. The interviews were recorded and transcribed. Key words and phrases were identified that produced themes which appeared throughout the twelve interviews and from which conclusions could be drawn. The

themes found within the data follow the description of a sample interview. The interviews were initially structured by following a script that focused on three major areas of interest to BEBA: what brought participants to the BEBA Clinic; what changes they observed in members of their families; and what they found of greatest benefit by coming to the BEBA Clinic.

There are two main limitations to this study. The individuals who agreed to be interviewed predominantly found value in the BEBA process, however, one interview yielded notably different responses. That information is shared in a separate full-length report as well in the interests of establishing credibility and validity. The qualitative study was designed to help BEBA Clinic leaders determine what was effective and what was retained over time by participants in their family-oriented sessions. The study was conducted in-house, so efforts were made by the interviewer to remain unbiased and welcome all comments, whether favorable or not. Each respondent was encouraged to share their thoughts and feelings honestly. Nonetheless, an additional limitation of this qualitative study is that it was not intended to be a thorough examination of all processes, results, or the long-term effects experienced by clients. Rather, the study was conducted to be able to describe what impact the BEBA process had on those who participated either recently or even as long as 27 years ago. What did participants find of enduring value, so that others interested in helping families relate to one another better, and especially with their children, could develop like programs modeled after one with proven long-term benefits? Ultimately a broader population could be served. It is also difficult to decipher from this retrospective study which, if any changes might have occurred with or without specific interventions from the BEBA Clinic.

Interview questions sought to determine: 1) what the interviewees' intentions were for coming to the BEBA Clinic, 2) what changes they observed in their families, especially their children who attended sessions, as well as changes in their parenting styles, and in their relationships; and 3) what principles and/or practices they found most valuable. Two other open-ended questions asked: did the respondents want to make any recommendations for improvement to the BEBA Clinic procedures and was there anything they wanted the BEBA Clinic staff to know that had not been covered by any of the previous questions?

What emerged from the data were several themes that obviously followed the pattern suggested by the questions themselves. Particular principles, language, and skills flowed from those themes. Due to space limitations, one interview is described in this section, with quotations provided as applicable. Names are omitted and portions of quotations are deleted, usually because the individual was referring to a partner or a child by name, to protect the privacy of each participant. Every respondent agreed in the informed consent to share their perceptions on video

recordings and to have their responses recounted in future BEBA reports, either written or visual.

The first interview was conducted in July of 2020 over Zoom. The couple began attending BEBA Clinic sessions in early 2012 before their first child was born and continued after their child's birth. They worked with BEBA Clinic facilitators for eight years including sessions during 2020. Their intent in participating in BEBA Clinic sessions was "to get support around having a healthier household with kids and supporting each other—learning to get along better." Reflecting back, the mother noted that after their child was born, at first they attended BEBA Clinic sessions to "get support with sleep with our son. Oh, [we thought] maybe we can go and then they can help us fix him so that he's better." She added that after attending sessions, "it began to unravel the whole ball of yarn" [of our family's issues].

In response to the second question regarding changes they experienced after attending BEBA Clinic sessions, the father responded, "We became more aware of the different ways of acknowledging feelings … Yeah, it definitely brought up a lot of stuff, too. All the changes were positive in the end, but it definitely stirred the soup." The mother elaborated:

> Definitely the intention was to be better parents, and to have more connection with each other . . . but that became the process of reflecting on ourselves and our ancestral history and the patterns that we had in our relationship and the patterns that were kind of coming out in our parenting. I feel like I have so much room for continued improvement as a parent, and will always continue to have that, but there's just more awareness, way more awareness of the sentience of our children.

They both noted changes and added more specific concepts and behaviors they learned as they answered the third question: What was of greatest benefit of participation in BEBA Clinic sessions? The mother shared:

> We didn't come with children in a pattern in our family already. We came when they were really little, and just got these really incredible tools. I just remember learning about the sentience of them, as fully evolved beings coming into our life. And so I'm just grateful for that awareness from the beginning. . . . I think the principles have just been these pillars, like these guiding touchstones or these guiding lights for us in our relationship, and certainly with our children in our family. And, learning how to do repair. Oh, I always say I definitely don't get it right all the time, but I'm really good at doing repair. . . . The pause has been like this golden jewel in our family and in our

> relationship. . . . And maybe just feeling held—I think that was it for me, the feeling of support and learning about layers of support.

When asked what they wanted to add, this conscientious father stated:

> I think that we did our best to implement the ideas and the techniques. It's easier said than done, and easy to forget. I think it [BEBA] definitely provided a lot of benefit in terms of just techniques and recognizing the full level of consciousness of the children and, instead of thinking of them as just unintelligent and not aware, to really realize that they're totally fully aware.

The mother also pointed out additional qualities she learned at the BEBA Clinic, particularly the expanded awareness of "the sentience of our children." She reflected, "I remember the pacing, the slowing down, the tempo of the babies, that slow tidal rhythm if I could slow down in myself enough to create that co-regulated field."

Other interviews revealed different intentions, a variety of changes made that improved family dynamics, and different levels of satisfaction, although most were genuinely satisfied with their experiences at the BEBA Clinic. One father appreciated a facilitator's "psychoanalytical background" while the mother was grateful to have learned to ask for a "pause" during times of tension in the family. One interviewee wanted to process a "traumatic birth experience" prior to giving birth a second time and was helped to "slow down and be more present and tune in" to their baby. They also learned to communicate more effectively with their partner. Another participant wanted to "relieve her [adoptive] children of any suffering that might be unconscious or subconscious from the births." She learned from Castellino about "co-regulation and slowing down, the pause, and how to sense in with our presence and awareness of: are we connected or not in this moment?" One participant, who "was never going to have children," discovered she was pregnant at age 39. She credited Castellino with helping her remain "calm through the process" of pregnancy, childbirth, and the resolution of a deteriorating relationship. A father had his perception of being a dad transformed. This man was so impacted by his life-changing views of birth, babies, and parenting he declared, "[The BEBA Clinic] informed my parenting so much that there's no before and after possible for me." It dramatically changed his "relationship to being a dad."

The word most frequently used to describe why the BEBA Clinic was contacted was "trauma." Six of the participants used the word trauma and four of those six specifically referred to "birth trauma." Each family sought to deal with the trauma they were observing in their children's lives and to resolve it. The uniqueness of each family became apparent as desires to

find new ways to deal with their own situations were described. As they reflected on those situations, phrases were used that expressed desires to have "more connection with each other," "support each other," "get along better," "process" a previous experience, "adjust" to an unexpected pregnancy, "consciously" face a decision, "develop a strong attachment," "connect" or bond with an unborn child, deal with a child's "epic meltdowns," reduce "anxiety," and even find out more about the "potential" for changing thought patterns and habits that were not working. The changes each participant described were woven into their responses regarding why the BEBA Clinic was chosen as a place to address concerns, that is, their intentions for seeking BEBA Clinic assistance.

When replying to the question regarding changes they or their family members made as a result of participating in BEBA Clinic sessions, interviewees most described how the trauma in their families or family members was resolved. One mother remarked that most of the sessions at the BEBA Clinic "were about playing to build relationships and to build connection," and that her child "really enjoyed those." She had played in tunnels with her child, "stuffing pillows on him and then letting him crawl out." They ran around and played chase, learning to relate to each other in new ways that seemed to heal old trauma and enhance their bonding and attachment dynamics. Tensions seemed to melt away in this playful atmosphere and desired changes were tangibly experienced not only in the moment—they were able to be sustained in their daily lives.

Another theme within the broader category of change was "communication." This topic included listening, speaking, and "connecting from presence" which encompassed allowing and accepting the feelings of others. One woman emphasized that "the foundation of BEBA starts that whole process of communication." Another woman reported that her facilitator "helped us with some basic communications skills, reflecting and listening skills that I found was really important." A young woman who attended sessions while pregnant with her second child said she began to talk to the baby in her womb. She also felt she learned "to speak from my heart more," and had "better communication with my husband." As a result of improved communication, she reported changes in her husband: "He was amazing, you know, for my second son's birth; [he] was present and more than what I needed." Changes appeared to ripple through relationships as new communication skills were implemented.

Words used within the subtheme of communication were "relationship" and "connection." These facets of communication were alluded to with other expressions like "family dynamics," "mutual support," "understanding," "checking in with each other," "accurately reflecting," "making repairs," "slowing down," "pausing," "making eye contact," "setting boundaries," and "being present." The changes reported represented the uniqueness of each participant and their individual

intentions for seeking help at the BEBA Clinic. New "high-powered tools" and techniques improved interactions well beyond the BEBA Clinic sessions. Every interview revealed that participants in sessions at the BEBA Clinic learned not just new skills, but new ways to relate to themselves, to each other in their adult relationships, and to their children. The changes they recalled making led naturally to what they felt was most valuable about their BEBA Clinic experiences.

