Early Emergence of the Subject through Haptonomic Antenatal Affective Contact

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Introduction

The education I had was quite special: as early as 1939, Françoise Dolto said that the foetus and the newborn were human beings that could feel pain and joy. Everybody thought that she was crazy and at school I was made fun of because I was the daughter of this crazy woman.

Beginning my medical studies with such an obvious element helped me to focus my practice and thus gain a lot of time. This talk is the result of 31 years of haptotherapeutic clinical work with men, women and children in difficulties and of haptonomic accompaniment of pre- and post-natal pregnancies, normal or pathological ones.

Frans Veldman, a Dutchman, discovered and developed Haptonomy in 1945. He defines it as the science of Affectivity and psychological-tactile (haptic) contact. Frans Veldman defines the Affective (with a capital A) as what in the psyche especially concerns the intimate life of feelings, emotions, sentiments, and binds the body and the psyche. Without the Affective, the body is only functional, and the psyche only rational. The Affective determines our loves and our hatreds as well as our engagements. It is expressed, among others things, by changes in tone due to the sub-cortical ways and in immediate hormonal secretions which can be identified clinically.

Haptonomy is named after the Greek verb 'hapto' which means, 'I take contact'. It is a phenomenological, empirical (from the Greek 'emperia', experience) and human science; it enables one to approach the human being, in his entirety, in the reality of the meeting, in the 'here and now', avoiding any dissociation or hierarchy between body and psyche united by Affectivity. Haptonomy gives a huge place to affective life and it is a way to get out of the duality – body and

psyche – in which Western thought has been stuck for centuries.

Haptonomy builds a phenomenality, which means a corpus of observable, identifiable and reproducible phenomena that characterise the human affective life. The skin is tremendously important. It is the first sensorial organ the child may use in-utero (the skin receptors are functional as of the seventh week of gestation) and the first organ of communication and exchange. The sense of touch is the single sense that is always reciprocal. We use a peculiar contact, which needs to be learned and which we call Psycho-Tactile Affective-Confirming Contact.

Affective Confirmation

According to haptonomy, the subject, being an autonomous source of desire, searches for security as early as conception. For this, he discriminates, very precociously, between what's good and what's bad for him. The psycho-tactile affective-confirming contact provides this affective confirmation. It is indispensable for the right development of the subject, who can then unfold all the possibilities gathered in his significant constellation, whose phylogenetic and ontological data are basic elements. Thanks to epigenetics we know now that, in order to express it, the genetic data need representation experiences, meetings, in which the fact of experiencing his goodness, in a mutually experienced affective environment of security, plays a decisive part.

The experience of pleasure, in an environment of affective security and reciprocity, enables the individual to mature, his intellect to blossom, and brings psychic well-being. Because of the structural importance of pleasure, we will speak about sensuality and not sensorial, from the beginning of foetal life. Sensuality – meaning here the sensorial perceptions factored by a feeling of pleasure or displeasure; of security or insecurity. This already plays a big part in pre-natal life.

Clinic of the Haptonomic Accompaniment

We receive the couples in individual sessions, if possible, starting right at the beginning of pregnancy, but most people only start at the fourth or fifth month of pregnancy. Though if a situation of distress arises for the child, the mother or the father at a later stage in the pregnancy, an experienced haptotherapist can intervene to propose a different kind of work adapted to the urgent situation. I quite often receive women who are running the risk of a premature delivery.

This kind of approach relies on the desire and the involvement of both parents.

Basically we work with both parents. If the father has disappeared for good, the mother will be asked to choose another person to accompany her. This person, most of the time a woman, won't be a substitute for the father, who is present through the child whatever the situation, but will enable the child to avoid a dual relationship with his mother, which would be oppressive for both of them. The third person, be it the parent or not, is the one who opens up the relationship and therefore prevents the mother-child fusion. The pre-natal work must absolutely be followed by post-natal sessions, we carry them child in a very specific way. The last session, a very important one, takes place when the child stands up and starts walking.

