Do Babies Need Psychotherapy?

An Introduction to Integrative Baby Therapy

Matthew Appleton

ABSTRACT

Integrative Baby Therapy (IBT) is an embodied relational approach to working with babies developed by the author. The theoretical basis and practical application of IBT skills draw from various sources, particularly Body Psychotherapy, Craniosacral Therapy, and Pre- and Perinatal Psychology. IBT represents a specific synthesis of the innovative groundwork laid by practitioners and researchers in these and other fields, all of which are acknowledged throughout the text. The focus of IBT is short-term crisis intervention to support parents with distressed babies and young children. Parents frequently report long-term benefits from these interventions. The typical age range for this therapy spans from shortly after birth to two years of age. Although the IBT approach can be adapted for older children, that topic falls outside the scope of this paper. Central to the practice of IBT is the creation of an empathic space where babies can integrate prenatal and birth experiences that may have been overwhelming. They express these experiences through *Baby Body Language* and *Memory Crying*, both of which are explored in this article.

Keywords: self-regulation, babies, birth trauma, prenatal stress

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> ***Research and clinical practice in the field of Pre- and Perinatal Psychology demonstrate that the memory of prenatal and birth traumas persists as unconscious imprints that powerfully influence us throughout life.***

The World of the Newborn, Infant, and Prenatal Person

The first 18 months of life, from conception onwards, constitute a foundational period that will have life-long consequences in terms of psychological and somatic development, with a high degree of influence on the future functioning of the autonomic nervous system (Odent, 1986). In recent decades, research into the world of the newborn, infant, and prenatal person or prenate has revealed a much richer strata of human experience than previously recognized (Chamberlain, 1998; Chamberlain, 2013; Stern, 1998). However, much of this research has failed to make its impact on prevailing cultural concepts or mainstream healthcare, including pediatrics, obstetrics, and midwifery. This inevitably impacts the well-being of the prenate, newborn, and infant. The existence of memories from prenatal life or birth is often treated with disdain by psychiatrists and many psychotherapists,

as well as by the public at large. The result of this is that many children, adolescents, and adults do not receive the appropriate care they deserve.

From the perspective of Integrative Baby Therapy (IBT), an important beginning in reassessing this formative territory begins with the research of Wilhelm Reich in the late 1940s. Reich's shift from psychoanalysis to working directly with the body gave him deeper access into the realm of preverbal experience. Concerned not only with the fate of the individual, but also with that of future humanity, a major focus of his work became "the study of the healthy child" (Reich, 1983, p. 7) and how to protect the child from damaging cultural influences and institutions. This marked a shift from predominantly therapeutic work to preventative concerns. He attributed the "source of the human 'NO' [to life]" (Reich, 1983, p. 3) as having its roots in how the infant is greeted at birth and the period shortly after, as well as in the womb environment. Research in the field of Pre- and Perinatal Psychology elaborates this theme (Brekhman, Turner & Gouni, 2021; Janus, 2001; Ruppert, 2016).

Reich was aware that his research into the nature of the human infant was in its infancy. Profoundly aware of how trauma was passed down through the generations and had become institutionalized in obstetrical and educational practices, he envisioned a future generation of children – *Children of the Future* – who might be free of these traumas and the need to contract against the harshness of the world at the beginning of life.

> It will take several generations of newborn infants growing up under an ever-widening horizon of knowledge of the child's true nature before the first signs of the world of the Children of the Future begin to appear. It is not the inborn nature of the child that constitutes the difficulty. The trouble lies in the thinking and acting of educators, parents, and physicians. It lies in the maze of wrong opinions which have nothing to do with the child. (Reich, 1983, p. 38)

The "wrong opinions" referred to by Reich include the idea that babies do not feel pain at birth, along with harsh obstetrical practices, separation from the mother after birth, timetable feeding, and harsh toilet training. Along with A. S. Neill, the founder of Summerhill, the democratic school in England, Reich advocated self-regulation for babies and children. As used today, self-regulation refers to methods of regulating the autonomic nervous system so as to manage stress levels (Shanker & Baker, 2016). Reich and Neill used the term differently, to indicate the innate capacity for full aliveness, which they believed was inhibited and distorted by the birthing and childrearing practices of their time. According to Neill, "Self-regulation means the right of the baby to live freely without outside authority in things psychic and somatic" (Neill, 1953, p. 42). This approach promoted a "lively awareness and appropriate response to the child's needs, emotions and impulses" (Fuckert, 2011).