When asked to identify what they most valued—the benefits they received—when they considered their experiences at the BEBA Clinic, all 12 respondents included one or more of the subthemes that had been mentioned when they considered the changes they had made. Five of the interviews contained all three subthemes: reduction of trauma, raised awareness, and improved communication. Even a person who desired these improvements but was not satisfied with their BEBA Clinic experience, could see the potential and was disappointed not to have received more. Three of the interviews focused solely on aspects of effective communication. Two focused on increased awareness while one of those also noted enriched communication skills, and one was immensely grateful for the reduction of trauma in her life. Overall, the theme learning to communicate more effectively emerged as the primary benefit of participation in BEBA Clinic sessions. Reducing trauma, both past and current, and enhancing awareness—noticing, observing, perceiving their environments and what was actually happening for others in their relationships—were critical aspects of these reports of having been satisfied with participating in BEBA Clinic programs. Three fundamental themes were identified as "intentions desired," "changes made," and "benefits received." For most of those who shared their personal stories during the interviews, all three of these themes were explored and ultimately valued.

Section VI: Conclusions Drawn from the Surveys and Interviews

The BEBA Clinic's Quantitative Survey was comprised of three parts: eight statements with which respondents could agree or disagree; 20 questions that could be ranked from 0—10 pertaining to "how much benefit" the respondents felt they received by coming to the BEBA Clinic; and two qualitative questions that allowed space for participants to write a brief narrative. If respondents wanted to participate further, contributing more in-depth opinions, they could take part in personal Zoom interviews which are described in the Qualitative Interviews in section IV of this report.

Part one of the survey presented eight statements with which respondents could agree or disagree. A Likert scale was utilized to evaluate each statement, with five choices ranging from strongly agree to

strongly disagree. Totaling percentages of those responses that somewhat agreed and strongly agreed with each statement, an average of 83.56% of those responding agreed with the eight statements indicating they believed their experiences at the BEBA Clinic were beneficial. In contrast, 5.59% either somewhat or strongly disagreed with the statements. Depictions of these percentages are presented in the charts in the section titled Quantitative Survey.

Most respondents agreed with question number seven: "Coming to the BEBA Clinic improved my ability to parent." Ninety-eight percent of the respondents either strongly or somewhat agreed with this statement, and no one strongly disagreed. A total of 88.7% of respondents either strongly or somewhat strongly agreed with statement number three: "Coming to the BEBA Clinic helped strengthen the relationships in our family." It is also noteworthy that 60.4% of those ranking this statement strongly agreed; this was the greatest number of responses at the level of "strongly agree" that any statement received. The BEBA Clinic's goal of supporting families to develop healthy relationships appears to be endorsed by these results.

A total of 87% of BEBA Clinic families found that the intentions that brought them to the clinic were fulfilled; 85.2% felt closer as a result of coming to the BEBA Clinic; 82.4% learned tools they could use within their nuclear family; 78.4% improved their capacity to feel connected with other members of their family, and another 78.4% improved their capacity to listen to other members of their nuclear families. The statement with which most respondents either experienced no change (16.7%), somewhat disagreed (11.1%) or strongly disagreed (1.9 percent) was number four: "Coming to the BEBA Clinic improved our problem-solving capacity as a family." It seems that the statements that called upon people's feelings of closeness, connection, and parenting elicited more positive responses. When reflecting on their ability to problem-solve, a more mental than emotional process, respondents were less satisfied with their results. Although 82.4% learned tools to use within their nuclear families, over time and with changing dynamics within families, respondents appeared to feel less sure that their problem-solving abilities improved.

It is important to note that, as reported earlier, the time dedicated to attending BEBA Clinic sessions varied widely: 25% of the respondents attended sessions for six months or less. One quarter of the respondents only attended BEBA Clinic sessions a few times or even just one time. The BEBA Clinic's philosophy and processes are predicated on the willingness of family members, particularly parents, to explore their own early imprints, differentiate, and interact with their children and partners from a place of awareness and of taking responsibility—and doing this can take time. Many individuals who first attend BEBA Clinic sessions have an expectation that the child is the identified patient and no changes in parental behavior will be necessary. The BEBA Clinic sessions address

the entire family system, teaching new ways to relate to one another as well as promoting recognition of children's perspectives so that, even if non-verbal, their behaviors are regarded as indicative of the health of the family as a whole. Those families who attended only one or two sessions were generally those who did not have their expectations met. If the child did not change quickly and/or changes were required by parents who did not make adjustments in their attitudes or behaviors, they often would only attend a session once or twice—and they would be dissatisfied with the lack of results they anticipated receiving. All clients of the BEBA Clinic that could be reached were contacted to take part in this retrospective study. No pre-selection was done to determine which families attended longer or participated minimally.

Although some respondents somewhat disagreed or strongly disagreed with statements regarding improvements they experienced in their families after attending the BEBA Clinic, they were few in number. Calculating percentages, an average of 83.56% of those responding to Part I of the BEBA Clinic Survey agreed with statements favoring their experiences at the clinic. In contrast, 5.59% disagreed with those statements.

In Part II of the BEBA Clinic Survey, 20 items were ranked on a scale from 0—10. The average overall mean score was 6.92 (*SD 2.44*, *SE 0.341*). These results are presented on the Bar Graph of Mean Scores in the Quantitative Section of this report. The members of the BEBA Survey team believe the mean score of 6.92 is representative of most clients' satisfaction with the results they gained. The scores reflected "how much benefit" the respondent received from each item. The item that received the highest mean score (*M = 7.69*) was number five: Practicing Child-Centered Play. Clients of the BEBA Clinic valued learning to engage in play with their children more than any other element of the program. Also ranked highly was "having more connection" to their family members (*M = 7.56*) and improving their "ability to really understand" their children (*M = 7.52*). To make these statistics more comparable to those reported in Part I where percentages were computed, the raw data was further analyzed to determine the percentage of those who favored each item. Thus, 80% of the respondents found "having more connection" with their family members of benefit, and 78.4% found "practicing child-centered play" of value. Nine of the 20 items received mean scores of seven or above. In terms of percentages, these scores represented 10 of the 20 items with 70% or more of the respondents assessing them as beneficial. For example, 77.5% improved their "ability to really understand" their children, and 82% allowed their children "to have choice when possible."

The item that received the lowest ranking was "having more frequent eye contact" with their partner. This item received a mean score of 5.72 (*SD = 3.22*), the only mean to fall under six. One explanation for this could be the fact that the BEBA Clinic did not introduce the practice of making

brief frequent eye contact until more recent years of its operation; therefore, some clients never learned to make, or value making, frequent eye contact. Also receiving low mean scores were "making 'I' statements," with a mean score of 6.35 (*SD = 3.3*), and "paying more attention to self-care" with a mean score of 6.08 (*SD = 3.02*). Learning to take better care of themselves and learning to make "I statements," which signify being attentive to personal needs as well as being accountable for individual thoughts and feelings, seem to be challenging.

Mean scores are impacted by extreme scores, those either very high or very low. Scores of low satisfaction, although few in number, affect the average mean score in any one category and the total mean score overall. Since nine of the 20 items received mean scores of seven or above, the survey results were considered favorable. Interpreting these scores gives the BEBA Clinic staff the feedback they need to determine which processes generate the most value for their clients over time. A process like making frequent and brief eye contact, which was introduced later in the course of BEBA's history, seemed to be valuable for those who were able to receive instruction in how and when to implement it. Most validating of the BEBA Clinic's practices are the scores awarded to those items that included parents' increased awareness of their children as individuals. These items, noted above, emphasize how the BEBA Clinic philosophy of acknowledging children, respecting their ability to communicate and heal through play, listening to them attentively, and learning to really understand them are all essential to the health and wellbeing of families.

Two qualitative questions were asked on the survey: "Is there something else you would like us to know about your unique experience as a parent/family coming to the BEBA Clinic?" and "Is there anything you would like to tell us about how your children are doing now that has been influenced by your family's experience at the BEBA Clinic?" The responses to these questions were qualitatively analyzed to determine themes within the narratives. Two themes were identified among the responses to question one. The first theme emerged as many respondents expressed that participating in BEBA Clinic sessions was "immensely helpful" or "very positive." Several received "the support" they needed, and "benefitted" from their experience. Many comments named a particular facilitator as being especially helpful or supportive. The major theme was having "found BEBA to be helpful, supportive, and a positive experience." The second theme was conveyed through expressions of how relationships with the respondents' children transformed as parents began to "follow the child." The BEBA Clinic's "child-centered focus" was appreciated by many of the respondents and was praised as enlightening to parents as they came to understand their children better. One parent called this "child-centered attunement." The recognition of children as being able to

communicate and change in positive ways, particularly through play, was a major theme within the unique experiences respondents chose to share.