The Intimate and the Extimate in the Secrecy of the Mother's Womb

The psycho-tactile affective-confirming contact activates the sub-cortical channels as well as the whole limbic system and has direct effects on hormonal secretions (endorphins, cortisol, serotonin) and on the muscular tonus. As soon as a woman has established an affective contact with the child she's bearing in her womb, her muscle tone modifies, creating an important change in her perceptions of her own body. She feels relaxed, at ease and the muscle tone of her uterus gets much more supple, even though she may have a hard time on an emotional or physical level. Her breath changes, without her even knowing it, her joints become more flexible. The child perceives these

changes and immediately reacts to them by a slight move of the spine.

Thanks to the possibilities offered by the affective contact, a woman can rock her child from within, inviting him to move towards her heart or her pelvis, to one side or the other, due to the modification of tone that she thus induces in her womb (the uterus and abdominal muscles experienced collectively as a tender, welcoming place for the child.) The child is moved in the direction towards which she invites it. If it is awake it goes along with the movement. That's how a mother can invite one twin towards the top and the other one towards the bottom, enabling a specific playtime with each of the children. The discovery of these possibilities is always a very joyful surprise for the mother. It is even more important for a depressive mother, or for an ambivalent mother who hesitated to keep her child, or for a mother who feels powerless to help a child who is in danger. One can imagine how those contacts help in case of fear for premature birth or for amniocenteses.

From the Father's Point of View

The father first alerts the child of his presence through his manner of accompanying the mother. We teach them different ways to bring comfort to the mother, through rocking and easing the arch of the back. This simple contact, if it is affective-confirming, modifies the mother's muscular tone. It brings to her, thus to the child, relaxation and ease. If a tensed and tired woman lies down, the child starts moving intensely, in a jerky and abrupt way, enjoying the relative ease in the uterus provided by this position. But if the father applies a light and tender touch on the mother's bosom, the child stops moving and remains quiet under this hand, which reassures both mother and child. After 5 to 10 minutes of quiet rest under this soothing hand, he will start his games again with a calmer, softer motility.

Fathers also play a very important part for their children through their voice. Contrary to the mother's voice, which always vibrates the womb, in the same way, the father's sporadic voice envelops them from different points and enables them to consider space. As of the third month of pregnancy, children

react to a voice that is directed at them. If they like it, they go nearer (unless the mother prevents them from doing so). Until the beginning of the third trimester of the pregnancy, hearing is not functional; but the skin, the muscles and the bones catch vibrations. I have been told that ancient obstetricians saw the skin of the foetus as a big ear. We experience this everyday.

From the Child's Point of View

The foetus gives motor answers. They come nearer, go away or sway by moving their pelvis, by leaning or pushing on the uterus wall in an infinite number of variations. Twins play together. But motility is a very subtle language, moving is not necessarily answering; stamping one's feet is not swaying. Rhythm, amplitude and the direction of each movement are important to understand within the complexity of interactions between anatomy and physiology. When everything is fine, the mother accompanies her child from within in each of its movements, even without noticing it, thanks to what we call a pre-logical, pre-rational affective awareness. But she can as well immobilise her child if she is not feeling well, if she is afraid, or if she is having a conflict, consciously or not, with the person who is trying to approach her child.

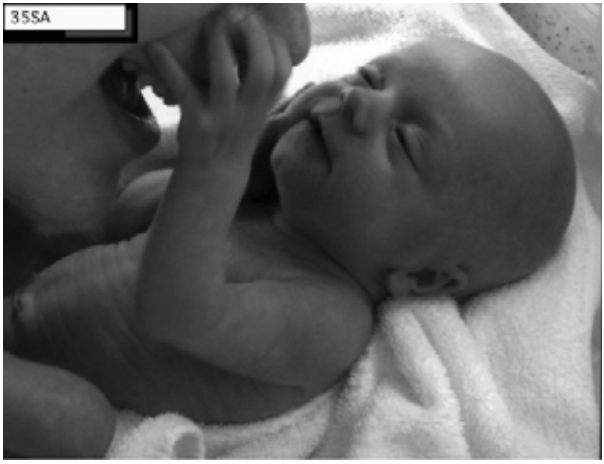
We find out that, long before birth, children are paying attention to everything that surrounds them, messages coming from their mother through the highly subtle interactions which bond them, but also exterior sounds and atmospheres. They receive them through their mother's feelings but also directly. They seem to be alert to any kind of sign. If a gentle and light hand calls them, and then withdraws, they look for it; a real 'hide and seek' game starts as long as the child is available. If the hand comes quietly, children will come and nestle under it and stay there. All children imperceptibly sway to the mother's breath. If we invite them to magnify their movement and they are awake and available, they take control of the swaying: its amplitude, rhythm, length and direction. They can choose a lateral or up-and-down swaying, or a whirling around their axis, this movement being always very slow. These are real dances we perceive very clearly under our hands, to the point that the parents and the accompanying person feel the child is now rocking them.