Self-regulation is a central principle in IBT. Much of what Reich was advocating in terms of the nature of the infant has now been validated. For example, a 2015 study at Oxford University concluded that newborns were far more sensitive to painful stimuli than adults (Goskan et al., 2015). The adverse impact of separating babies from their mothers following birth has also been well-documented (Császár-Nagy & Bókkon, 2018, pp. 337-351). However, cultural myths and ingrained institutional habits are slow to change. Research and clinical practice in the field of Pre- and Perinatal Psychology demonstrate that the memory of prenatal and birth traumas persists as unconscious imprints that powerfully influence us throughout life (Feher, 1980; Lake, 1986; Noble, 1993). Craniosacral therapists are able to palpate and treat these traumas as expressed at the somatic level (Agustoni, 2013). However, they may lack the skills to support and integrate any strong affect associated with these traumas.

In IBT sessions, babies are active participants, exhibiting an innate knowing of what they need, and a much higher degree of expressing themselves than posited by the prevailing understanding of infant behavior. This includes specific body language and associated emotional expressions that convey unresolved birth trauma and prenatal stress. In so far as these gestures by the baby are not understood and met with appropriate empathic responses, the baby withdraws from contact and tenses up, having no satisfactory avenue of expression through which to discharge tension. This is poorly understood by both parents and the medical profession. Dr. Kevin Nugent, director of the Brazelton Institute at the Children's Hospital, Boston, writes in *Your Baby is Speaking to You*, "Not all babies are cuddly. Their small bodies are rigid and so sensitive to touch they seem to recoil from their parents' ef-

forts to hold them close… if she feels stiff and rigid despite your best efforts to cuddle her, you need to recognise that this is simply how she is" (Nugent & Morell, 2011, p. 48). While aiming to reassure parents, this unfortunately normalizes stress and trauma held in the baby's body. This keeps the baby trapped in the stress or trauma. In IBT sessions, we often work with babies who at first are holding themselves rigidly, but become soft and flexible as we engage with their body language and emotional expressions in a relational and empathic way. This, in turn, enables deeper bonding between baby and parents as greater trust and relaxation of all parties is established.

A New Cartography of Early Human Consciousness

IBT draws upon the lineage of working directly with the embodied expression of prenatal and birth experience, which begins with psychiatrist Frank Lake. In the 1950s, Lake began to uncover birth memories in his patients with the use of lysergic acid (LSD-25) during clinical research (Peters, 1989). Later, he began working in small groups while encouraging relaxation and deep breathing to elicit birth and prenatal memories (Peters, 1989). This shift from the use of LSD to breathwork follows the same trajectory taken by the more famous Czech psychiatrist, Stanislav Grof (Grof, 2010). Towards the end of his life, the Scottish psychiatrist R.D. Laing also focused on exploring these formative processes, and actively promoted awareness of the lifelong influence of prenatal and birth memories (Laing, 1976). These included cellular memories going back to conception (Laing, 1976; Lake, 1981). The fact that prenatal and birth memories can be uncovered in this way hugely challenges the dominant paradigm of how memories are laid down, and the nature of human consciousness. Since Lake's initial findings, there has been significant research to suggest the emergence of a new model of consciousness that expands upon the narrow model of consciousness as an epiphenomenon of the brain (Gober, 2018; Sheldrake, 2022; Verny, 2021; Whitmont, 1993). However, this research and acceptance of the existence of prenatal and birth memories remains marginal to the mainstream materialistic worldview. This "cultural blind spot" (Appleton, 2020a) can create significant difficulties for practitioners in this field, especially in working with infants.