In response to question two, many parents thought that "the positive effects of coming to the BEBA Clinic were sustained over time" when they reflected on their grown children. Children of all ages were described as doing well or wonderfully, happy, emotionally aware, self-sufficient, awesome, unflappable, tenacious, self-loving, and more. Parents responding to this survey practiced child-centered play with their children and appeared to value the joy of discovery and healing that can occur when parents and children play together with the children leading the way.

Twelve interviews were conducted via Zoom during 2020 with clients of the BEBA Clinic. By and large, the BEBA Clinic objectives and declarations, particularly those stated on the BEBA website, of what services the clinic provides were shown to be those sought after and provided. Each participant was asked what their intentions were for seeking help at the BEBA Clinic, what changes they observed within their families, and what benefits they felt they gained. These three questions suggested the major themes: "intentions," "changes," and "benefits." Sub-themes were found within each of those categories.

The intentions that interviewees expressed were unique to their individual families but were all well within the scope of practice that could be met at the BEBA Clinic. Among the 12 interviews, 11 participants felt their intentions for choosing the BEBA Clinic had been met or exceeded. Many were seeking relief, support, and/or strategies to deal with disturbing emotions, challenging situations or a child who was distressed. The word that was spoken most frequently was "trauma." Six of the 12 participants interviewed mentioned a desire to resolve their own or their children's trauma, four specifically citing "birth trauma." This intention became a major component of responses to the next two questions, focusing on the changes that were experienced and then the benefits that were perceived. With only one exception, interviewees related specific experiences that fulfilled their intentions. The BEBA Clinic staff have greatly appreciated all the reports of having intentions met, and also those that were unmet, as policies and practices can improve when clients' responses are fully considered. An apology was expressed to the client whose expectations were not met and amends offered.

The interviewees all addressed the changes they observed in their families' interactions, their children's behavior, and their own thoughts, feelings, and actions. This report suggests that the changes they made predominantly improved their immediate situations and endured over time. Within the theme of change, several minor themes emerged. The first of those was the "resolution of trauma." Many clients reported that they observed changes indicative of a reduction or elimination of the effects of trauma. A mother whose child was "stuck" during their birth and

was delivered by Cesarean section, described her child playing happily during BEBA Clinic sessions. Along with facilitators, she interpreted their play as reenacting and repairing the birth trauma and felt her own anxiety diminish as well. Another mother reported that she and her husband's parenting skills improved significantly. The quality of their relationship improved as did the behavior of their children. A mother who wanted help to resolve the birth trauma she thought her child had experienced was given practices that helped alleviate symptoms. Now, as a young adult, her child was an accomplished and well-adjusted individual. These examples, and others reported in the study, suggest that the BEBA Clinic can and does have the capacity to help families.

Objectives of the BEBA Clinic are to teach new concepts and skills to parents—to help parents be more aware of the consciousness of their children—and to follow the lead of the child who has innate wisdom worthy of acknowledgement and respect. Several pregnant participants were encouraged to talk to the babies in their wombs. Parents were urged to talk to their children even if they were non-verbal or perceived to be too young to understand. The sounds and body language of those children were acknowledged as communicating to the parents as well. The positive responses of the 12 participants may suggest that the BEBA Clinic's philosophy can be effective in introducing techniques to parents to help them become more aware of themselves, learning to interact with more intention with each other and their children, and creating more harmony in their hearts and homes.

The changes clients made as a result of coming to the BEBA Clinic were often the things they most valued. Therefore, it was not surprising to find the sub-themes of resolution of trauma, raised awareness, and improved communication appearing again as respondents reported benefits received. One young mother found the principles she learned at the BEBA Clinic to be "guiding lights" for her relationship with her husband and children. She named principles of mutual support and cooperation, "no matter what was happening," as fundamental to a healthy relationship. She was enthusiastic about "learning how to do *repair*," which helped her accept the mistakes she felt she sometimes made in parenting because she could apologize or express her regret that she had not done as well as she had intended. Learning to pause was a communication skill a number of people mentioned as valuable. Learning to slow down particularly when dealing with children was seen as a benefit. Feeling supported was especially appreciated as participants in BEBA sessions resolved past trauma.

Overall, the responses to what they perceived as benefits received produced the same themes that appeared in answer to the question regarding changes that resulted from participation in BEBA Clinic sessions: "resolution of trauma, raised awareness, and improved

communication." The goals of the BEBA Clinic include raising the awareness of early trauma and helping to resolve it, which involves effective communication. All three of the sub-themes are essentially goals set by the BEBA Clinic. Clients then come to the Clinic dedicated to providing the support and services they desire, find resolution to trauma, gain greater understanding and awareness of trauma and how it persists as well as how it can be healed, and simultaneously learn specific tools to improve communication with their partners and children. This study has shown that in many ways the BEBA Clinic is attracting appropriate clients and fulfilling their intentions.

Section VII: Discussion and Recommendations

The BEBA Clinic Retrospective Study was planned in 2019 and conducted during 2020 with the guidance and supervision of Castellino and Blasco. This report is now able to share the illumination of the principles and practices at the BEBA Clinic, the organization that has served families for more than a quarter century, as it honors the life and work of its beloved founder and co-director Ray Castellino.

In essence, the study suggests that the 12 families that participated in the study were satisfied with the results they obtained. Overall, most had their intentions met for seeking the services of the BEBA Clinic; most experienced changes that enriched the quality of their relationships and parenting abilities, as well as heightened their appreciation for the inherent wisdom of their children; and most received benefits that endured for years beyond their initial sessions. Personal stories shared during interviews disclosed deeply meaningful transitions from distress and disharmony to resolved traumas, increased awareness and understanding, and improved communication skills.

It is most important at this time that practitioners who are serving children and families prevent the trauma and distress so many are experiencing and reduce or eliminate the impact of those experiences. It is vital to envision a better future for our children. Of course, a first step would be to conduct more research, which is already being carried out in many prestigious institutions, since this study contains a small sample. Castellino's 1995 call for more research still resonates today:

> More research needs to be done to make this work as available to practitioners and other treatment providers as possible. As practitioners are trained in these methods, more babies [and children] will be given the profound opportunity to heal and reach new levels of human potential. (p. 38)

Families can be served by the growing number of Internet-accessible programs as well as in-person programs being developed around the globe. Success stories, like many reported here, can be shared to enlighten and inspire others to shift the paradigm in childbirth, family care systems, and institutional policies. Castellino, together with Debby Takikawa, D.C., and Samantha Wood, MA, prepared a paper for the Eighth International Congress of the Association for Prenatal and Perinatal Psychology and Health (APPPAH) in December, 1997. That paper, *The Caregiver's Role in Birth and Newborn Self-Attachment Needs*, began with a quote from the brochure describing the Congress theme, *Birth, Love and Relationships*:

> The truth, simply stated, is we all live in a matrix of relationships which affect the quality of our lives. Beyond blood kinship, we are related to others at many levels. Some relationships may be fraught with pain and anxiety, others may be full of trust and joy, but connectedness *is* life. Our first connection is with our mother, her body, her feelings, her mind and spirit. This primal relationship teaches us about living in the world. These pre- and perinatal experiences are imprinted on a cellular level. . . . Our goal is to educate and inspire you with the message of APPPAH that consciousness and learning begin before birth and form the foundation of how humans relate. It is the responsibility of caregivers to bring this information to families. All children coming into the world need to be wanted, respected, loved and honored for their uniqueness. Mothers deserve to be empowered and supported to carry and birth their babies in the way that is best for them. Fathers are facing new challenges and need support and encouragement in defining their role in the family. (p. 1)

In his call for a new paradigm, Castellino stated that, at the BEBA Clinic, "We endeavor to provide research that will enable babies to have treatment for unresolved prenatal and birth trauma as the norm" (1995, p. 38). Further, in 1997/2001, he said:

> We look forward to a time when competent prenatal and infant [and children] centered family clinics like BEBA are commonplace. It is important that this type of care be available to all families. The consequences of making this type of support the norm are far-reaching for individual growth and positive cultural change. (p. 35)

In conclusion, we recommend that healing centers and clinics around the world continue to be developed. Even as we hold a higher vision for every child to be "wanted and joyously welcomed with love" (Castellino, 1995b/1996a, p. 1), services still need to be provided to those children and adults who need support in the resolution of trauma, the improvement of

communication skills, and the enhancement of parenting knowledge and abilities. Providers of these services need to have support themselves as well as training that encompasses opportunities to explore and integrate their own births and early life experiences. The dissemination of all the data gathered to date that substantiate the sentience of prenates and babies needs to continue at a greater pace. The growing awareness of conscious babies will shift the paradigm to one that welcomes life and creates layers of support for babies, children and families to thrive.

Acknowledgements

The BEBA Retrospective Study Team wishes to thank all of those who completed the online survey and those who participated in the personal interviews. The team feels enriched by your responses and your honesty in relating what BEBA does that you found of value and reminding us of what BEBA can do to improve.

