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Sample Chapter Package
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TRAUMA INTEGRATION

in the

NEONATAL

INTENSIVE CARE UNIT

APPLICATION OF CASTELLINO

PRENATAL AND BIRTH THERAPY

SAMPLE CHAPTER PACKAGE

Zephyr

NONFICTION
May 2024

CONTENTS

States of Grace

NICU as Womb Surround

Topic Cross-Reference

Bibliography

Index

PREFACE

This book is an invitation. To everyone who loves neonates – parents, siblings, nurses, neonatologists, occupational therapists, prenatal and birth practitioners, osteopaths, and biodynamic craniosacral therapists – please join me in the neonatal intensive care unit (NICU). Let's support each other to support babies to grow, heal, integrate trauma, and attach to their families in resonance.

I ask because I can't do it alone. Which is to say, no one can do it alone. This is the fundamental message of this book. As Ray Castellino used to say, *babies do not arrive alone*. They come with families, with caregivers. It is the energetics of the relational field of those who come with the baby that set the baseline for regulation of the neonate's autonomic nervous system.

Within the context of the NICU, it is the energetic field of the collaboration of family, medical personnel, and all supporting specialists that sets that baseline. How we treat each other, how we come into and maintain connection, how practiced we are at holding center-ground-neutral, how we offer each other *mutual support and cooperation* – this defines the nature of the field within which the neonate regulates or not, connects with their impulse or not, integrates trauma or not, and benefits from allopathic interventions or not – or, alleviates the need for such interventions.

To do this right, we need each other. Neonates need us. They need us to do this right.

This book shows what happens when we do it wrong. This book illuminates why efficient communication, camaraderie, and teamwork are not enough. Despite the self-sabotage of our belief that we must all go it alone – the doctor treats alone, the nurse cares alone, the cuddler comforts alone – some good things still happen. I hope the stories in this book of one cuddler going it alone, trying to be a resonant field alone, are enough to pique your interest, maybe even stoke your passion to discover what we could accomplish together.

Something potent is happening. *Trauma Integration in the NICU – Application of Castellino Prenatal and Birth Therapy* is offered in hopes that it may inspire the medical directors of NICUs to consider *something else*. To realize that stabilizing the autonomic nervous system is the root of healing and that attending to the energetic realm supports improved outcomes. I hope that this book benefits parents and NICU nurses, who, beyond neonates and infants, stand to gain the most from the introduction of Castellino Prenatal and Birth Therapy (CPBT) into the NICU. For, when we give neonates and infants all the support they need, parents and NICU nurses will have received all of the support they need.

I hope that this book may inspire parents of children in the NICU to discover the deep connection they can have with and support they can provide for the soul(s) they have brought into this world. I hope it will serve as encouragement for CPBT and biodynamic craniosacral therapy practitioners to enter the NICU, where they otherwise may not go. The efficacy of the work will only increase as we bring in more *layers of support*.

For the layperson, whether or not they are a parent, I hope this book may reveal the great sensitivity and intelligence with which they entered this world, the accurate reflection they needed and likely did not receive, the old trauma they carry in their body that has become unspoken weight. Most of all, I hope the book will help them find the courage to feel the pain of that early loss that they may step into their full self.

INTRODUCTION

Dr. Raymond Castellino

I first heard of Dr. Raymond Castellino – whom I came to know as "Ray" – from my bodyworker at the time, Victoria Sloan. Victoria is an exceptional bodyworker who has trained with Marion Woodman, Hugh Milne, Judith Aston, and Harvey Ruderian, among others. Victoria encouraged me to attend a womb surround process workshop (womb surround) with Ray, which turned out to be the most transformative experience of my life.

I don't want to minimize the benefits I've received from thirty years of inner work in the tradition of depth psychology and twenty-five years of receiving different forms of bodywork. However, the relatively short amount of time one invests in a womb surround, the depth of transformation, the sustainability of the change, and the accessibility to the layperson make it hands down the most powerful healing modality I've encountered. It should also be said that participation in a womb surround requires a level of ego strength that I perhaps could not have attained without the prior and ongoing support of depth psychology and bodywork.

At the time of my first womb surround, I had been seeking for approximately fifteen years a healing art to practice. I did not imagine myself capable of returning to school to attain the necessary qualifications to practice as a depth psychologist. Nor can I say that sitting in a chair and talking held appeal as a form of practice. The womb surround had a physicality, as well as an experiential quality that attracted me. I knew from the first that I wanted to conduct womb surround process workshops.

Much credit is due, again, to Victoria Sloan for encouraging me to apply to attend Ray's Foundation Training in Castellino Prenatal and Birth Therapy (CPBT). I was decades into my career in

construction management and would have taken far longer to build up the nerve to attempt such a radical departure from my expertise. My respect for Victoria and her confidence in me gave me the courage to open that door. Thank you, Victoria, for changing my life!