As of the fifth month of pregnancy, children are able to choose one kind of swaying, to memorise it, and moreover, to propose it to their parents, provided that the mother is available. Some children like only one kind of swaying; others change and go from one to the other every five to ten seconds. We communicate with them through slight changes of hand weight and pressure. They express themselves, each in their own way, surprising their parents who thus get to know them long before the birth meeting. These dances are not only joyful manifestations, in reaction to our invitation or on their own initiative; they are also precious signs of their state. A child who isn't well will neither sway nor invite his parents. This is why prematurity can be so difficult. Many of them escape into their own world and anaesthetise their perceptions; they dissociate themselves, which later on will influence their way of living. I am often brought some newborns, just coming out of neo-natal services, who are suffering from what I call the 'Sleeping Beauty Syndrome'. They are passive, waiting to be animated, to be brought back to life. You really have to strongly call upon them, physically but also on emotional and psychic levels, to help them get out of this survival state, which is not really life.

Tragedies

Such a vast and complex subject deserves a lengthy development. I can strongly affirm today that, as of the uterine life, children can help their parents when going through difficult moments. The Subject is already there, fully involved in exchanges. I call it 'proto identity'. Are they already driven by a therapeutic urge? This is difficult to prove, but they assert themselves concretely in crucial moments in a singular manner. When women are ambivalent, self-derogatory, feel guilty for not being the ideal mother they had imagined, hurt by the news of a handicap or by a mourning, very often the child is the one who comes to help them in a most efficient way. It rocks quietly, while she is crying or saying very painful or violent things. Sometimes it goes up to her heart in the deepest moments of despair. That's the child's way of telling her that she is a good enough mother. Even if she considered having an abortion or if she doesn't feel capable of being a mother, the child shows her that here and now she is ITS mother and that it is doing fine. It is obviously a great help for the mother,

who is thus surprisingly able to get over very painful hurdles.



35 weeks premature baby helping its mother

I must admit that I am not always able to say what is really happening during the period of what I like to call the 'totally intertwined mother and child'. Who signals whom? It's not always possible to know, but a good accompaniment should only help to enable the bond to be permeable between the two, and then these astonishing and undoubtedly effective affective exchanges will happen before our eyes. When a woman is not well, the presence of the father (or the third person) is essential, because the child reacts to his approach and this helps the mother to come back to her child. A bi-polar situation would lead them to a dead-end, a total incapacity to change, symptomatic of a bond frozen in pain and reinforced by the feeling of guilt. But the third person, contacting the child, enables it to assert itself and find its path towards its mother.

The suspicion of a handicap, for which you might have to wait weeks before getting a confirmation or invalidation, leaves long lasting traces. Some parents come to me because they want to contact their child who is going to suffer a medically required abortion because of a severe malformation. These sessions

are always moving and strangely enough, both sad and happy. Parents then have the opportunity to 'hold the hand' metaphorically of their condemned child until the end. During its short in-utero life, it will have received the goodness of their affection. That's exactly how you accompany a sick child to the end of its life too. We work then for the future of the parents, brothers and sisters already here or to be born. Experience has taught us that mourning is thus easier to 'do', whereas a mourning that wouldn't have been properly done would weigh on several generations. When they finally learn that the karyotype is normal, the child still needs to be helped to face life once the ordeal of doubt is over.

Traces of these moments of doubt may poison the life of a family for years. Parents then have to retie a bond of confidence with it. The affective exchanges give the child the courage to live. This is pretty obvious when the child has to go through a very medicalised birth and a period in neo-natal services. Children with a good accompaniment fight for life but remain quiet. They have developed a strong tolerance for frustration. This happens very quickly. Sometimes, we contact for the first time, very late in the gestation, children who have endured a lot of ultra sounds, or even some foetal surgery. When I apply my hands, even though the mother knows and trusts me, those children go through a moment of panic and of abrupt agitation, before slowly regaining peace. These children are intensely prone to contact, as if their ordeals had given them, more than to others, the taste for communication.