Appendix A

BEBA Recommended Resource List

ACEs Too High. https://acestoohigh.com

Beacon House. https://beaconhouse.org.uk/resources/

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Being with Newborns: An Introduction to Somatotropic Therapy®
Attention to the Newborn: Healing Betrayal, New Hope for Prevention of Violence

Ray Castellino

Abstract: *Being with Newborns* represents the essence of the lifework of Ray Castellino (1991,1995), a pioneer and innovator in the realm of Prenatal and Perinatal Psychology. Written in 1996, he introduces Somatotropic Therapy®, which expands cognitive and emotive therapies to include the body—the soma—in the evaluation, treatment, and prevention of prenatal and perinatal trauma. Origins of shock and trauma in the bodies of neonates are identified as well as characteristics exhibited by those infants imprinted by overwhelming events. Therapeutic interventions are suggested for treating these imprints, and seven steps are outlined to heal the thoughts, feelings, and sensations of betrayal. This paradigm shift holds the key to healthier individuals, families, and society at large.

Keywords: prenatal psychology, imprinting, trauma, betrayal, trust

Contrasting passages and new hope: Conception, gestation, and birth are miraculous events. One can easily look into the eyes of a newborn child and be wonder-struck by the miracle of life. Ideally, the little one has two loving parents who prepared themselves spiritually, emotionally, and physically before they conceived. The new conceptus is wanted and joyously welcomed with love. Early in their pregnancy, the parents developed an awareness and felt sense of the new soul's presence, and are also mutually supportive of one another. The parents have learned to treat each other with love, respect, and gratitude. Sharing a deep, intimate

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connection, they lovingly resolve conflicts with each other. They eat well, exercise, self-reflect, give and receive nurturing, and are loving. Moreover, they are able to accept and reflect, to the new life within them, their awareness and awe of that being's profound essence. They offer this reflection without projecting their self-fulfilling desires and expectations on the new one. On his[1] birth day, this baby is supported to fully participate as he finds his way through the birth canal. The parents of this baby and the birth support team know that, given the appropriate circumstances, he is able to be aware and able to participate in the process. This birth passage reflects and expands the joyous welcome he received at his conception. In contrast to this ideal example, most babies find their passage into physical life much more challenging. In fact, I believe the greater percentage of all babies experience some degree of shock in their birth process.

For much of the twentieth century and, indeed, for a considerable time before that, pregnancy care and birth practices focused around the obstetrician's perceptions and needs. By the 1950s, concerns for the mother were growing, but only within the last 25 years has the experience of the baby been an important consideration, and then only rarely. In fact, the prevailing views of parents and health care professionals in 1995 still reflect beliefs that babies are too little and undeveloped for prenatal experiences and birth to have traumatic effects on them. It is an understatement to say that birth, at best, is hard work for the babies.

We, William Emerson, Franklyn Sills (1989), and myself conservatively estimate that more than 85% to 95% (and I personally believe that perhaps 98%) of the population experiences some degree of prenatal and birth trauma. This trauma has lifelong impacts on the individual unless it is somehow healed. We are collecting a mounting body of evidence that indicates that prenates and babies routinely experience trauma which has substantial spiritual, mental, emotional, and physical consequences. We have found prenatal and birth trauma to primarily impact goal structures, life assumptions, self-identity, self-esteem, personality structure, and behavior of the emerging person. Prenatal and birth trauma is so widespread that only the most obviously injured are recognized and identified. Rarely do I meet a parent or health professional who has the ability to relate a baby's behavior and struggles to events that happened in the womb or at birth.

Recently, I had a discussion with a dedicated lactation consultant about a particular baby's inability to attach at the nipple. She was surprised to hear that colic and breastfeeding difficulties can be post-traumatic stress symptoms resulting from birth trauma. The idea that

[1] For ease of reading, all babies will be referred to as "he" and caregivers as "she" rather than use "his or her" or "them."

resolution of physical and psychological issues which interrupt bonding between infant and parents could lead to specific improvement in infant breastfeeding was foreign to her. Though a baby will often display signs of trauma history, few understand that the baby can be assisted in coming to terms with traumatic experiences.

For more than two decades, advocates for prenates and babies like David Chamberlain, PhD (1988, 1992, 1994), Suzanne Arms (1975, 1994), Thomas R. Verny, MD, (1981, 1991), Frederick Leboyer (1975), Michel Odent (1984) and others have gently yet emphatically directed our attention to the experience of the prenate and newborn. As they make abundantly clear, the primary consideration for prenatal and birth experience must now focus on asking: What is the unborn and birthing baby's experience of prenatal life and birth, and how can we best support the unborn, birthing, and newborn baby to reach his or her full potential?

Evolution of an Energetic and Somatic Prenatal and Birth Model

A theoretical basis for the evaluation and treatment of prenatal and birth trauma in infants has been developed by Dr. William Emerson, Franklyn Sills, and Dr. Raymond Castellino. We have developed new tools for assessing and treating prenatal and birth trauma. This new evaluation and treatment model has evolved out of our personal internal quests and seeking. We have correlated our personal regression explorations, our exhaustive inquiries into pre- and perinatal psychology, Polarity Therapy, other bodywork disciplines (including osteopathy, craniopathy, chiropractic, and Chinese medicine), psychotherapy, a thorough study of obstetric and midwifery practices during pregnancy, labor, birth and post birth, pediatric care, and a review of related scientific literature, with clinical observations of thousands of babies, children, teenagers and adults in our practices.

We (Emerson, Sills, & Castellino) have cross-correlated energetic, mental, emotional and physical patterns observed in adults while they were in prenatal and birth regressions, with energetic, mental, emotional and physical patterns observed in babies and children. These patterns have then been correlated with what is known about their birth histories. Often historical prenatal and birth events discovered during therapy sessions were positively confirmed by parents' recollections and/or medical records *after* the therapy sessions.

We have charted specific body structural patterns, cranial molding patterns, cranial lesion patterns, fine micro body movement patterns, and larger gross body movement patterns in relationship to what happens to babies during the birth process. Specific structural, cranial, and movement patterns of the baby relate directly to the pelvic shapes, soft tissue tension patterns of their mother, and how they move through the

birth canal. It is interesting to note that the bulk of this clinical research was done by observing how babies, teenagers, and adults presented during therapy sessions *before* we researched obstetric literature. When we reviewed preexisting obstetric research dating back to the 1930s and still being reported in modern obstetric texts (Oxorn-Foote, 1985), we found confirmation of our empirical, personal, and clinical research in medical x-ray studies of babies and moms while they were in labor (Caldwell & Malloy, 1933).

Prenates and newborn babies are capable of much more than previously believed. Prenates and newborn babies are conscious, sentient beings. Sonography reveals that prenates communicate through expressive body language with self-initiated, reactive, and interactive movements (Chamberlain, 1994). Newborns and babies actively and passively communicate their needs, their feelings, and their stories. Their behavior and body language teach us how to contact and support them.

Stressful and traumatic events during prenatal life and birth imprint both the baby's body and the baby's psyche. Traumatic imprints overlay the true self and profoundly impact the emerging person and how they will be later on in life. Body structure, movement patterns, sense of self, and lifelong strategies manifest from these early traumatic imprints. Simply stated, trauma impacts can result from a single event or series of events that, in any way, cause overwhelm to a person's spirit, psyche, or physical body. A trauma to one level of being will necessarily affect other areas. An impact to a person's psyche will have a corresponding record in the body and vice versa. The severity of trauma impacts is directly related to the degree of overwhelm, the extent to which a person's system experiences shock and the ability of the individual to recover.

When trauma imprints a prenate or birthing baby, stress responses or reactive patterns are also established. These stress patterns are then repeated and reinforced throughout life unless something happens to resolve that trauma. This pattern response is initiated during prenatal life and set into physical structure during birth. We hypothesize that people with unresolved prenatal and birth trauma have higher levels of catecholamines in their blood levels, which have been correlated with acceleration of the aging process and the loss of elasticity in connective tissue. We suspect the reverse to also be true. Those who have resolved their prenatal and birth trauma have reduced levels of catecholamines in their systems. The long-range effects expected in people who have resolved their prenatal and birth trauma include longer, more productive and creative lives, less stress, and fewer chronic health concerns.

We (Emerson, Sills, & Castellino) have well documented case histories of babies treated with the innovative methods we have developed. Over the years, we have seen babies heal their birth trauma, often within their first year. Many of these babies are now children. Some of them are

teenagers approaching adulthood. These young people are turning out to be rather extraordinary people who are physically well coordinated, emotionally clear, and mentally alert. Moreover, they appear to have profound spiritual depth and compassion for their fellow human beings and other living creatures. These children tend to show leadership qualities, clear boundary structures in their relationships, and clear communication skills. Their parents often describe them as being the "most together" people in their families. Lastly, these children show interests, aptitudes and exceptional abilities in areas not necessarily related to their parents.