I feel tremendous gratitude toward Ray for developing this body of work that has changed me, as well as for accepting a construction manager into his training. I'm sure he felt affirmed in his decision when, on the first day of training, I pulled a buck knife out of my backpack and jimmied open the locked patio door, providing much-needed ventilation. Ray was exactly the teacher I needed. His emphasis on experiential learning paired well with my hands-on nature. His subtlety, which I later discovered could drive others to exasperation, preempted my tendency to push against authority. He provided just enough for me to understand the question; I loved discovering things on my own.

In regard to the womb surround, this is Ray's invention. The safety of that container is unparalleled. I have done so much deep, profound, transformative work within that modality, as well as witnessed others do the same; I will be forever loyal to this work. At root, the womb surround is Ray and all of the people in the surround showing up for the turn person – *being with* the turn person; proceeding or pausing at their pace; following their cues as to what they need; affirming their story verbally, energetically, somatically. It is the experience of being met. Ray showed up with his body. In my personal work, Ray was on the ground rolling with me, providing *dynamic creative opposition* and somatic reflection, supporting me, protecting me. The quality of support from the surround and Ray fostered an extraordinary experience of feeling seen and heard, of being able to settle within myself, of connecting to my inner impulse.

Never did I perceive any kind of sexual energy toward myself or anyone else. This was not an accident. This was a conscious choice from a person who understood the importance of respecting boundaries and preserving the clarity of roles. That alone was such a gift. To feel safe. Thank you, Ray.

Ray was professional not only in his comportment, but in every aspect of his approach to the work. The extent of our reading list and Ray's facility at placing the works within the evolution of the fields of prenatal and perinatal (PPN) psychology, trauma integration, osteopathy, craniosacral therapy, and polarity therapy inspired confidence. Ray understood the contributions of his predecessors and peers. Ray's study of obstetric practices throughout the 1900s let him meet any person in a womb surround with an awareness of the practices common at the time of their birth. Ray's videotapes of his family sessions were an invaluable tool for refining his work, as well as a resource for the families, and, with the families' permission, incomparable teaching aids.

The arc of my time with Ray spanned eleven years, roughly, the last decade of his life. I participated in seven womb surrounds facilitated or co-facilitated by Ray, assisted four womb surrounds that Ray facilitated or co-facilitated, and, Ray and I co-facilitated one womb surround. In addition to his two-and-a-half-year CPBT training, I attended Ray's trainings, Introduction to Polarity Therapy and Body Into Being. The latter was a five-module, one-year course in advanced energetics that was co-taught with Anna Chitty. Over the years, I had numerous personal sessions with Ray.

As graduation from the CPBT training drew near, I approached Ray to ask what I could do to apply my training while still working full-time as an engineer. His response was – be a cuddler in a NICU. I don't think either of us could have anticipated the implications of such an undertaking. I certainly did not fathom that holding multiple neonates in one night would feel the equivalent of conducting a womb surround every week. Fresh from two-and-a-half years of training, I did not imagine that cuddling in the NICU would humble me and force me to fight to muster the resources – inner and outer – to show up and recover every week.

Maybe Ray foresaw exactly where it would lead. He held the better vantage. Though never in a direct manner, Ray made it known that he would like me to write about his work. He was fond of my novel, having read a couple of drafts, as well as the final publication. When I first assisted a womb surround for Ray, he was co-facilitating with Mary Seamster, a prior CPBT graduate who had adapted the

work for aquatic expression. The evening before the womb surround, Ray and Mary held a private conference from which Mary emerged to say, “I think he would like you to write about the work,” to which I replied, “I don’t have anything to say.”

At heart, I am a writer. I don’t write what I choose. I don’t write what others choose. I write the stories that choose me. As my awareness grows of a piece that needs to be written, my relationship with the project, which may not commence for years, takes on a sense of moral obligation. I don’t understand writers who say, “I think I’ll write about *x* next.” I have never had such liberty.

I don’t remember when I first felt that I did have something to say about CPBT and trauma integration in the NICU. I can only say there came a time when I began to comprehend that I was unique – not for my expertise in CPBT, nor for my expertise in biodynamic craniosacral therapy (BCST), nor for my expertise with neonates. At some point, I came to understand that I may be the only person with training in CPBT and BCST who has more than a decade of experience applying these arts to trauma integration in the NICU.

While writing the manuscript, I came across notes from a phone conversation with Ray that occurred about three months into my service in the NICU, in which he had said,

> *You are doing something no one has ever done before. I’m happy to hear how you’re doing. Keep me posted and let me know if I can help.*

I wish that I had called upon him more. In the writing of the manuscript, it has grown clear for me how rich the conversation could have been, how much my work in the NICU and the writing of the book could have benefited from his insights. I did not begrudge Ray’s passing in 2020. He had shared things with us that led me to imagine his soul found joy in returning to that something greater. But, I miss you, Ray.

