AN EXPLORATION INTO THE VANISHING TWIN SYNDROME AND ITS POSSIBLE PSYCHOLOGICAL INFLUENCE ON THE SURVIVING TWIN:

A PHENOMENOLOGICAL ANALYSIS OF THE BEHAVIORS OF A THREE-YEAR-OLD DURING THERAPY

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of Doctor of Philosophy
in Clinical Psychology
Specialty in Prenatal and Perinatal Psychology

by
Nancy Greenfield

Santa Barbara Graduate Institute
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This is to certify that the dissertation entitled:

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Wendy Anne McCarty, PhD, Chairperson	Date
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ABSTRACT

An Exploration Into the Vanishing Twin Syndrome
and Its Possible Psychological Influence on the Surviving Twin:
A Phenomenological Analysis of the Behaviors of a Three-Year-Old During Therapy
Nancy Greenfield
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This qualitative inquiry explored a form of early gestational twin loss known as the vanishing twin or lost twin syndrome. It looked at the possible influence that this experience might have on the surviving twin. Focus was given to the therapeutic process of a three-year-old boy who may have suffered from the loss of a twin. The research question asked was: How might the therapeutic behaviors of a three-year-old child be indicative of vanishing twin syndrome?

Prenatal and perinatal psychology (PPN) research suggests that early gestational twin loss can profoundly impact the surviving twin and his/her sense of self, capacity to experience life, ability to trust, capacity to form relationships, and fundamental belief structures. This inquiry, which was conducted from that perspective, utilized phenomenological and portraiture research methodologies to explore these possible imprints.

Research consisted of analyzing the therapeutic sessions of a three-year-old boy who successfully integrated challenging behaviors which, from the PPN perspective, were indicative of possible vanishing twin wounding. This child began his sessions withdrawn, timid, and closed and emerged empowered, expressive, and proactive with his life. Focus was placed on the analysis of his behaviors and their implications. Some attention was also given to the basic therapeutic principals which were followed and which supported his growth. The author facilitated the therapy. Analysis was conducted with the help of session videos, chart notes, and history.

PPN psychology research suggests that the vanishing twin experience occurs far

more frequently than previously believed. In addition, findings indicate that many more individuals may suffer from the possible resulting psychological and emotional imprints than has heretofore been acknowledged. For this reason, it is important that as much as possible be learned about this experience, its potential effect on the surviving twin, and viable therapeutic means with which to support integration and healing during childhood.

ACKNOWLEDGEMENTS

This research, which analyzed the therapeutic process of a three-year-old boy I call Sam, was made possible because of the generous permission that I received from his family to share his courageous and intimate story with others. It is their hope that his journey will help other children who may be struggling with similar dynamics and trying to find resolve and freedom as he did. I wish to express my deepest gratitude to Sam and his family for allowing all of us to learn from his experiences and to be touched and helped by his honesty, commitment, and love.

I would like to thank Dr. Wendy Anne McCarty, my chairperson and my dissertation mother, for her impeccable instincts and guidance. She supported me to formulate my ideas, give birth to the multifaceted study that I yearned to create, and negotiate my way through challenging and difficult junctures. I wish to thank Drs. Jill Kern and Bobbie Jo Lyman, my committee members, for their support as well, and Dr. Diane Jackson for being my external reader.

Analyzing Sam's story required that I write a very comprehensive literature review. That review could not have been written without the help of four internationally recognized experts, all of whom provided me with essential data that were critical to my study. I wish to thank Drs. William Emerson, Raymond Castellino, and Wendy Anne McCarty, all leading therapists, researchers, and teachers in PPN psychology; and Dr. Michael Shea, leading therapist, researcher, and teacher in the field of biodynamic craniosacral therapy. Each shared important and vital data with me that enhanced and facilitated my research. I wish to express special gratitude to Dr. Raymond Castellino for his ongoing love, support, and guidance as my mentor, teacher, and good friend since 1994. His work and research has facilitated my essential and core understanding of PPN

psychology and provided me with the foundation upon which I have developed myself as a therapist. I wish to thank the Santa Barbara Graduate Institute for enabling individuals like myself to earn Master's and Doctorate's in prenatal and perinatal, and somatic psychology.