William Emerson reported to the 4th International Congress on Pre- and Perinatal Psychology in Amherst, MA in 1989 the results of a 14-year study that included 30 babies. Fifteen babies were treated and 15 were in the control group. All of the babies were from normal and psychologically healthy families. All were thought to have had normal births. Eighty-seven percent of the children in the treatment group showed early signs of individuation. In the non-treatment, control group only 14% of the children showed signs of individuation. Individuation is the process whereby individuals learn to perceive themselves as different and unique human beings, able to discover their own uniqueness and materialize their deepest interest, talents, and abilities.

Treating the Neonate—The Transition from Birth Shock

Shock imprinting results from any event that overwhelms an individual spiritually, psychologically, physiologically, and/or structurally. Unless resolved, shock imprinting will impact one on all levels throughout their life. Trauma and shock imprinting overlay and interrupt access to the primary self, psychological development, learning abilities, sensory and motor function, autonomic and organ function, proprioception, balance, coordinative function, and structural integrity. Resolution of pre- and perinatal shock imprinting occurs when shock imprinting is transformed to allow one unimpeded access to his or her primary being and integrated functioning of their organism. Somatotropic Therapy® provides people of all ages, including infants, the unique opportunity to heal and resolve prenatal and birth trauma and shock.

Shock from the pre- and perinatal period clearly affects the neonate on the imprinting level. Generally, it takes a baby three weeks to emerge from a shock affect state after birth. Some babies can take three months and longer. Emerging out of shock affect, however, does not mean the baby heals the shock trauma. Most babies emerge from the shock affect period by developing survival and compensation habits that are directly influenced by shock imprinting.

In this paper, the newborn period is defined as the time a neonate takes to transition from shock affect behaviors. Non-traumatized or trauma-resolved babies do not demonstrate shock affect behaviors. Most babies, however, demonstrate affective shock behaviors through physiologic, physical, and emotional patterns immediately after birth and for several weeks. Several neonatal examination and assessment tools have been developed. The more widely used medical and pediatric examination tools include physiologic, physical, neurologic, Dubowitz Scoring System, and the Brazelton Neonatal Behavioral Assessment Scale (Brazelton, 1984; Reeder et al., 1992). These evaluation systems are indeed useful. However, they do not account for the long-term effects of shock imprinting on the newborn. It is our hypothesis that the current infant developmental norms are based on traumatized populations not on non-traumatized or trauma resolved populations. Later in this paper, lists of characteristics, behaviors, and abilities of the non-traumatized neonate and shock affect characteristics in neonates are presented.

Infant-Centered Approach

One goal of the Somatotropic process is to resolve prenatal and birth shock imprinting. This approach is infant centered. The baby is more important than assessment scales and assessment processes. All therapeutic interactions are to be conducted with the baby's permission and the parents' protection of the baby. The practitioner needs to develop contact, trust, and rapport with the baby and the parents. The practitioner's responsibility is to advocate for the baby and educate the parents.

The Somatotropic practitioner observes and acknowledges the neonate's pacing cues, attention responses (the direction he moves his attention to the external world and how he withdraws his attention away from the external world), states of consciousness, movement patterns, reflex behaviors, musculoskeletal tonality and tonal changes from hypotonic to hypertonic, verbal expressions (murmurs, coos, giggles, different crying states), facial expressions, and postural preferences. Practitioner, caretaker, or parent acknowledgments may be verbal, empathic, and/or physical. Practitioners' acknowledgment responses, particularly emotional reflective responses are modulated to accommodate the neonate's ability to integrate them. For example, a baby may be in a concentrated state and experimenting with new behavior by picking up an object or turning himself over. The unmodulated excitement of attending adults may distract the baby, thus interrupting the continuity of the baby's concentration and movement pattern. Modulating practitioner responses will be discussed below under the heading, "The importance of negotiating distance and boundaries." The practitioner attends to the neonate's environmental needs as well, especially with

respect to room temperature, need for covering, ambient and sound levels in the room, ambient and direct light in the room. Room conditions are monitored to support the infant to discover a state of present relaxation. All therapeutic interactions are done with gentle verbal forewarnings to the infant, acknowledging their responses, and soliciting their active cooperation. This principle is so important that it holds true even if emergency care is needed or the baby appears asleep or unconscious.

Characteristics, Behaviors and Abilities of the Non-traumatized Neonate

Non-traumatized Neonates Demonstrate the Following Characteristics, Abilities, and Behaviors:

- eyes are clear and present
- eyes coordinate normal convergence
- ability to orient to visual, auditory, and tactile stimuli
- ability to smoothly move from one sensory stimulus to another without breaks in movement continuity
- general balanced tonicity throughout the body
- appropriate homeostatic autonomic responses to stimuli (i.e., if the light changes, the pupils will respond in kind; if activity demands change, respiratory and pulse responses will meet the demand)
- Moro or startle response is present with clear and present danger only
- movements of the extremities are smooth and without breaks in continuity
- smooth trunk movements of the body in flexion, extension, lateral flexion, and rotation movements at will
- accurate proprioception (they know where they are in space)
- strong sucking response
- holds head up and turns head from side to side to orient at will

- balanced cervical and suboccipital muscle tone
- absence of shaking or tremors
- deliberate response to near or direct touch
- matches gentle tactile pressure with extremities, head, or trunk of body
- crying corresponds to need
- able to cry with full range of sounds and emotional content
- able to differentiate emotional expressions
- enjoys experimenting with movements, sounds, and expressions
- body positions and movement patterns do not interrupt ability to orient
- vibrant skin color
- chooses to make contact deliberately
- voluntarily moves attention from inside to outside
- shows interest in new experiences
- voluntarily grasps
- moves to mom's breast, latches on, and feeds

Subtle Energetic, Fluid Tide and Cranial Characteristics of Non-Traumatized Neonates:

- full palpable energy field with distinct clear boundaries
- free flow of vital energy throughout the body
- round, full cranium, absence of cranial molding
- full strong potency of vital fluid tides

- full fluid tide inspiration and expiration patterns with appropriate physiologic reciprocity
- easy expansion and contraction of the cranial field within normal physiologic movement patterns
- able to meet stress with appropriate energetic fluid responses, lateral fluctuations, and still points

Shock Affect Characteristics in Neonates

Gross Observable Shock in The Neonate Is Indicated by the Following:

- glossy eyes
- eyes do not converge normally, but cross or split
- total or partial inability to orient to visual, auditory, and tactile stimuli
- generalized or body area specific hypotonicity
- involuntary changes in autonomic responses including pulse, respiratory rate, skin color changes, pupil changes in the eye
- Moro response or startle response to sound or movement
- jerking movements of extremities
- inability to hold head up
- hypermobility of neck, especially at occipital-atlantal junction
- involuntary shaking or tremors
- tactile sensitivity to near or direct touch
- total or partial inability to match gentle pressure from direct touch with extremities, head, or trunk of body
- weak, hollow, or empty crying sounds

- high pitched crying sounds
- crying inconsolably, getting lost in their emotions without ability to make visual, auditory, or tactile contact
- frequent crying without apparent reason
- lack of skin color
- total or partial absence of alertness during awake states
- withdrawal sleep to light, sound, or movement sensory stimulation
- inability to voluntarily shuttle attention from inside to outside or outside to inside
- inability to grasp

Subtle Energetic Fluid Tide and Cranial Shock Affect Indicators:

- weak energy field without clear boundaries
- erratic energy field patterns
- counter-clockwise umbilical pattern
- unresolved cranial molding
- unresolved postural patterns
- weak potency within vital fluid tide
- total or partial inability of fluid tide potency to build
- long weak still points
- stops in the fluid tide patterns
- cranial strain patterns
- non-physiologic cranial movement patterns

All Behavior Has Purpose

Every expression and movement a newborn makes has purpose. Babies do not do anything without purpose. Breaks in the continuity of movement patterns are obvious and easy to identify. An obvious movement pattern which demonstrates breaks in the neonate's integral continuity is jerky movements. The baby's nervous system is unable to deliver an integrated motor signal in a consistent even flow from their neocortex. Non-traumatized babies, including neonates, are observed to move their limbs and body in even continuous patterns.

Muscle Tone Change in Response to Shock

Muscle tone, body and extremity movements factor together in the process of emerging from the shock affect period. Hypotonicity in any muscle layer is indicative of preceding shock trauma. Hypotonicity at the occipital atlantal junction has been positively correlated with sudden infant death syndrome (SIDS; Schneier & Burns, 1991). The degree of hypotonicity present correlates to the degree of shock the neonate has experienced. Movement patterns and interruptions in movement patterns are also indicative of previous shock experience. As babies grow, increase in size, weight, and muscle tone will compensate for the unresolved shock affect patterns in their bodies. The increased muscle tone will override and mask the underlying discontinuity in the motor impulses resulting in movements that appear smooth but are actually not fully coordinated.