These early pioneers of what was to become the field of Pre- and Perinatal Psychology did not work directly with infants, but they developed a cartography of prenatal life – birth from the perspective of the baby, which informed later therapeutic work with babies. Themes and imagery associated with specific prenatal and birth stages began to emerge, and were developed by subsequent researchers and practitioners (Emerson, 2004a; Emerson 2004b). Spontaneous body language correlating to different prenatal and birth stages was also identified (Appleton, 2020; Farrant & Larimore, 1995; Terry, 2022). Further clarification of the somatic impact on babies of the birth experience came from cranial osteopaths and craniosacral therapists (Arbuckle, 1994; Sills, 2004). Direct body-based psychotherapy with babies began with psychiatrist William Emerson (Emerson, 1989), and was further developed by other practitioners, such as Karlton Terry (Terry, 2022) and Ray Castellino (Highsmith et al., 2021).

Terry uses the term *baby body language* (BBL) to describe the somatic signals that babies show in relation to their prenatal and birth experience (Terry, 2022, p. 47). This is a parent-friendly term that can be easily understood. Adults and older children also express BBL. Along with the themes and images that emerge in therapy, BBL can help identify the influence of a particular prenatal or birth stage that is shaping a present-moment situation. BBL emerges out of the unconscious, but by drawing attention to this implicit body memory, and exploring it as part of an embodied relational dialogue, more of the early story may emerge to be engaged in a meaningful way. BBL as expressed by infants is no different, except that they cannot verbalize their inner worlds in the ways that adults can. However, babies directly express the emotional quality associated with their BBL, as they have no social filters to inhibit it. As BBL is often associated with prenatal and birth stress or trauma, it can often be accompanied by strong crying. Terry calls this *memory crying* (Terry, 2022, p. 35). One of the main reasons that parents give for bringing babies to IBT sessions is "inconsolable crying." Seeing this as meaningful, and as something that can be navigated, often frees parents from helplessness and self-criticism, such as "I must be doing something wrong."

In the IBT approach, BBL and memory crying are seen as attempts to elicit an appropriate empath-

ic response from the environment. This is part of the infant's instinctual repertoire, rather than a conscious decision to try and elicit a response. The capacity to consciously elicit a response from the environment does not develop until around 18 months of age, and fully matures only between the ages of four to six years (Firth & Firth, 2003). The ability to communicate the need for an empathic response to a prenatal or birth-related issue is another expression of an infant's innate attempt at self-regulation, which expands on the concept as originally described by Reich and Neill. Both were aware that babies and young children are unable to regulate their own stress levels or meet their own needs, but are dependent on caregivers to be attuned to their needs (Neill, 1953, Reich, 1983). Understanding this need for co-regulation between baby and adult caregiver has been further developed in recent decades through infant observation research (Beebe, Cohen & Lachmann, 2016) and interpersonal neurobiology (Sanders & Thompson, 2022). What IBT integrates into its therapeutic approach to working with co-regulation disturbances are the roles of BBL and memory crying in infant-parent communication.

The Dynamic Principles of Integrative Baby Therapy

There is no such thing as a typical IBT session. Parents and babies arrive in the therapy room in many different configurations and varying levels of stress. Therefore, protocols are of little use. Instead, IBT practitioners work with a set of dynamic principles, which can inform each situation in a fluid and lively manner. Embodied presence is one of the core principles for the IBT practitioner. Trainees are taught to connect with their midline – a practice derived from craniosacral therapy (Sills, 2004), and to attune to the heart – using the framework of heart-to-heart entrainment as developed by the HeartMath Institute (Dahlitz & Hall, 2015). Families often arrive feeling very stressed, and cycling between feelings of helplessness and hopelessness. This can be especially intense when the baby is crying inconsolably. The calm embodied presence of the practitioner helps the parents co-regulate. This creates a *coherent relational field* or *good enough holding environment* (Sills, 2009, p. 123) in which to explore what is happening in both parents and infants.