Contents and Structure

It has been my custom to handwrite notes of each session immediately upon leaving one neonate or infant and before holding the next. From time to time, a session would make such an impression upon me that I transcribed and elaborated the notes into a full, typed narrative at the earliest opportunity. The source material for the vignettes in this book is my handwritten notes and/or the previously typed narrative.

The contents of this book are circumscribed by the extent of my notetaking. In this sense, the book had to be built from the ground up. I first culled from over ten years of notes those sessions that seemed to merit inclusion, rejecting those for which the notes contained insufficient detail. The selected sessions were then categorized by topic, with many sessions corresponding to multiple topics. These topics are the chapter headings.

All of the topics were posted on my writing wall. In the course of writing, some topics were removed due to a lack of supporting vignettes. As I attempted to write a vignette, there did not always appear to be enough information from which to develop a story. I would resist the impatient impulse to toss it. In me something lived of the feeling of being with that particular neonate or infant. I had to discipline myself to slow down and connect with that feeling, to "see" what was not, at first, apparent.

It was an experience of discovery. I may have read the notes of the session numerous times. They may have seemed mundane or cryptic. Impressions of the session may have been written in chunks that were not chronological. Often, I had to return to my original handwritten notes for clues to decipher the salience of the session. The slant of my script or arrows denoting sequence had been lost in the typewritten transcription. Many times, my effort was rewarded when what had seemed innocuous came into resolution as poignant or compelling. It was thrilling to discover a narrative that did justice to the session.

This is a note I scribbled while drafting vignettes:

> *The challenge is like birth every time. The notes written in random order. The typed version sanitized, lacking the clues of the handwritten form. At first, it is impossible to get a feel for where the story is going, if it's going anywhere. Maybe I should trash this one. I work with it and think I get the sense of it. I continue refining and then something magical, like being born, I see the light and I'm in tears.*

As the vignettes for a topic were completed, that topic was moved to the "finished" side of the wall. One day, as I looked up at the majority of topics then randomly amassed on the finished side, the structure of the book came into focus. It happened in a moment. I recognized the four groupings that would comprise the four parts of the book: Castellino Prenatal and Birth Therapy, NICU Basics, Biodynamic Craniosacral Therapy, and States of Grace.

It must be understood that the intention of this book is not to provide a comprehensive discussion of the four parts. For example, Part I, "Castellino Prenatal and Birth Therapy," consists of the following chapters: Coregulation, PPN (Prenatal and Perinatal) Affirmation, Merging and Differentiation, Confidentiality, and Self Care. While these are all concepts within the realm of CPBT, collectively, they constitute a small portion of the body of CPBT teachings. For a thorough presentation of Ray's life and work, please look for the forthcoming publication of his writings and teaching manual by the Castellino Training Corporation.

Part I provides exposure to the CPBT approach. Part II, "NICU Basics," applies CPBT to issues common to the NICU: Crying, Pacifier, Inconsolable, Lack of Connection, and Newborn. Part III, "Biodynamic Craniosacral Therapy," demonstrates the application of BCST in support of trauma integration: Sensory, Field, Occiput-Sacrum, Ventricles or Tracking the Minnow, and Luminous. Until

recently, certification in BCST was a prerequisite to becoming certified as a practitioner of CPBT.[1] This was a major motivation in my becoming an RCST®, registered biodynamic craniosacral therapist. To some degree, I was checking a box. However, the more I practice BCST, the more I realize that it *is* the work. CPBT is inseparable from BCST. Becoming the best BCST practitioner that I can will make me the best CPBT practitioner that I can be.

Part IV, "States of Grace," addresses exceptional circumstances encountered in the NICU: Prejudicial Diagnoses, Withdrawal and Drug Imprint, Selfhood, and Who Regulates Whom? The book closes with Part V, "The NICU as Womb Surround." The womb surround process workshop is the hallmark of CPBT. Throughout the book, there is a dialectic between the behavior, expression, and trauma integration process of neonates and infants in the NICU and that of adults in womb surrounds. Each informs the other.

Similarly, plumbing the depths of the dialectic between the form of the NICU and the form of the womb surround will empower all present – neonates, infants, parents, nurses, and all caregivers – to manifest their full self within the resonance of a social nervous system and to contribute to the healing of one another. Not only will this lead to heightened stabilization of the patient's autonomic nervous system, it will yield the most efficient path to the greatest health in both energetic and allopathic terms.