On a personal level, I wish to honor and thank my son Mishone for introducing me, during my pregnancy with him in 1990, to the reality of prenatal consciousness, communication, and Presence which set me on my PPN trajectory; and for his support during graduate school. A deep expression of gratitude and love goes to my husband, David, for his unconditional love and encouragement throughout our years together and for his ongoing support during my graduate studies. I wish to thank my good friends and colleagues, Dr. Tara Blasco and Marian Ferry, M.A., for being at my side throughout and my colleague and friend Dr. Susan Highsmith for her essential contributions to the final preparation of my dissertation for print. I would like to mention Jim Powell who provided me with initial APA formatting support; and express gratitude to my mother and father, Edith and Howard, and my two brothers, Jim and Hayes, for their continued enthusiastic appreciation of my work as a PPN therapist and my endeavors to earn a Ph.D.

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Chapter I: Introduction

Overview

This phenomenological case study, which was conducted and then analyzed through the lens of prenatal and perinatal (PPN) psychology, explored the vanishing twin syndrome as it may relate to a three-year-old boy. This child is referred to as Sam and his mother and father as Katherine and Paul. These pseudonyms have been used in order to protect the identities of this courageous family whose cooperation made this research possible.

The vanishing twin syndrome is a situation in which one or more of a multiple concepti dies during the early weeks of the first trimester (Landy & Keith, 1998; Landy & Nies, 1995). The subject of very early gestational twin loss is a relatively new concept and one that is attracting research. Medicine is very familiar with this occurrence (Anderson-Berry & Zach, 2004; Landy & Keith, 1998; Landy & Nies, 1995; Newton, Casabonne, Johnson, & Pharoah, 2003, Sampson & de Crespigny, 1992). The emergent field of PPN psychology suggests that this experience of loss can have long-range influences on the emotional and psychological well-being of the surviving twin (Castellino, 2001; Emerson, 1996; Noble, 1993).

The subject of early gestational twin loss as an experience that can influence the emotional and psychological make-up of the surviving twin is a challenging one to explore. It delves into a proposed aspect of the human development process that is not measured or proven by objective quantitative means. Rather, it is known through subjective experience and behavior pattern correlates. However, because of the suggested implications for health and well-being, it is important to continue to explore the possibility that early gestational twin loss can affect the surviving twin. The more

relevant data we can gather and assess, the more we can expand our knowledge base regarding this potential and very unique experience of loss.

In light of these considerations, the intention of this study was to utilize the PPN orientation to forge an opening for further consideration of the nature of vanishing twin wounding and its possible implications for the surviving twin during early childhood. This phenomenological qualitative research inquiry explored and examined, through portraiture methodology, the possible nature of this experience and its imprinting.

In 2000 Sam was assessed by his chiropractor as possibly suffering from vanishing twin wounds and was referred to the PPN-oriented BEBA clinic (see Appendix A) in Santa Barbara, California where I practice. He became my client. His parents accepted the original assessment given by their chiropractor and came to the clinic with the intention of supporting their son to resolve his loss and his presenting behaviors. During Sam's therapy his presenting behaviors, which were of a restrictive and negative nature, began to resolve. At the end of his process he emerged as a positive, expressive, and self-empowered little boy.

The focus of this study was Sam's therapeutic process which consisted of a total of nineteen therapy sessions and seven phone consultations with his parents. I facilitated all the sessions and consultations between March and September 2000. All therapy sessions were videotaped and documented in extensive chart notes that were originally written with research in mind. The research consisted of analyzing Sam's key behaviors during therapy through the process of reflective synthesis.

Definition of Relevant Terms

The term *vanishing twin* is a medical term that refers to a form of gestational twin loss that occurs during the early part of the first trimester of pregnancy. Other commonly

used terms are *lost twin* and, less frequently, *blighted twin*. During this loss, one or more concepti of a multiple conception is unable to survive and dies. The remaining twin(s) continues to develop on its own. Though there are several known causes of the vanishing twin phenomenon, and even signs that seem to indicate that the loss may be occurring, definitive detection and proof from a medical perspective is usually difficult to ascertain. Often, the twin that dies seems to disappear without a trace. Medical research suggests that the vanishing twin syndrome is more common than previously thought (Anderson-Berry & Zach, 2004; Landy & Keith, 1998; Landy & Nies, 1995).