If possible, both parents are encouraged to come to sessions. Although their reason for coming is usually an issue with the baby, babies are embedded in the family system, and are extremely sensitive to the parents' stress levels. One way we explain this to parents is that they are like an extended nervous system to the nervous system of the baby. High stress levels communicate to the baby that the environment is not safe. So, although the baby is being seen as the "problem," the issue is often stemming from the environment. The baby is simply responding to it. Many parents carry their own trauma from the birth (Svanberg, 2019). They may feel objectified, violated, or disempowered by medical staff, or ashamed and guilty that they could not stand up for themselves or their baby at this time. With a new baby demanding all the attention, many parents have not had the space to talk about the birth and share their feelings. Their own birth and early childhood traumas can also be stimulated by the birth and becoming parents themselves. At the beginning of a session, everyone – both parents and baby – feels alone in their distress. Creating a *potential space*[1] for everyone to be deeply listened to begins to create connection and a larger container for deepening into the therapeutic process, as each individual story is woven into the whole picture.

Attention is always being brought back to present-moment embodied experience. Questions such as "What are you noticing now?" or "What's happening in your body?" encourage awareness and presence. When stress levels rise, parents are encouraged to pay attention to the breath, and to keep breathing. Holding the breath is a natural stress response to an inconsolably crying baby. However, this builds tension, and parents become caught in a feedback loop of breath-holding, muscular tension, and ongoing stress. At the same time, rather than being present and embodied with their baby, parents will frantically try to figure out what they should do. This creates another stress feedback loop whereby the babies are flooded by the parents' stress, and are alone in their own stress. Babies lose

1. A term borrowed from Winnicott (Winnicott, 1986).

the embodied presence of their parents when the parents are up in their heads, rather than down in their bodies. Bringing attention to the breath can help parents come back into the body, become present, and break out of the feedback loops of stress in which they have become trapped. This is not always an easy process, and may demand a lot of patience on the part of the therapist.

Physical contact may also be offered to a distressed parent, usually in the form of a supportive hand on the back, which we call an *emotional anchor*. It offers stability in the emotional storm. The therapist encourages the parent to feel into the contact and describe what they are noticing. As well as offering support, this also brings awareness back into the body. This can be especially beneficial when trying to open up a potential space for a baby who is intensely memory crying. What the baby needs in these circumstances is to be empathically listened to and mirrored, rather than being shushed.[2] Having our stories heard and appropriately responded to does not begin with the capacity for speech, but is there from the very beginning of life. However, this is not an easy task, as it is counter to what we may have been taught about babies. Also, if we learned early in life that it was not safe to express strong emotions, our own unheard stories and traumas may get stimulated. The emotional anchor helps raise the parents' tolerance threshold. Through this contact, the therapist can also reflect back to the parent when they have begun to lose presence, and spin off into frantic solution-seeking or disaster scenarios. Through repeating these processes a number of times, parents also learn to track their own stress levels and develop their own capacity for emotional anchoring at home.

Listening to the Baby's Story

Having an empathic holding field creates a safe space in which babies are able to express their emotions and release tension. When we are present and deeply listening, babies make deep eye contact. If we are not listening with appropriate emotional resonance, or if we are misinterpreting the baby's needs (for example, mistaking memory crying for hunger or tiredness), or if we cannot tolerate the strong emotions being expressed, the baby will move out of contact by closing the eyes or turning away. Only then do we need to fear re-traumatizing the baby. Eye contact signifies trust, safety, and connection ("I am not alone with this experience"). This is congruent with the Polyvagal Theory of co-regulation through social engagement (Sanders & Thompson, 2022). As with human interaction at any age, when a baby's experience is empathically received, more of what has been held internally comes to the surface. Therefore, memory crying may initially intensify before reaching a *release apex* (Terry, 2022), after which the baby will begin to relax and settle. This can be especially challenging if the baby is initially dissociated, and so appears calm. These babies have given up on being met in their "story." As they sense that the conditions are now right for them to express their inner truth, they begin memory crying. It is important on these occasions to support parents to understand that this is a movement towards health, rather than away from it.