The NICU

I would like to acknowledge the NICU that made all of this possible. It is a cutting-edge, Level IV NICU that prides itself on constant self-evaluation, restructuring, and updating of approach in order to provide the best possible care. I cannot count the number of times that the NICU has been reconfigured in

[1] Some other forms of energetic and somatic work are now allowed in lieu of biodynamic craniosacral therapy.

order to focus new protocols on a target population. Introduction of the cuddler program was, itself, one such advancement.

I believe this culture of constant improvement contributed to my being invited to join the cuddler program. I had been told that because of my CPBT training I had been jumped ahead of 750 people on the cuddler wait list. After my interview, the manager of the cuddler program told me, "I think you're going to do great things for babies." Her enthusiasm was genuine and I have felt tremendous support as a cuddler. Yet, I have not felt that there has been space to speak of the work I am doing. The manager of the cuddler program, the NICU nurses, other NICU personnel, and other cuddlers have no context for understanding the CPBT approach. My hope that this book will bridge that gap has been a major motivation for writing it.

This is an excerpt of the hospital's description of the cuddler role:

> *Working and busy parents take great solace in the fact that if they can't be at the hospital during daytime hours, NICU "cuddlers," who are hospital trained, are there to provide that "human touch" so desperately needed by all babies, especially those in the NICU.*
>
> *The "cuddlers" provide therapeutic talk and touch – they don't feed, change diapers or walk around with the babies. They simply hold them, read to them or quietly singing [sic] to them. It is required that the NICU "cuddlers" hold them for a minimum of 45 minutes up to four consecutive hours, providing the infant comfort and appropriate stimulation. The work the "cuddlers" do helps preemies grow faster, so they can go home to their families sooner.*

Everything that I do falls within the parameters of "talk and touch . . . hold . . . or [sing] . . . comfort and appropriate stimulation." The difference is that I do so with conscious intention. I hold

presence and listen. That is really all that I do. The unfolding of a session is determined by the client. My holding presence invites the neonate or infant to be present. The quality of my listening, including the provision of accurate reflection, invites them to share what they would like to share. The difference is that my CPBT training helps me recognize when the neonate or infant is expressing. Being seen may encourage the neonate or infant to express further or it may help resolve a tension (trauma) such that they can settle and sleep.

Trauma Integration in the NICU – Application of Castellino Prenatal and Birth Therapy shows how effective the CPBT approach can be – or not – when applied by a single cuddler. *Layers of support* and *caregiver resonance* are key elements missing from the work of a lone cuddler. Consistent with polyvagal theory, the neonate and infant develop within the field created by their caregivers. As conveyed throughout the book in glimpses of the CPBT training, the interior of womb surround process workshops, and the transformation that occurs during BCST sessions, the full efficacy of CPBT in the NICU requires the resonance of a field of conscious caregivers – parents, siblings, nurses, neonatologists, occupational therapists, prenatal and birth practitioners, osteopaths, and biodynamic craniosacral therapists. This is not optional. The resonant field is the birthright of every neonate.

It is also the birthright of the parent, NICU nurse, the neonatologist, the occupational therapist, family members, and all caregivers. What we do for the neonate, we do for ourselves. Ray would say,

> *When the needs of the youngest person in the room are being met, the needs of every person in the room are being met.*

This refers to multiple *layers of support* for every caregiver. The robustness of the support is perceived by the neonate, who is able to avoid the pitfall of caretaking their caretaker, settle in the resonant field, enjoy the foundation of a regulated autonomic nervous system, feel safe in the quality of listening they are offered, and express themself.

One need that every caregiver in the NICU has is to be familiar with their own PPN material and have the resources to integrate their own trauma. It takes courage to work in the NICU. Nurses work twelve-hour shifts, often, several days in a row. Talk about a womb surround! Being around neonates invites the caregiver's implicit memory of their personal prenatal and perinatal experience to the fore.

Without PPN training and mapping of the terrain of their own PPN experience, the caregiver has no context for comprehending their preverbal life. It is unsettling and usually results in activation – speeding up, speaking louder, experiencing drowsiness, or minimizing the source – all forms of checking out, dissociating, and distancing the conscious self from implicit memories for which there may be no words. Minimizing the source may include showering affection on the neonate with expressions such as, "He's so cute!" and "She's a doll!"

In honoring the neonate, we honor ourselves. Nurturing the neonate means nurturing ourselves. I believe it was an intuitive sense of this that informed the writing of this poem for a friend's son years before I had any contact with the PPN field:

One Candle

We are here for you, Jeremy
Offering cake and candle
Blow out the light and taste sweetness

See the gifts we have brought?
We are here for you, Jeremy
Newly from the spirit world
Your wisdom we have lost

Wish for that most dear

Let your desire inform this gathering

We have come that you may tell us who we are

One candle, Jeremy

It will never be so easy

Soon you will know, as only a child can,

That this day is for you

Proudly claim every year

Happily sacrifice your light

Welcome your days of rebirth

We need you, Jeremy,

For we have grown ashamed of our years

And guilty of our desires

We have forgotten our sacred gifts

And tell our community there is nothing to celebrate.