Prenatal and Perinatal Psychology Paradigm

PPN psychology is the backdrop and lens through which this study was conducted. It seeks to understand gestational and birth experiences from many perspectives. Clinical findings from this field suggest that embryos, fetuses, and prenates are sentient and conscious beings; that they are relational, capable of communicating, capable of forming beliefs, vulnerable to influences from their experiences and their environment, and capable of having memories of their earliest beginnings. In addition, these findings propose that what happens to us during the prenatal and perinatal period can have a profound impact on how we develop and who we become (Castellino 2001; Chamberlain, 1994, 1999a, 1999b; Emerson, 2002a; McCarty 2002, 2004, 2006a, 2006b; Verny, 1981).

PPN psychology considers the loss of a twin at any time during gestation to be a potentially significant prenatal experience. It postulates that this loss can create long-range emotional and psychological influences for the surviving twin that can persist throughout the lifespan and implicate overall health, well-being, and development (Castellino, 2001; Emerson, 1996; LaGoy, 1993a, 1993b; MacLean, 2003). These

postulations comprise some of the fundamental premises upon which this study is situated. The PPN data that support this hypothesis come from more than thirty years of clinical experience with many thousands of clients, out of which observations, assessments, and case study reports have been collected, combined, and synthesized into postulations. These clinical findings have identified and correlated recurring themes and patterns in adults and children, and have contributed to the concept of vanishing twin wounding. These themes include the following possible influences: fear of loss, long-term depression, inability to trust, inability to form bonding relationships, survivor guilt, shame, double-bind/life-death dynamics, and low self esteem (Castellino, 2001; Emerson, 2005; Rose, 1996). In addition to these data, this PPN hypothesis that prenatal twin loss may have life-long emotional and psychological implications for the surviving twin has also been informed by research from other disciplines. These include medicine, traditional psychology, memory theory, consciousness studies, trauma resolution theory and therapy, Somatic therapy, attachment theory, embryology, embryogenesis, biology, obstetrics, craniosacral therapy, and midwifery.

The Hypothesis from Another Perspective

The concept that a vanishing twin experience can leave emotional and psychological wounds in the surviving prenate emerges from years of clinical findings, analysis, and interpretations. Yet, it also can be independently argued on the basis of inductive reasoning that utilizes both empirical and clinical research. If one considers the possible interrelated nature of the following five themes that are all relevant to the vanishing twin wound hypothesis, then the plausibility of this postulation becomes more logical:

(a) The medical conclusion that vanishing twins occur more frequently than

previously thought (Landy & Nies, 1995);

(b) The psychological data that indicate that twin loss can be a traumatic experience and that adult twins who have lost a twin brother or sister can suffer from long-lasting influences which can include pain, sadness, anxiety, loneliness, guilt, fear, and a deep sense of loss of self (Sandbank, 1999; Segal, 2000);

(c) Modern consciousness studies that indicate that consciousness "is not a product of the physiological process in the brain but is a primary attribute of existence" (Grof, 1996, p.3) and that it may exist before and after the life of the person as well as during the earliest stages of life (Wade, 1998a);

(d) Modern memory theories that suggest that some forms of memory exist independently of the body/brain parameters (Chamberlain, 1990, 1999a, 1999b, 1999d; Pribram, 1971), that there are local, non-local, and transcendent forms of memory (Wade, 1998b), that memory may exist during our earliest prenatal times, and that it may be held in our cells, including the egg and the sperm cells (Larimore & Farrant, 1996; Lipton, 2000; Pert, 1999; Verny, 1981), and

(e) PPN research which claims that embryos, fetuses, and prenates are conscious, sentient beings who are impacted by their experiences and are also capable of communicating, relating, having beliefs, and having prenatal memories (Chamberlain, 1990, 1994, 1998a, 1999e, 2003; Chilton-Pearce, 2002; Ham & Klomo, 2000; McCarty, 2002; Mauger, 1998; Verny, 1981).