Memory crying is often accompanied by BBL.[3] We respond to these expressive signals from the baby by mirroring their emotional qualities and gestures. This will include vocal mirroring through empathic prosody and emotional attunement. The therapist needs to be able to attune to the baby's experience through their embodied experience so as to create the appropriate empathic resonance. This cannot be done simply as a technique. Permission is always sought from the parents before engaging with the child; they are informed that if they want to stop the session and take a break, they can do so at any time. Permission to engage is also sought from the baby. This is done non-verbally, but may also be articulated, so as to convey the request more directly, while also modeling this type of respectful approach to babies. Again, if babies are not willing to engage, they will turn away or break eye contact. Their "no" is respected. We may

2. It is important to differentiate between memory crying and crying associated with a present moment need, such as hunger, tiredness, discomfort etc. It is also vital to emphasize that while being given space to cry within an empathic relationship releases stress and tension, being left alone to cry builds stress and tension. This eventually becomes unbearable for the child, leading to resignation and dissociation.
3. I am especially indebted to Karlton Terry, director of the Institute of Pre and Perinatal Education, for deepening my understanding of how babies share their prenatal and birth experience in this way.

Babies are incredibly attuned to the relational field, and may only begin to engage with their story when the field feels clear enough to do so.

need to pay attention to something else, such as something happening with the parents, before we try to engage the baby again. Babies are incredibly attuned to the relational field, and may only begin to engage with their story when the field feels clear enough to do so.

A Clinical Example

Paulo is 10 months old. He has been crying intensely for about 20 minutes. I have been building a relationship with the mother and father by asking them what they want from the session, and explaining a little about how I work. They are both slightly dissociated, and not very engaged with Paulo. Their main concern is that Paulo suffered a lot of invasive interventions while in intensive care for several weeks after birth, which was an emergency caesarian performed as the labor was not progressing. As we are talking, Paulo begins to repeatedly touch certain places on his head. As IBT practitioners, we are familiar with how the cranium is molded during birth, and can identify *conjunct sites* and *conjunct pathways* (Terry, 2022). These are areas of compression caused by the baby's head being pressed against the mother's pelvic bones. By looking at the conjunct sites, I can tell that Paulo got stuck in the pelvic inlet, and that he was not able to descend into the mid-pelvis.

With permission, I begin to palpate these sites, with a very light touch. This amplifies the baby's birth story. Paulo pushes my hand away, which I let him do. This gives him agency and a sense of empowerment in relation to an experience in which he was stuck and helpless. After we repeat this a few times, he stops crying, gazes deeply into my eyes, and becomes very still. [4] He then invites me to engage with the conjunct sites over and over again for the next few minutes, by touching them and then pushing my hand away. It is clearly meaningful to him, and he becomes increasingly more confident in pushing me away. He creates more space, not letting me get anywhere near his head. At a certain point, I feel the quality of interaction has changed. It does not feel like it's about conjunct sites anymore. For many older children and adults who were born by caesarian section, the invading hand of the obstetrician often shows up as a theme. This may be acted out in play, represented in artwork, or simply described as an emergent image during a therapy session. Working in this field over time, practitioners become attuned to the subtleties of these themes, and may receive subliminal information through the felt sense of what is happening in the relational field. My sense now is that Paulo is defending against the invading hand of the obstetrician. Again, instead of being helpless, he is able to create a strong and confident boundary. I reflect this back to him: "Wow, you are really strong."

With this sense of empowerment, excitement begins to build in Paolo's pelvis and legs, which seem to come alive. He moves his legs and squeezes his thighs together, pushing his pelvis forward in rhythmic thrusts. Before this, he had seemed disconnected from his lower body. In the last stage of birth, as they emerge through the pelvic outlet, vaginally-born babies push with their feet, extending their legs to propel themselves forward and out into the world. Missing this formative stage of self-empowerment, many people born by caesarian section feel disconnected from the pelvis and legs. With this integration of his lower body with his upper body, Paulo relaxes. The baby's body language ceases. His focus is internal, as feels into the new possibilities he has embodied. There is a sense of stillness in the room. I now engage with his parents, who have themselves become more present and embodied through witnessing the pro-

4. Some babies will intensify their crying when the birth story is amplified; others will stop crying, and move into a more immediate level of exploring new possibilities.

cess, with a sense of pleasure and wonderment. We discuss some of the themes that may have played out in the session.