Help us remember, Jeremy,

With your one candle

Remind us who we are.

This is the real work that is happening in the NICU. That could happen if we opened ourselves to work in resonance in support of each other and the neonates and infants in our care. When we do this, we open ourselves to what neonates have to teach us. This is not work for the faint of heart. Those who

choose this work deserve multiple *layers of support*, professional and personal. Castellino Prenatal and Birth Therapy, an integration of the disciplines of PPN psychology, trauma integration, osteopathy, craniosacral therapy, and polarity therapy, possesses the riches and resource to achieve this transformation of the NICU.

Zephyr

March 15, 2024

CONVENTIONS

- It is recommended to read the parts of the book in the sequence presented, as each part builds upon the preceding material. That said, some concepts may not be elaborated upon until well after their first use. This is deliberate emulation of Ray's experiential teaching style.
- "CPBT" means "Castellino Prenatal and Birth Therapy."
- With few exceptions, *italics* indicate words and phrases from Ray's repertoire that evolved over a quarter century of refining CPBT.
- With few exceptions, numerals are used to indicate age, heart rate, and respiratory rate, as well as to distinguish between nurses: Nurse 1, Nurse 2, etc.
- An age of 34.5 weeks means an age of 34 weeks plus 5 days, not 34-and-a-half weeks.
- Gestational age is the time from conception, measured in weeks.
- Chronological age is the time from birth, measured in hours, days, weeks, or months.
- A full-term baby includes babies born with a gestational age in the range of 37-42 weeks.
- A premature baby includes babies born with a gestational age less than 37 weeks.
- "Neonate" is a newborn up to one month old. "Infant" is a baby from one to twelve months old.
- The age of a premature neonate may be represented by what the gestational age would have been had the child remained in utero. Thus, "born at 34 weeks and now 35.6 weeks of age" indicates a premature neonate that has aged 1.6 weeks since birth. Whereas, "born at 34 weeks and now 2 months of age" indicates the premature neonate has aged 2 months since birth.
- Pacifiers are constructed with a hollow nipple, allowing the option of inserting a finger.
- "Gavage" means "tube." Gavage lines are feeding tubes that may be routed to various parts of the body: the stomach via the mouth (orogastric, OG tube), stomach via the nose (nasogastric, NG tube), stomach via the wall of the abdomen (gastrostomy, G tube), midsection of the small intestine via the wall of the abdomen (jejunostomy, J tube), etc.
- Cuddlers are volunteers intended to hold babies when parents cannot be present. Parents give advance consent for their child to participate in the cuddler program.
- Cuddlers can hold babies during gavage feeding. Bottle feeding is conducted by nurses.
- "+40" means forty minutes into the cuddler session.
- "PICC line" is a peripherally inserted central catheter. Typically, in this book, this refers to a larger diameter line inserted into the back of the hand for delivering nutrients and medications. PICC lines are used to minimize needle pricks over longer durations and to deliver inputs closer to the heart.
- "IV" is an intravenous line for delivering nutrients and medications. It is of smaller diameter and shorter length than a PICC line, and inserts into a vein.
- "Nasal cannula" is a tube with two prongs that fit into the nostrils to deliver oxygen.
- "PPN" means "prenatal and perinatal."
- "BCST" means "biodynamic craniosacral therapy."
- "NICU" means "neonatal intensive care unit."
- "Contact parent" is the parent who carries the pregnancy.
- "Guardian parent" is any parent who does not carry the pregnancy.
- As used in this book, CPBT encompasses BCST.
- "APPPAH" is the Association for Prenatal and Perinatal Psychology and Health
- "BEBA" is Building and Enhancing Bonding and Attachment, a CPBT clinic for families

ACKNOWLEDGEMENTS

CASTELLINO

PRENATAL AND BIRTH

THERAPY

Chapter 1

Coregulation

Coregulation refers to the energetic resonance between and among people that stabilizes the autonomic nervous system and induces the release of oxytocin, ushering in presence and resilience. One skill taught in CPBT is the decoupling of romance and sexuality from connection and resonance. This is a feat in American culture, which conflates sex with all kinds of touch and intimacy. Coregulation is essential for human beings and critical to early development. Development of the fetus and neonate is optimal when it occurs within the resonant field of the parents. The coregulating dyad of the neonate and the parent who carried the pregnancy – the contact parent – is paramount in the postnatal period through the end of the first year.