If gestational twin loss exists; if post-birth twin loss can wound and leave long-lasting imprints; if consciousness and memory are, on some level, an attribute of prenatal life; and, if embryos and prenates have some form of sentiency and awareness, then it could logically follow that early gestational twin loss could influence the surviving twin. From this perspective, it could be argued inductively that experiencing the loss of an early gestational twin could be as wounding as experiencing the loss of a twin later in life. This conclusion follows when one considers PPN clinical findings as a viable source of evidence within this larger context of understanding.

Situating the Study

As a prenatal and perinatal facilitator whose personal experiences have led me to consider vanishing twin wounding as a viable dynamic, I was receptive to Sam's original assessment as a possibility. However, at the time, I did not have a lot of facilitation experience with these issues. Most of my knowledge about the subject had come from my own personal vanishing twin work and observations that I had made in Womb Surround Process Workshops® with Dr. Raymond Castellino. At the time that I began working with Sam, I had been a co-facilitator at the BEBA clinic for almost two years. Sam was the first client that I took on as a solo practitioner. I felt quite excited but was also unsure about my ability to track those issues in others. I felt that I could neither verify nor disavow his chiropractor's diagnosis. So I held it as a suggestion and tried to approach the sessions from as neutral a PPN perspective as possible. My goal was to support this child to tell, show, and explore his story freely, whatever it might be, and in whatever way he needed to do so. As I sat in each session and observed my client's behaviors through the PPN lens, I began to perceive the progression of his behaviors and his possible symbology as an indication that, indeed, he might have been dealing with and

ultimately integrating and releasing a vanishing twin wound. Of course, my own positive bias towards the concept of vanishing twin wounding influenced the conceptual field that I held, the unfolding of Sam's process, and the way that I perceived his work.

Statement of the Research Question and Inquiry Structure

This inquiry asked the question, "How might the therapeutic behaviors of a three-year-old child be indicative of a potential vanishing twin loss?" Most of the PPN data regarding vanishing twin dynamics come from research that has been conducted with adults. Though there is some research that has been derived from analyzing therapy sessions with children, none of that research has been formulated by analyzing a child's entire therapeutic process from start to finish. Because of this, I believe that my study breaks new ground and extends current knowledge.

My intention in doing my research with Sam was to explore the major behavioral patterns and significant sequences in his therapy that suggested a possible vanishing twin history. It was also important to me that these behaviors and sequences were substantial enough, either in their own right or as part of a group, that they contributed something essential to his therapeutic process. The behaviors and sequences that met these criteria were explored and portrayed in this research through four portraits and then analyzed in terms of their viable indication of a vanishing twin history.

I realized that ultimately I could never actually know what Sam's experience was, let alone whether or not he may have been dealing with a vanishing twin wound. Nor could I be certain that the therapy I facilitated was necessarily the cause of his growth and evolution. I could, however, assess the evolution of all the observable dynamics of the sessions in conjunction with my own personal experience of the sessions, including my professional expertise and biases, and, from there, form an assessment

about what he might have been experiencing. My hope was that readers of this dissertation would develop their own felt sense of Sam's therapeutic process and to be able to formulate their own considerations based on their experiences and biases.

There are many psychological orientations that could be used to interpret Sam's behaviors and the possible symbolic meaning behind them. However, this analysis was conducted through the PPN lens only. My expectation was that this study would further inform the understanding of the vanishing twin experience. I trusted that the PPN lens, through which I analyzed Sam's behaviors, would not only offer a way to explore and interpret the symbolic nature of Sam's behaviors and the possibility that he may have been dealing with a vanishing twin wound, but would ultimately provide a model for other researchers studying prenatal material. I was looking to add this perspective to the body of interpretive possibilities that traditional disciplines might provide. I did not intend for this to be a comparative study of traditions but, rather, a purposeful study utilizing PPN psychology. I anticipated that this study would culminate with the conclusion that Sam may have been exploring and releasing a vanishing twin wound.