Inhibition and depression are inseparable and it is interesting to discover that they are already tied in prenatal life. Depression inhibits the maternal feeling or a mother's capacity to express it. She tightens her womb around the child and thus inhibits the relational dynamics of the child. This has definite effects on the constantly, quickly evolving child. Anxiety and anguish have the same inhibiting effects. The child withdraws, loses its impulses, just as if it were trying to fade away, then suddenly moves very abruptly or stamps his feet. Even if the child's development is not most of the time modified to the point of being medically serious, the post-natal work with children shows that there are some traces left on the personality. Direct and indirect traces coming from the experience of the mother before and during the birth strongly influence her

behaviour with the baby.

There is no doubt that early pre-natal ordeals or problems in the weeks following the birth leave much deeper influences than we thought until now. During the first nine months of life, what Françoise Dolto had suggested to us has been confirmed: children (and their parents) experience anniversary syndromes, (described by Anne Ancelin Schützenberger, Nicolas Abraham and Marika Torok in their works on trans generational pathology) related to difficult periods of the pregnancy. The anguish of the eighth or ninth month can be considered as an anniversary syndrome of the anguish experienced by the mother (and/or father) and hence the child around its birth. If a child or its parents go through an ordeal at four or five month of the pregnancy, we have to recommend that the parents be very attentive to their baby when it reaches four or five months after birth. Very often they experience some sort of dysfunction. Merely speaking with them about what happened for them and their parents at the fourth or fifth month in the womb makes everything return to normal.

This knowledge shouldn't upset parents and practitioners facing traumatic events and their inevitable effects. On the contrary, knowledge of these powerful Affective interactions around pregnancy enables us to help a great deal by giving the chance to speak about old or current difficulties in an affective proximity with mother, father and child, replaced in a very specific way on the mother's belly. By allowing each one, especially the child, to take its place, within the dignity of its story, there is an immediate therapeutic effect and it becomes free of too heavy a burden. Some children start psychotherapy at around six or seven years old, with a pathology that makes me immediately think about a birth story. If this happens to be the case, we just need to tell the story, making him the hero of the story, his story, from which he came out victorious, which proves he has powers that he can rely on. We then see the child straightening up and entering his story, being proud of it, no longer crushed by it. This should always be tried before giving up when a child or a teen that had early pre or postnatal problems is in trouble.

Memories of pre-natal pains or difficulties during the first separation, the birth and the delivery arise throughout life each time there is an abrupt transition, a separation, each time it is necessary to get mobilised to play a part in the world. In these moments, the effects of early maternal depression, pre-natal tragedies or traumatic birth reappear, particularly during adolescence (but also at the menopause or when retiring). We notice that the child or the teenager experiences heavy inhibitions to act, to dare, which might put them in a conflicted position, because they live with a strong desire to express themselves. The child who is born in fear, in anxiety, who has spent months in an incubator, who tried to be born, but in vain, or on the contrary who has been born asleep when he wasn't ready, bears traces of this trauma, such as forbidden dynamics, lack of confidence in himself, in life, in others, lack of courage and strength. We can work on all this in a much simpler way than we think. It is surprising to see the power and duration of the positive or negative impact of these first deep affective imprints. People, until old age, can suffer because of a defective bond with their mother as small children, or alternatively, in good cases can be supported and carried through the hardest ordeals by the mutual trust and the affective security they experienced in the most archaic part of their life. The first psycho-affective layer has an incredible value.

After 30 years of clinical practice of pre- and post-natal haptonomy, I can say, with many others, that well accompanied babies are calm, smiling and easy. For them, the pediatric semiology must be re-defined, since they undergo the clinical examination with confidence even when in pain, because they are very confident. They cry little and are pain enduring; they have better posture tone and less hypertension of members. The most peculiar aspect is their 'presence' and their capacity to take their place in life. Of course, as a consequence, haptopsychotherapeutic work with parents and children also opens new perspectives.

These discoveries call upon our individual and collective responsibility.

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