As well as birth themes, prenatal themes (such as the mother-prenate umbilical relationship) and cellular memories relating to conception and implantation may emerge in therapy sessions. Each of these stages has recognizable baby body language and associated themes. Session outcomes depend on many factors. These can include the number of sessions, which might range from one to ongoing sessions over weeks or months, and to what degree the therapist is able to engage with the parents. The two main limiting factors tend to be parental, especially maternal guilt experiences, such as the sense "I hurt my baby," and the paradigm shift many parents must make to be open to the possibility of their baby communicating in this way. Through the building of trust, with non-judgmental presence, and inviting the curiosity of parents in witnessing what often becomes self-evident in the session, most parents are able to engage with the process in an open and interested way. Outcomes include deeper bonding and empathy with the baby, reduced periods or complete cessation of memory crying, better sleep, less fractiousness, improved feeding, and greater parental confidence. Being aware of the lifelong consequences of early trauma, we may also assume that there are longer-term benefits in terms of emotional and somatic health. Future research would be valuable. All babies and their parents can benefit from IBT sessions. Although IBT practitioners work with trauma, this is not the sole focus of the work. The deeper intention is the focus on health, the integration of prenatal and birth experience, and the facilitation of deeper empathic connection between babies and their parents. Having IBT sessions as a routine part of postnatal care remains an aspiration for the future.

Summary

The idea of babies benefitting from therapy is a foreign concept for most people, especially when a psychotherapeutic component is introduced and the baby is invited to engage as an active participant. From birth onwards, babies are often objectified, and terms such as "fussy baby" diminish their subjective reality. This in itself is stressful, and can be traumatic for babies, adding another layer of stress to what may be an earlier birth or prenatal trauma. Engaging with babies in a meaningful way that acknowledges prenatal and birth memories, along with a recognition of how these may be communicated, can free both babies and their caregivers from ongoing feedback loops of stress and isolation. This creates an improved experience of parenting, in which what was experienced as dysfunctional can now be experienced as meaningful, and can be appropriately engaged. For babies, the process offers an opportunity to enjoy their formative years with more ease, and to resolve early traumas before they become entrenched as trauma-based behaviors later in life. There is still much work to do in this field in terms of research and education. As Reich described it more than half a century ago, we stand at the edge of "an ever-widening horizon of knowledge of the child's true nature" (Reich, 1983).

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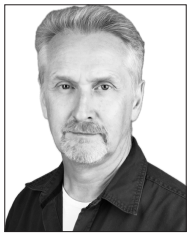

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REFERENCES

Augustini, D. (2013). *Craniosacral therapy for children*. North Atlantic Books.

Appleton, M. (2020a). Birth trauma: A cultural blindspot. *Pathways to Family Wellness* (65).

Appleton, M. (2020b). *Transitions to wholeness: Integrating prenatal, transpersonal and somatic psychology*. Cosmoanelixis.

Arbuckle, B. (1994). *The selected writings of Beryl Arbuckle, D.O., F.A.C.O.P.* American Academy of Osteopathy.

Beebe, B., Cohen, P., & Lachmann, F. (2016). *The mother-infant interaction picture book: Origins of attachment.* W. W. Norton & Company.

Brekhman, G., Turner, J., Turner, T., & Gouni, O. (2021). *The phenomenon of violence: From domestic to global* (3rd rev. ed.). Cosmoanelixis.

Csaszár-Nagy, N. & Bókkon, I. (2018). Mother-newborn separation at birth in hospitals: A possible risk for neurodevelopmental disorders. *Neuroscience & Biobehavioral Reviews* (84), 337-351.

Chamberlain, D. (1998). *The mind of your newborn baby*. North Atlantic Books.

Chamberlain, D. (2013). *Windows to the womb: Revealing the conscious baby from conception to birth.* North Atlantic Books.

Dahlitz, M. & Hall, G. (2015). An issue of the heart. *The Neuropsychotherapist* (Special Issue). Dahlitz Media.

Emerson, W. (1989). Psychotherapy with infants and children. *Pre and Perinatal Journal*, 3(3).