As posited by Stephen Porges' polyvagal theory, human beings are hard-wired, primarily via the vagus nerve, for connection and coregulation. The neonate must develop a relationship with a caregiver, typically, the contact parent, to ensure their survival. Eye contact, facial expression, touch, and speech, as well as silent, conscious presence are all means of fostering human connection. When circumstances dictate that the neonate resides in the neonatal intensive care unit (NICU), parent-infant bonding and attachment faces disruption.

The use of cuddlers in the NICU provides an additional *layer of support*, a cadre of people whose sole mission is coregulation to support settling, regulation, and sleep of the neonate. Deep sleep is critical for ongoing neurological development and can be difficult to obtain within the setting of the NICU. Coming into resonance with the cuddler can stabilize the neonate's autonomic nervous system, supporting coregulation and deep sleep.

The following six vignettes portray the practice and benefits of coregulation between neonate and NICU cuddler.

Dustin

A nurse asked that I hold Dustin, whom she was holding to soothe him. Dustin had been born at 40 weeks and weighing 10 pounds, 14.5 ounces. He was now 46.6 weeks and just under 12 pounds. The two blankets over the nurse's shoulder and washcloths for spit up testified to Dustin's reflux. I imitated the nurse's configuration with Dustin. The nurse shared that Dustin had been born by caesarean section due to low fetal activity.

Dustin cycled through a hard left turn of his head accompanied by crying. He cried often and, as he was not calming, at +20 (twenty minutes into the session), I shifted him to face me, chest-to-chest. To help hold such a large child, I placed pillows at the sides and embraced Dustin in a sandwich. The nurse shared that Dustin was treated with therapeutic hypothermia[2] for the first seventy-two hours after birth. He had had many low indicators initially. When intubated, he had cried so much that they had removed the tube. His numbers were more "normal" now.

The new nurse, who had arrived at shift change, shared that Dustin's parents resisted medications. They were very engaged and wanted to know test results immediately. Dustin let his head drop with his face in my chest and slept. Because his breathing was labored, a few times, I shifted his face so he could breathe better. Around +75, I offered the *No Fault: Everything that is here was here before you came. You did not cause. It is not your fault. It is not your job to fix it*. He gave a slight cry, then dropped into deeper sleep.

[2] https://www.childrenscolorado.org/doctors-and-departments/departments/neonatal-intensive-care-unit/neonatology-programs/whole-body-cooling/#:~:text=During%20neonatal%20cooling%2C%20your%20baby,the%20severity%20of%20brain%20injuries. Neonatal body cooling, also called newborn therapeutic hypothermia, lowers your baby's body temperature to treat hypoxic ischemic encephalopathy (HIE). HIE is a neonatal brain injury that occurs if your baby's brain doesn't receive enough oxygen.

About a half hour later, I was hot and hungry and ready for a break. The nurse placed Dustin in his isolette. After she left, I was able to place my hands to Dustin's crown and feet. *I'm moving my hands*. *I'm moving attention*. Dustin remained in his deep sleep.

* * *

About 45 minutes after my first session with Dustin, his nurse asked me to hold him, again, because he was dysregulated. I held Dustin chest-to-chest in a pillow sandwich, as before. In no time, he was asleep. By +20, I felt the deep shift in myself from our coregulation. I left at +30, the end of my shift.

Dashel

A nurse asked me to hold Dashel, who had been born at 26.5 weeks, and was now 49.5 weeks old. Dashel was not dysregulated, but was despondent. The nurse commented that his mother had not been coming. She was not completing the tasks requisite to taking Dashel home. I held the large boy across my lower lap, facing outward. The nurse chirped at him, "Where's your smile?" I wondered what she thought Dashel had to smile about, given a six-month stay in the NICU and his mother's absence.

I sat looking straight ahead, occasionally, looking down to check on Dashel. I remembered a workshop I had attended at an APPPAH (Association of Prenatal and Perinatal Psychology and Health) conference. Ray Castellino and acclaimed midwife, Mary Jackson, were co-facilitating. Mary and Ray were long-time collaborators, Mary having co-taught my CPBT training with Ray. For the first thirty minutes of the workshop, they said little. Ray laughed and said, "You're all going to leave and tell people, 'They sat there for half an hour and didn't do anything.'" After a pause, Ray said, "We're coming into resonance."

He meant the entire room. The entire audience was coming into resonance, not just Ray and Mary. The point was, we are not healers. We do not *do* anything. We provide the support for something greater, the inherent healing mechanism, to work. The point was *content follows connection*. Dashel's nurse came from a different orientation. She wanted to see a happy baby. She wanted to see a cuddler coaxing a smile. She repeated many times her cajoling of Dashel in a high pitch, "Why aren't you smiling?" Finally, taken aback by my stoic approach, the nurse asked in a critical tone, "Are you okay?"