Parents, caregivers, and healthcare practitioners will often mistakenly assume that babies have grown out of the shock affect period because the jerky movement patterns and other indicators like Moro reflexes have gone away. More often, it means the babies have learned to compensate for the shock trauma by developing survival strategies and behaviors. As babies gain muscle tone, they will necessarily have more physical sensations in their bodies. At first, these feelings can be uncomfortable, painful, and disorienting. Seemingly calm quiet babies who were actually withdrawn may all of a sudden become irritable and inconsolable several weeks after their birth as they emerge from the neonatal shock affect period.

The Importance of Negotiating Distance and Boundaries

Neonates in the shock affect period are often hyper-responsive to outside energy including the intentionality of people around them. Practitioners must learn to monitor their own intentionality and observe when and how a baby reacts to the energetic tension fields originating

from the practitioner. The practitioner, parent, or caregiver may, out of concern, move their attention toward the neonate, which has the potential to create an energetic pressure on the neonate that stimulates an overwhelm, or shock affect, response in the baby.

A practitioner must first negotiate distance and boundaries with their intention so they can know the parameters of what the baby can accept. Once this is accomplished, the practitioner will be able to intentionally track the baby's energetic patterns, fluid tides, emotional and autonomic responses, and physiologic and physical patterns. This kind of tracking will reflect the baby's subtle movement patterns in a way that affirms his presence and the choices he makes for his consciousness and his body. This reflective affirmation process on the intentional level increases the baby's ability to know for himself his individuated felt sense and sense of safety within the environment. When he is truly not safe, he will communicate that lack of safety by motioning for support and making sounds that elicit support from caregivers (a baby's way to ask for help).

Strategies for Establishing Contact through Touch or Near Touch

Parents, caregivers, and health care practitioners need to know that the process of coming out of the shock affect neonatal period can be painful. As the babies come out of shock affect, they become increasingly aware of their bodies. It is a process of coming into their bodies. The process of coming out of the shock affect period is multilayered. Practitioners must titrate this process. If babies come out too fast, they will be shocked into their bodies. This was the problem with hanging babies upside down and spanking them at their births (a procedure discontinued for about 20 years).

A conscious process is necessary to establish the contact, safety, and rapport which allows the practitioner to develop a primary therapeutic relationship with the baby. Babies need to be forewarned of any therapeutic intervention, no matter how gentle the intervention appears. The same care needs to be taken when establishing near or direct touch with the neonate, whether the baby appears awake or asleep.

A useful strategy in establishing contact with a neonate who is demonstrating mild shock affect behavior is to first watch his movements. Observe him move an arm toward you or to the side. Note the degree of jerkiness or weakness in the movement. Put your hand out as an offering and allow him to choose to come to you. In this way the babies initiate the contact. Then follow the infant. As the baby makes contact with you, the presence of your relaxed, open, stable hand supports him to experience stable movements with the extremity that you are following.

In contrast, if the practitioner moves their hand toward the baby, especially if it is inadvertently moving toward a trauma site, they will

more than likely stimulate a reactive response in the baby. Such stimulation can often activate an infant into his trauma and recapitulate his preexisting trauma. This can happen especially if the practitioner is moving fast. Their hand will move through energetic boundaries, thus activating trauma memories in the infant. My preference is to observe a baby's movement patterns first. Then I simply put my hand at the edge of the baby's movement pattern so that he contacts my hand as he continues his movements.

Babies Mediate Their Sensory World

Watch what the baby does with his consciousness in relationship to outside input. Is the baby capable of moving his consciousness or attention toward the outside input? Does he move his attention visually, auditorily, or kinesthetically? Watch him on all three of these planes. The outside input is typically over-stimulating to a baby with shock imprinting.

A baby can't really stop outside sound, but the first thing he can modulate is the muscles of his eyes or eyelids. He can look away from overwhelming stimuli or he can close his eyes. He may close his eyes when there is too much light, to cut out the stimuli and to have some control over it. He may also close his eyes in an attempt to ward off overwhelming mental/emotional or psychic intention from others. The eyes are said to be windows to the soul. By watching a baby's eyes, the trained practitioner can observe where the baby is placing his attention in time and space and note if the baby is withdrawing from certain stimuli or moving his attention toward stimuli. Neonatal overwhelm can impede an infant's ability to orient to space or primary caregivers. Moreover, neonatal overwhelm can impede the infant's ability to realize how to observe, show interest, and make contact with his world.

Babies can even move away from another person or overwhelming outside stimuli. For example, if you move your hand toward a baby, he may move his arm away or turn his body away if he doesn't want to be touched. The contraction wave that moves through the tissues as an intentional moving away from a stimulus starts on the inside and moves to the outer layers because the contraction is a motor response.

If the baby doesn't physically move away but just withdraws his attention from the stimuli, the practitioner will see or feel an energetic and/or tissue contraction wave move from the outside inward. You can experience this in yourself by slowly and intentionally pulling your attention inward and mildly resisting the withdrawal at the same time. This can feel like a slight sinking in the body. The resistance you create will amplify the sensation of withdrawing your attention.

Suggested Therapeutic Interventions for Approaching the Neonate Demonstrating Shock Affect

1. Track the baby's energetic and autonomic responses.
2. Verbally acknowledge what he is doing and give him permission. The practitioner may make statements like, "Oh, going in. That's right."
3. Suggest the notion that he is making a choice. The practitioner statement might then be, "Oh, going in. That's right. It is a choice."
4. Change the environment. If it is too bright, dim it. If it is too loud, lower the volume. If it is too tactilely coarse, give the baby softer textures.
5. Slow the pace down by relaxing, slowing your own energetic, autonomic responses and voice.

Crying, Comforting and Nursing for Comfort

Many new parents have difficulty "letting" their babies cry. They may feel uncomfortable, ashamed, or guilty and attempt to soothe them. Addressing the baby's need to cry and the parent's need to soothe is a very important aspect of therapy. Having parents identify, process, and repattern their own feelings about their baby's need to cry can be helpful. Some practitioners are adamant that babies need to cry to discharge unresolved emotions. William Emerson, Peter Levine (1991), Aletha Solter (1984, 1989), Wendy McCarty, and I all agree that an infant crying should be supported to not get lost in the emotions. We all agree that babies should not be left alone "to cry it out." When babies cry, I believe it is the primary caretakers' responsibility to rule out the most obvious reasons for crying such as hunger, wet diapers, physical pain, and discomfort. The primary caretaker is then responsible to maintain visual, emotional, and physical contact with the baby until the crying resolves.

If a mother is consistently using the breast to soothe her baby, then she may be giving the baby the message that it is not okay to cry. This process can result in fetal therapist (Emerson & Schorr-Kon, 1994) inclinations in the baby. The baby may be inclined to take care of the emotions of the mom and other primary caregivers. If the mother nurses the baby for her (the mother's) own comfort, then the baby becomes the mother's emotional caretaker.

Or the mother may have unresolved feelings of guilt that come from previous generations, her own personal unresolved issues, and/or from traumatic events that occurred during pregnancy and birth. She may then over-compensate by attempting to subdue the baby's cries when the baby

needs to cry. These, I believe, are primary confusing factors for babies that can potentially lead to dysfunctional behavior such as eating and sleeping disorders in the future.

Some nursing support professionals counsel new parents to be careful not to mix feeding with satisfying the baby's need for comfort. They state that it is best to nurse only when the baby is hungry. These practitioners hold the view that the purpose of breastfeeding is for eating. Breastfeeding, they feel, should not be used to soothe the baby. In their view, babies should be encouraged to manage their emotions with different resources other than at the breast. This strategy can be useful for babies who do not demonstrate shock affect behaviors or babies who have access to other resources to console themselves or be consoled by others. This strategy can be counterproductive for babies during the neonatal shock affect period.

I do agree, however, that it is not in the baby's best interest for mom to put the baby to breast in an effort to quiet him. When a baby cries, the cry has a purpose. Obvious indicators such as hunger, wet diapers, physical pain, etc. should be ruled out first. Aletha Solter (1984, 1989) points out that babies need to cry to discharge stored feelings. However, Dr. McCarty and I find that, as we train babies and parents to discover the ability to go to a state of quiet presence within themselves, babies are more able to express deep felt emotions with contact and consolability.

Shock affect often inhibits access to consolation. Babies with shock affect behaviors often cry inconsolably and will appear to cry themselves to sleep. It is my observation that this is not sleep at all. These babies may actually be crying themselves into a dissociated shock withdrawal state that appears to be sleep. It is essential to take into account that during the shock process, different emotional sets are compressed together (Levine & Graybeal, 1991). This means the baby will experience several emotions and sensations that at least cause confusion and at most can cause the psyche to compartmentalize this condensed experience or split. (Levine and others report that adults with post-traumatic stress symptoms often compartmentalize emotional states or aspects of themselves as a survival strategy.)