Chapter II: Literature Review

Overview

This literature review examines major concepts, theories, and research data that contributed to the understanding of the vanishing twin experience and its possible emotional and psychological influences on the surviving twin. Data from the fields of medicine, traditional psychology, and PPN psychology are reviewed. In addition, an in-depth look at the PPN paradigm includes discussions about PPN consciousness, sentiency, memory, bonding and attachment, imprinting, early trauma, and current vanishing twin research. Relevant stages of embryological development are also referenced. Finally, since this case study focuses on a three-year-old boy's therapeutic process, a brief exploration of therapy with children is discussed from the perspectives of traditional and PPN psychology.

Medical Research

Definitions

The term *vanishing twin*, also known as *blighted twin* (ovum) or *vanishing twin syndrome*, refers to the specific situation in pregnancy in which there is a multifetal gestation, but for one reason or another one or more of the fetuses disappears. This disappearance occurs during the first trimester. The medical literature states that this occurrence "is known to be a relatively common event in early pregnancy" (Sampson & de Crespigny, 1992, p. 107) and generally happens before eight or nine weeks (Anderson-Berry & Zach, 2004; Landy & Keith, 1998; Landy & Nies, 1995; Newton et al., 2003). More over, some researchers believe that "most human conceptions fail before birth" (Blockage, 1995, p. 43). A vanishing twin can occur spontaneously from natural causes, abortion attempts, or deliberate multifetal reduction processes that are performed as part

of assisted reproductive technology (ART) (Chasen & Skupski, 2002).

In order to have a fully informed discussion about early gestational twin loss, it is also important to understand what constitutes twinship. The term *twin* means double, or growing in pairs. *Fraternal twins*, also called *dizygotic* or *heterozygous twins*, are twins that develop from two separate ova and may or may not share the same sex. *Identical twins*, also called *monozygotic* or *uniovular twins*, are twins that develop from a single fertilized egg that splits. When this happens the embryos share the same gene pool and are always of the same sex. *Polar body twins* are twins that are formed from an unfertilized egg that splits. Each new egg is then fertilized by a separate sperm, yielding twins that share the same maternal gene pool but have different paternal gene pools (Dox, Melloni, & Eisner, 1993). *Siamese twins* are twins that come from one fertilized egg that splits, but incompletely, so that the twins share a body part (Carlson, 1999).

History of Vanishing Twin Research

According to Landy and Keith (1998), Stoeckel, in 1945, was the first to suggest that the conception rate of multiple gestations was greater than birth rates. Through the mid-1980s, gestational-twin research was conducted with the use of transabdominal sonography which was the primary diagnostic tool for identifying a vanishing twin. Then in 1987, the transvaginal sonographic approach was refined and soon became the diagnostic tool of choice. As Landy and Nies (1995) commented, "With improvements in sonographic techniques, the 'vanishing twin' phenomenon, first documented in the earlier days of ultrasound, has become widely accepted" (p. 59). Though it is not understood exactly why a twin disappears, many researchers hypothesize causes such as genetic or chromosomal abnormalities, an improper cord implantation, or a blood incompatibility between an Rh-positive fetus and an unsensitized Rh-negative mother (Anderson-Berry

& Zach, 2004; Landy & Nies, 1995).

Frequency of the Vanishing Twin Occurrence

There are a variety of opinions concerning the frequency of the vanishing twin occurrence. Determining the frequency of occurrence of a vanishing twin is a challenging task because of the inherent obstacles in the research process itself. To begin with, there is no consistent definition for the term *vanishing twin*. Some researchers use it to refer only to a circumstance in which initially two viable heartbeats are actually identified, but then later only one, with only one baby coming to term. Others use it to refer to any circumstance in which two gestational sacs are identified, regardless of whether or not two viable heartbeats are heard. The difference between just these two definitions is enormous in terms of how studies are conducted, who is considered an appropriate subject, and how data are interpreted. Landy and Nies (1995) addressed these discrepancies: "Each study involves different patient populations, sonographic criteria and follow-up studies" (p. 66).