I was holding midline. Center-ground-neutral. A wide perceptual field. Waiting. I was waiting for Dashel and I to come into resonance. That was the work I was here to do. "Yes," I replied to the nurse.

At +30, Dashel was asleep. At +60, still asleep, Dashel squeezed his face as if to cry. *Yes!* I reflected. *That's right! That's part of your story*. *That really happened*. Dashel listened, then settled. After a time, we repeated – Dashel cycled, I reflected, he settled. We did this a few times.

Shift change came at +90. The new nurse stood in front of us, looking down at Dashel, who was now sprawled on his back, his arms and legs outstretched and dangling, his energy that of one lost in deep sleep. "He loves being held by you!" said the new nurse. The departing nurse observed this and, when she came upon me later in the break room, said, "He enjoyed your zen." I had appreciated that she could change her view. Thereafter, this nurse and I enjoyed a warm relationship, seeking opportunities to work together.

Ernst

A nurse requested that I hold Ernst during gavage feeding. He was in an isolation room. Ernst was born at 30 weeks and was now 39 weeks old. He had dual, large-diameter oxygen tubes, blue and white, an orogastric gavage line (through his mouth), and two monitoring wires. I held him for seventy minutes.

The nurse laid Ernst with his head in the crook of my right arm. Pretty soon he twisted around with his back against me and looked about. Later, he returned to the crook. Shortly after, he had his hand around the gavage tube. I pried his fingers away. Ernst's initial cry was not too long or too loud. When he was calm, I brought the pacifier to one side of his mouth. He moved to take it in a casual way, not fast, not hesitant, and settled into compressing against the tip of my finger. Cradled in my right arm, I could cup his bottom with my right hand, but couldn't reach his feet. My left finger was in the hollow of the nipple.

At one point, I lost the pillow from under Ernst. I had learned already that he dysregulated if I took my finger from the pacifier, so I waited for a nurse to come near and asked her to adjust the pillow. Another time, the morning sun got brighter and Ernst seemed annoyed by it. I asked a nurse for a blanket to shield him, but she was able to lower a second window shade.

At about +40, to stave off falling asleep, it occurred to me to review the anatomy of the reciprocal tension membrane (RTM) – my own somewhat corrupt version. Starting with the crista galli, I ran through the RTM sequence twice: crista galli, falx, tentorium, straight sinus, Sutherland's fulcrum, 3rd ventricle, lamina terminalis, 4th ventricle, cerebrospinal fluid (CSF) to brain and down spinal column, sympathetic system down spine, cauda equina, filum terminalis; the complete RTM, the wondrous tensegrity.

Then I tracked the minnow. For elaboration of tracking the minnow see the introduction to the chapter of this name. In the left lateral ventricle, the minnow spun about its vertical axis at a rapid speed while dropping in a less rapid manner down into the fluid, the CSF. The sensation was of activity, life, but I perceived the downward movement as loss of life force. At the third ventricle, there was nothing distinctive. The minnow spun around the cyclone. In the fourth ventricle, there was high energy and light, and nothing notable in the flow split out of the ventricle.

I made it twice through the my survey of the minnow when Ernst began showing birth story. He started by twisting his head to one side and holding, then to the other side, each time gaining velocity until he was in a rapid twisting of his head from side to side; then a strong arch back of the head and a strong push with his feet; his face squeezed and sometimes he was crying – but not horrendous cries. I immediately recognized what he was doing and provided PPN affirmations – *Yes! That's right! That really happened. That's part of your story. . . . And, you made it! You're here! I know you have a big story and I'm really glad that you're here, Ernst*.

Ernst would settle and cycle again. Eventually he dropped the pacifier and I was able to put my left hand under his feet for resistance. There was space between cycles, kind of the same leisure as when he engaged the pacifier. After several cycles, I began to suggest that he could *just go to the edge*. This took a few attempts. On the last one, he did not express the full sequence before settling.

At about +55, a doctor came and listened to his chest, anterior and posterior. When she finished, she looked at the monitor and said, "I've never seen his respiratory rate so low. Maybe you should hold him all the time. Usually it's in the 70s or 80s."

"What is it now?" I asked.

"In the 30s."

"I've been holding him for about an hour."

At about +65, a pulmonologist came by. He explained to the nurse that this baby is a mystery. They don't know why he has cysts in his lungs. He wanted to examine Ernst for lymph nodes.

I thanked Ernst for his gift before the nurse took him.

Paul

I held Paul four times in two weeks. He was born at 24 weeks, and was two months old when we met. The nurse noted that Paul had been cuddled the previous day for eight hours and had cried nonstop. I tried various strategies to help Paul settle with varying effect, none lasting. At +20, the nurse showed me how Paul liked to be moved side-to-side while vibrated up and down from his bottom. She did this while standing for about ten minutes and Paul calmed.