In the BEBA Clinic, Dr. McCarty and I worked with a baby who was born at home and was hypotonic at birth with weak respiration and poor neurological signs. This baby was separated from his mother, transported to the hospital with his father in an ambulance, and spent three days in a NICU. In our opinion, this baby did not have the resources to separate out all of these complicated emotions and compressed experiences. This baby's energy and physiological systems were dissipated and weak. His basic system was not strong. He exhibited hypotonicity in the neck and atlantal-occipital junction, which rendered him a candidate for SIDS (Schneier & Burns, 1991). In this and similar cases, we feel that nursing for comfort

and, more importantly connection, is a very appropriate approach. Confusing feeding with consolation should not be a consideration in this case and others like it. The first thing is to establish the resources.

When caregivers and the environment are able to support the baby's ability to experience the felt sense (Levine & Graybeal, 1991) of that internal quiet, slow, warm, soothing parasympathetic place, the baby will then be able to make the choice himself to come out of the shock affect period. This quiet slow way out of the shock affect period will allow the baby's nervous system to build the necessary sequences within for smooth connection from the brain stem, through the limbic system to the neocortex. Thus, the baby's sensory motor integration, proprioception, balance, emotional and mental clarity will be free to function optimally without interruption from shock and trauma.

Healing Betrayal: New Hope for the Prevention of Violence

I believe that the problem of betrayal is epidemic in our culture and is a significant contributor to personal and psychosocial dysfunction. Betrayal is unknowingly and unwittingly perpetrated on our prenates, neonates, and children. Left unresolved, betrayal leads to domestic and social violence. The pre- and perinatal perspective offers hope for the healing of betrayal and the prevention of violence.

The American Heritage Dictionary of the English Language (1969/2015) defines the word "betray" as follows:

1. a. To give aid or information to an enemy of; commit treason against. b. To deliver into the hands of an enemy in violation of a trust or allegiance.
2. To be false or disloyal to.
3. To divulge in a breach of confidence.
4. To make known unintentionally.
5. To reveal against one's desire or will.
6. To lead astray; deceive.

I think each of these definitions is relevant to pre- and neonatal consciousness especially 1b, 4, and 5. Statements like: "I didn't know it would be like this," to, "How could you! How could you let them do this to me?" exemplify different intensities of betrayal.

Emotionally, betrayal affect is a profound constellation of rage, terror, separation-loss-grief and shame: rage that I was handed over to the "enemy;" terror of not knowing what the "enemy" will do to me; grief from the separation and loss of a trusted ally; and, the lingering sense of shame

that I should have, or could have done something to make it better or keep it from happening, that I somehow caused the other to betray me.

Trust

Ideally, parents, caregivers, and healthcare providers are supposed to be trustworthy. The building and maintenance of trustworthiness necessitates clear communication. Trust is not something that happens automatically. Trust must be earned and maintained by consistent behavior. If trust is broken, something must be done to heal the broken trust and rebuild it. It is incumbent on us as parents, caregivers, and healthcare providers to earn our children's trust. Without trust, our children are left betrayed.

I think one of the most common examples of betrayal our babies experience comes from the previous mistaken assumption that our babies are too little and too young to know what is going on. Parents, caregivers, and healthcare practitioners can often be observed talking about a baby to another adult in the baby's presence. There is little or no awareness that the baby's expressions might have something to do with what is being said. I am suggesting that talking about our babies in front of them without including them in the communication breaks down trust and leaves the baby in the feelings of betrayal.

Until very recently, few professionals and parents knew that prenates, birthing babies, and newborns are conscious, sentient beings, possibly as early as conception. This means that prenates, birthing babies, and newborns have a sense of what is going on. They know when they are disconnected, not acknowledged, and not included in decision making. Whether or not they are capable of making decisions, they still have something to say about them. Prenates and babies are conscious, sentient beings who deserve our attention and respect in the same way we would offer it to anyone our own age.

During pre- and perinatal life, betrayal is unwittingly and unintentionally perpetrated onto the pre- and neonate. The neonate feels unprotected, delivered into the hands of the enemy and betrayed. Clinically, I have seen betrayal feelings reported by adults and portrayed in babies and children from all of the following: alcohol or drug use at conception or during pregnancy, abortion ideation (thinking about abortion while pregnant), abortion attempts, scalp fetal heart monitors at birth, anesthesia or analgesia, forceps, vacuum extraction, cesarean section birth, cutting the umbilical cord too soon or too rapidly, eye drops, insensitive bathing after birth, pediatric interventions after birth, heel sticks to draw blood for medical tests, vaccinations, and circumcision. This list is by no means complete. Betrayal feelings can easily be recapitulated by parents just by telling the birth story without including the baby in the

conversation. Parents, caregivers, and healthcare professionals often do not understand, nor acknowledge protests and tears babies express while experiencing procedures or while someone is talking about them without including them. Research has shown that babies do experience perceptions and express feelings in direct response to what is happening to them.

These unresolved betrayal feelings undermine the primary trust the neonate has of his parents. Without trust firmly in place, parenting and being parented is unnecessarily encumbered. Unresolved betrayal inhibits the child parent relationship and, more often than not, results in power struggles between the child and his parents.

Parents often ask about behaviors like biting or hitting during nursing. Unresolved, these behaviors will transfer to other siblings, children, and animals as the children get older. I believe that hurt babies and children desperately want others to know and acknowledge the pain they have experienced. When a child hits me or attempts to bite me, I will gently restrain them from hitting or biting me. I will then say, "Oh you were hurt that much. Ouch. I get it. I can see and experience the pain under your anger. No, you may not hit me. I am here to hear how you feel." My actions will be consistent with the words I use.

Unacknowledged pain can lead to anger, frustration, rage, ambivalence, and then, finally, to depression. We are looking at a betrayal cycle. If, when our babies bite us or express anger toward us, we acknowledge them and set a limit for them, they would quickly learn more constructive ways to express their pain and anger.

I think it is impossible for a child to be born and grow up in this and many cultures without knowing some level of betrayal. To start with, we don't understand that our children are being betrayed. Then, when our children are acting out betrayal behaviors, we don't understand that either. Finally, we don't know how to appropriately respond to the child's behavior. Both parent and child remain confused, and the betrayal cycle continues.

Paradigm Shift

The BEBA work or Somatotropic Therapy® that I do with patients of all ages represents a profound paradigm shift. This work includes and integrates aspects of pre- and perinatal psychology, bodywork disciplines, Polarity Therapy, Osteopathy, Chiropractic, understanding about trauma impacts and the resolution of trauma, and midwifery and obstetrics knowledge. However, Somatotropic Therapy® does not look like any of these individual disciplines. Somatotropic Therapy® is based on specific principles, knowledge, and philosophical premises. The principles govern what is done. Words do not give us experience. The work is best experienced. With videotape you can see what happens in treatment

sessions and how the principles are applied. I videotape all the work I am doing with infants because it is much easier to show than to talk about. The work is happening on many levels, because many patterns exist.

Dr. McCarty and I worked with a family and baby who started labor at home, were transported to the hospital, and ended up with a cesarean section birth. I didn't do any work with them prior to the birth. I was called by the grandmother and, with the parents' consent, was asked to meet them at the hospital to join the birth support team. This family is now involved in the BEBA project. At this writing, the baby is three months old.

Just this last week the mom was telling the story about how hard it was to receive the spinal anesthesia during labor. As she was talking, the baby was connected at her breast. Mom and baby had extraordinary eye contact. It was really touching. Tears welled in the mom's eyes. The mom was describing how the anesthesiologist was talking about her in the third person to an assistant. Mom felt enraged and betrayed by the way she was being treated. She was having to sit up straddling a table bending over her full womb in the middle of Pitocin driven contractions so that the anesthesiologist could get the needle into her spine. They told her to put her head down farther. She felt she couldn't go any farther.

At one point during the story, mom emphatically stated, "I felt alone. There was no one else there!" Her baby immediately and abruptly disconnected from breast and let out a huge whelp that sounded angry and hurt at the same time. Mom looked into her baby's eyes, who was by this time in a full cry and said to her three-month-old infant, "Yes, and you were there too!"

The baby then calmed, looked into his mother's eyes and reattached to the breast. I believe that this young mother's response to her baby's cry served to help heal the betrayal that they both felt during the anesthesia process. Had she not acknowledged her baby's presence there and the baby's response to her statement about feeling alone the baby would have continued to cry, re-experience, and reinforce or recapitulate the betrayal feelings.

The level of betrayal that we hold in ourselves is massive in our cultures and is unconsciously passed on to our children. It is the source of tremendous rage that is entangled in our family dynamics and affects our ability to protect our children, set boundaries, and set limits for them.

Conception, gestation, and birth are profound events that have significant impacts on consciousness, physical development, and later life. Culturally, we are just beginning to explore these outer edges with the reporting of near-death experiences, as seen in the extensive works of Kubler-Ross and of Steven Levine. This kind of writing about death and near-death experiences has recently become more popular in our culture. We can look at the other side of the death experience and consider the conception experience. Those of us who have been doing different forms of regression work have been exploring the time frame of conception through

birth. Patients report significant realizations about what happened to them during their conception, prenatal life, birth, and early infancy that helps free them from the traumatic influences of those events. To consider the pre- and perinatal perspective is indeed a paradigm shift.