Emerson, W. (2004a). The Emerson prenatal stages manual. Emerson Training Seminars.

Emerson, W. (2004b). The Emerson perinatal stages manual. Emerson Training Seminars.

Farrant, G. & Larimore, T. (1995). Six universal body movements expressed in cellular consciousness and their meanings. *Primal Renaissance: The Journal of Primal Psychology*, 1(1).

Feher, L. (1980). *The psychology of birth: The foundation of human personality*. Souvenir Press.

Firth, U. & Firth, C. (2003). Development and neurophysiology of mentalizing. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences*, 358(1431), 459-473. https://doi.org/10.1098/rstb.2002.1218

Fuckert, D. (2011). Children as teachers. *Annals of the Institute of Orgonomic Science* (11).

Gober, M. (2018). *An end to upside down thinking: Dispelling the myth that the brain produces consciousness, and the implications for everyday life*. Waterside Press.

Goskan, S., et al. (2015). fMRI reveals neural activity overlap between adult and infant pain. University of Oxford. https://www.ox.ac.uk>news>2015-04-21-babies-feel-pain-like-adults.

Grof, S. (1990). *The holotropic mind: The three levels of human consciousness and how they shape our lives.* HarperSan Francisco.

Grof, S. (2010). *Holotropic breathwork: A new approach to self-exploration and therapy.* Excelsior Editions, State University of New York Press.

Highsmith, S., Blasco, T., White, K., Melin, M., Jackson, M., Kelsey, C. & Leigh, I. (2002). Supporting families to integrate their birth experience: The BEBA clinic retrospective study. Beba Clinic.

Janus, L. (2001). *The enduring effects of prenatal experience: Echoes from the womb.* Mattes Verlag GmbH.

Laing, R. D. (1976). *The facts of life*. Penguin Books.

Lake, F. (1986). *Clinical theology: A theological and psychological basis to clinical pastoral care.* Darton, Longman & Todd.

Lake, F. (1981). *Tight corners in pastoral counseling.* Darton, Longman & Todd.

Neill, A. S. (1953). *The Free Child.* Herbert Jenkins Ltd.

Noble, L. (1993). *Primal connections: How our experiences from birth influence our emotions, behavior, and health.* Simon & Schuster.

Nugent, K. & Morell, A. (2011). *Your baby is speaking to you: A visual guide to the amazing behaviors of your newborn and growing baby.* Houghton Mifflin Harcourt.

Odent, M. (1989). *Primal health: A blueprint for our survival.* Century.

Peters, J. (1989). *Frank Lake: The man and his work*. Darton, Longman and Todd.

Reich, W. (1983). *Children of the future: On the prevention of sexual pathology*. Farrar Straus Giroux.

Ruppert, F. (2016). *Early trauma: Pregnancy, birth and first years of life.* Green Balloon Publishing.

Sanders, M. & Thompson, G. (2002). *Polyvagal theory and the developing child: Systems of care for strengthening kids, families and communities.* W. W. Norton & Company.

Sills, F. (2003). *Craniosacral biodynamics, Volume 2: The primal midline and the organization of the body*. North Atlantic Books.

Sills, F. (2009). *Being and becoming: Psychodynamics, Buddhism, and the origins of selfhood.* North Atlantic Books.

Shanker, S. & Barker, T. (2017). *Self-reg: How to help your child (and you) break the stress cycle and successfully engage with life.* Penguin.

Sheldrake, R. (2012). *The science delusion: Freeing the spirit of enquiry*. Coronet.

Stern, D. (1998). *The interpersonal world of the infant: A view From psychoanalysis and developmental psychology.* Karnac.

Svanberg, E. (2019). *Why birth trauma matters*. Pinter & Martin Ltd.

Terry, K. (2002). *New parenting can change your world.* The Institute of Pre and Perinatal Psychology.

Verny, T. (2021). *The embodied mind: Understanding the mysteries of cellular memory, consciousness, and our bodies.* Pegasus Books.

Whitmont, E. (1993). *The alchemy of healing: Psyche and soma.* North Atlantic Books.

Winnicott, D. W. (1986). *Home is where we start from*. Penguin.