I carried on from my sitting position and was able to get Paul to settle and to sleep. Whenever he cried, I would hold him by the hips and raise him up in air above my head, up and down, several times. Once Paul quieted, I would move him side-to-side combined with the vertical motion to settle and sleep.

At +45, Paul fell into a long sleep. It felt as if there were a physical bond between us, belly-to-belly. In our last hour together, Paul dropped into much deeper sleep and was no longer disturbed by room sounds. Previously, the metal door – a good twenty feet away – latching closed or opening was enough to cause Paul to wake and dysregulate.

The physical therapist arrived to work with Paul, saying that his head and neck were hyper-flexed. He commented that Paul had coded for fourteen minutes when he was born.

* * *

A week later, I held Paul for a little over two hours. He was still a frequent, even continuous, crier and made no eye contact. The method developed the last time continued to be my best tool. When Paul cried, I hoisted him up in a vertical plane above my head. When he stopped crying, I rocked him until he fell asleep.

The nurse shared that Paul had coded for seventeen minutes and been on ECMO[3] (extracorporeal membrane oxygenation) for three weeks. He had swallowed a lot of meconium. Now, Paul was on a methadone withdrawal protocol. For more on withdrawal and drug imprint, see the chapter of that name.

* * *

About fifteen minutes after putting Paul down, I was able to hold him, again, for a third hour. I tracked his minnow and found a shark's fin that had purpose, intention, potency. I narrated the minnow from the left lateral to the third to the fourth ventricle and Paul was quiet the entire time.

I told Paul that we are alike in that movement is a big aid. I told him that moving helps me to integrate and settle, as it seems to be of great help to him.

When my shift ended, I told Paul I would see him next week. I left him awake in his crib, *moving my hands*, then, *my attention*. Paul did not cry when I left.

* * *

The following week, a nurse asked me to hold Paul. Many nurses stopped by to say hello and to express concern for Paul. Today, Paul was not as amenable to settling in a chest-to-chest rocking position. He wanted the full deal. I let him fall asleep in a vertical position in the air above my head, then pulled him to my chest. He dropped in deep at about +50.

Between doctors and supply carts, there was a lot of disruption in the room. I felt angry after all the work that Paul and I had done to settle. I focused on the feeling of our deep connection at heart-belly

[3] https://www.yalemedicine.org/conditions/ecmo#:~:text=Extracorporeal%20Membrane%20Oxygenation%2C%20or%20ECMO,to%20work%20on%20their%20own
Extracorporeal Membrane Oxygenation, or ECMO for short, is an advanced therapy that is sometimes used to do the work of the heart and lungs when a patient's own organs are too sick or weak to work on their own.

and our energetics. Paul managed to stay asleep during the traverse of the supply cart. However, at +65, the doctor's stethoscope sent him into dysregulation.

I found that if I sat forward and vertical, Paul could settle with chest-to-chest rocking. He was asleep again at +70. The therapist arrived after +80. He didn't want to wake Paul and indicated he would standby for the end of my shift. At +90, Paul and I were in deep connection when I returned him to his crib. I did the ritual of *moving my hands*, now, *moving my attention*. Paul stayed asleep.

The therapist was amazed that Paul didn't wake. I realized that poor Paul probably doesn't get much continuous sleep. Everyone is working so hard to manage him. I thanked Paul for his gift.

Juniper

Juniper was born at 34.4 weeks and was 11 days old when we met. I was asked to hold her for fifteen minutes, until her feeding time. She had a powerful minnow, moving toward me, rising out of the water.

* * *

An hour later, the nurse asked me to hold Juniper, again. We were able to spend forty-five minutes together. Juniper was awake, lying on her right side. There was a softness to her. Her arms were extended. I held Juniper to my chest in the posture in which I had received her. Her deep sentience could be felt. I thanked Juniper for her gift.

At +15, I gave Juniper the *No Fault: Everything that is here was here before you came. You did not cause it. It is not your fault. It is not your job to fix it.* Her eyes grew heavy as she listened. Holding Juniper as she slept, being in coregulation with her felt sublime.

Orabeth

A nurse asked me to hold Orabeth because she was screaming. She was a large baby due to have surgery the next day. I felt a half-inch bump on her scalp and saw the red ring around it. Orabeth was often quiet, raising her head, eyes open and looking around. But she was not settling. Finally, around +30, I realized that this was her sequence, she was cycling.

Yes, that's right. That really happened. That's part of your story. I said this over and over. Orabeth listened, dropped her head in a slow manner, and settled. At +40, she was asleep, prone across my belly and chest.

Just before I left at the end of my shift, Orabeth resumed screaming. I settled her in her crib, but she, again, screamed. I felt sorry to leave the nurse in the same shape as when I had arrived.