Imprinting and the Trauma Mechanism

As we consider the lack of boundaries that the experience of betrayal leaves in its wake, we must raise the questions: What are traumatic influences and what is the mechanism of traumatic imprinting? What is the stress or trauma mechanism?

Imprinting is most profound when our endorphin or catecholamine hormones are being secreted into our system. Endorphins are our pleasure hormones. If we are having some kind of intense pleasurable experience, endorphins are secreted and we experience pleasure and sometimes euphoria. When we are having some kind of stressful experience that drives our adrenal cortex, our fight or flight responses are stimulated and the level of catecholamine hormones in our system rises. It is during these kinds of heightened experiences that our body memory patterns, emotional memory patterns, and mental memory patterns get imprinted. Imprinting occurs in a triad of body first, emotions, and then mind. The earlier the event in prenatal life, the deeper the imprinting.

Imprinting and COEX Systems

We are seeing how these single imprinting events build on top of each other. Later traumatic events, which include betrayal, compress on top of or "recapitulate" the earlier imprinting events. Some of you may know Stan Grof's work (1975, 1985, 1988). He speaks about a COEX matrix. He describes how similar emotional sets and memories form a system of "condensed experience" that are formed during events of strong emotional charge of the same quality.

In Somatotropic Therapy® we look at similar mental, emotional, and physical sets or COEX systems. Unconscious expressions that have their origin in prenatal and birth imprinting are expressed countless times during a single day as emotional sets, facial expressions, and physical postures by all people. Just watch newscasters on TV for example. You will see their heads constantly tilt and turn in the same direction. You may notice a repetitive facial expression or body movement. These are postural imprintings and movement patterns that are most often left over from their births or, less often, other traumatic events.

We've been talking about betrayal and how betrayal and separation get compressed together and imprinted in early experience. We have talked a little bit about how trauma events stack on top of each other. So,

when a person goes into an event that raises those same issues again, it doesn't just bring up the issues surrounding the present event, it also brings or triggers into the present moment, sensations, feelings, sensory awareness, physical expression, movement patterns, and posturings that are left over from similar events that happened in the past.

Memory

Every traumatic event has an effect on the person. A traumatic event threatens to overwhelm or does in fact overwhelm one's system. There are a series of stress and trauma responses that are predictable and occur in relationship to all traumatic events. There are certain things that happen during our human development that compound or compress unresolved traumatic memory patterns into present time.

Memory is an interesting mechanism. In the moment we are living in the present, right now. Memory of what happened in the past is more illusionary than what is presently happening. This moment is more real than anything that happened in the past. But anything that is left unfinished, that hasn't come to completion or resolution, is carried by our being into the present moment. The mechanism for this is little understood. Psychologists and physiologists are just beginning to have some understanding of how memory works. Moreover, we seldom consider that our physical body is also a primary carrier of memory.

The Somatotropic perspective broadens the way we consider memory. Usually, we think of memory as only a conscious mental process. However, memory really involves more than just having mental thoughts. Memory includes mental, emotional, and physical information. Each aspect of our being has its own way of remembering. Mentally, we remember thoughts, pictures, images, words, sounds, symbols, and ideas. Mental memories occur on the level of thought.

We remember emotions. They are the passions that drive us. Emotions are a complex of sensations that are coupled with emotional feelings: i.e., love, joy, happiness, gladness, warmth, grief, sadness, greed, anger, rage, lust, fear, jealousy, betrayal, etc. Emotions involve both the feeling and a commensurate sensation or physical experience. Each emotion has its own energetic sensation that is part of the "feeling." It is the emotions that link the mental aspect of our minds to our physical bodies. We can think thoughts and not necessarily feel anything. Our emotions connect our thoughts to our passions and our physical bodies.

Unresolved emotions from prior traumatic events are held in our body's nervous system, connective tissue, muscles, and organs as unconscious energetic and physically manifest tension patterns. These tension patterns are simultaneously activated every time a specific memory pattern is stimulated or "triggered." These patterns are

unconsciously activated many times in a day. The repetition of these activated patterns manifest as specific behaviors, movement patterns, facial expressions, and postures. Dr. William Emerson calls these "psychological leaks." These unresolved memory activation patterns contribute to the asymmetry of the body.

The physical body is not symmetrical in nature. The physical body is asymmetrical. True, we have several paired organs: eyes, ears, lungs, for example. However, by design we are not symmetrical. We have several single organs, some of which are not even in the center of our body, like the liver which is off to the right side of the abdomen, tucked under our diaphragm muscle. Even our heart is positioned a little to the left in our chest cavity. Moreover, we have only to look at our anatomical features, especially our faces, to see asymmetrical anatomical variation. These asymmetries, together with breaks in the continuity of our movement patterns, are amplified and exaggerated by traumatic prenatal and birth experiences.

Lastly, the Somatotropic perspective includes the physical body as having somatic memory. The shape of one's head is strongly influenced by one's birth process and the shape of the mother's pelvis. The shape of one's head can be strongly influenced by being stuck in the birth canal for a period of time. This is called "cranial molding." Despite what most obstetricians and pediatricians counsel us to believe, not all of the cranial molding resolves within several hours or days after birth. Cranial molding often does not fully resolve and can be sustained throughout life. Unresolved cranial molding is an example of how the body remembers traumatic birth experience. The head or cranium holds or remembers aspects of the shape from the birth molding experience. As babies resolve their prenatal and birth trauma, their cranial molding will also resolve.

Parents often bring in children who have a habit of bumping their heads in the same place. Babies and children frequently display patterns of falling and hitting their heads in the middle of the forehead, on the side of their heads, or back of their heads. They will often have an uncanny ability to hit the same place over and over again. The babies that repeatedly bump their heads in the same place will often do so in a place where their head happened to have been stuck or compressed during birth against mom's pelvis.

The body also remembers specific movement patterns from birth. Most parents have experienced their baby or toddler arching over backwards while they hold them in an upright position in a seemingly spontaneous fashion. This arching movement is a specific movement pattern that is imprinted in the body during the latter part of birth as the head crowns and is born. So, memory is not just a mental phenomenon. Memory is mental, emotional, and physical.

Parents or healthcare practitioners who don't know how to perceive and properly identify babies' movement and recurrent behavior patterns as expressions of prenatal or birth imprinting are unable to be in relationship to that part of the babies' experiences. When they have learned how to connect movement patterns and recurrent behaviors to earlier traumatic experience, they can relate to the baby from a very different and more effective place.

Some of the parents we are working with are learning to identify their baby's birth patterns and have developed new ways to relate to their children. When observing her baby hitting her head, a mom may say empathically, "Oh. That reminds me of when we were stuck. I was stuck, and you were stuck inside me. We were both struggling really hard during that time." This enables the child to then relate to his mom in a way that helps resolve the underlying pattern which caused the head bumping in the first place. Babies will do what they need to get their parents' attention. The more awareness the parent has, the more experience can be included in the memory and interaction of the child and parents. The relationship can then become a deeply healing one.

Conception, gestation, and birth are major events that are closer in time to a baby's immediate experience than they are for adults. When we have something big happen, like the death of a friend or someone close to us, we tend to talk about that event with others until we get some distance from it. I think we do this so the impact of that event does not occupy so much of our psychic space. Receiving empathic, reflective attention from others helps us overcome our loss. Babies do the same thing with their body and emotional language. Giving empathic reflective attention helps babies resolve their prenatal and birth trauma.

Seven Steps to Healing Betrayal

Conception and birth are as impactful for a baby as the loss of a close friend is to us. New babies need a quality of attention and acknowledgment we are just beginning to understand. Newborn babies and children have the capacity to comprehend and heal unresolved broken trust and betrayal. Parents, caregivers, and healthcare professionals can support the healing of betrayal with the following behaviors:

1. Connect with your own internal felt sense and knowing of betrayal.
2. Acknowledge the baby's feelings. Give the baby appropriate containers to express his betrayal feelings. Biting and hitting others are not appropriate expressions of rage or anger.
3. Communicate empathically with the baby from that place of knowing.

4. Acknowledge to the baby our part in the betrayal cycle.
5. Tell him we are sorry.
6. Protect our children from outside harm. Respond to the baby's cues about having his or her space encroached upon or invasive environmental influences like too much light, sound, or movement.
7. Set clear and appropriate limits for our babies' and children's behavior.

Betrayal feelings do not need to be lost in our shadows. They can be healed. Professionals trained in the Somatotropic approach for the resolution of prenatal and birth trauma in infants and children can support families to heal unresolved betrayal. Domestic and social violence can be prevented. This, in turn, can allow parents and children to have open, trusting, expressive, and growth-filled relationships, free of betrayal.

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