Second, diagnosis of early multiple pregnancy can be difficult and deceiving due to misidentification of early embryonic anatomy. Amniotic cavities, chorionic sacs, yolk sacs, and extraembryonic coelom can sometimes be misinterpreted as evidence of a twin gestation (Landy & Nies, 1995).

Third, and most importantly, is the timing of the ultrasonic exams which is crucial. If exams are not done early enough, and there would be no reason to do an early ultrasound exam unless there was a serious complication, a twin can die and the remains can disappear before any detection is possible. Some twins leave so early that they seem to disappear without leaving a trace, whereas others simply stop growing and leave remains that can be detected later (Landy & Nies, 1995). Yoshida (1995) found that the

disappearance rate of one or more fetuses in multiple pregnancy ranges from 0-70 percent. The large discrepancy results from a difficulty in confirming pathological findings.

> Disappearance rates vary widely, depending to some degree on the timing of ultrasonographic procedures and the techniques available to the obstetrician. . . . It usually is difficult to find evidence of the vanishing twin, because the fetus typically has been resorbed or has degenerated as pregnancy advances. (p. 51)

Evidence is indicating that the earlier the sonography, the greater the percentage of identified vanishing twin occurrences. Landy & Nies (1995) found that "gestational sacs, often seen earlier in pregnancy, disappear more frequently than do well-defined fetuses observed after six or seven gestational weeks" (p. 66).

Blockage (1995) and Landy and Keith (1998) suggest that 12-15 percent of all live births are products of twin embryogenesis, and, of those, 30 percent will ultimately result in singletons. Anderson-Berry and Zach (2004), who tested for vanishing twins at eight weeks in the United States, report that the frequency of multiple gestations is 3.3-5.4 percent and that the vanishing twin syndrome occurs in 21-30 percent of all multifetal gestations. Sampson and de Crespigny (1992) say that when live twins are detected prior to seven weeks gestation, the vanishing twin syndrome occurs in 29 percent of pregnancies and only 71 percent will result in live twin neonates.

Landy and Nies (1995) cite an Australian study in which multiple pregnancies detected between seven and nine weeks had a 16 percent fetal reduction rate. Multiple pregnancies detected between six and seven weeks had a 29 percent fetal disappearance rate. These researchers also cite a 1992 Israeli study in which 88 multiple pregnancies were evaluated by transvaginal sonography between five and six weeks post ovulation

induction. The results showed a much higher rate of vanishing twin incidence. After detection of 54 viable twin gestations, researchers showed that 51 resulted in the birth of singletons and three ended in spontaneous abortions with no children born.

This evidence, which indicates that the vanishing twin rate rises with earlier testing procedures, corroborates data from PPN psychology findings. PPN clinical data suggest that most vanishing twins actually occur within the first three weeks of pregnancy, from conception through implantation (Emerson, 2005). Embryology indicates that this period contains several critical embryological transitions that can be precarious for the survival of the embryo (Blechschmidt, 1977; Shea, 2007; van der Bie, 2001; van der Wal, 1998). PPN findings suggest that the actual percentage rate for singleton births having originated in a twinship might be as high as 70 percent. This data is reviewed in the section entitled "PPN Vanishing Twin Frequency." Medical research does not look at the first three weeks of gestation because ultrasound, which is typically used for detection, is not commonly used prior to six weeks.

Indications of a Vanishing Twin Occurrence

There are several clinical indicators that are considered the most reliable signs of a possible early gestational twin death and/or the disappearance of an embryo or a gestational sac. These include vaginal bleeding, cramping, pelvic pain, and/or spotting. In some medical circles these indicators are taken so seriously that they are followed by exploratory ultrasound exams and can sometimes lead to an extended prenatal management program (Anderson-Berry & Zach, 2004; Chasen & Skupski, 2001, 2002; Landy & Ketih, 1998; Landy & Nies, 1995).

As stated above, it can be virtually impossible to detect a vanishing twin if the disappearance occurs prior to testing. According to Landy and Keith (1998), Landy and

Nies (1995), and Kapur, Mahony, Nyberg, Resta, & Shepard (1991), an embryo or early fetus that is deceased can be either completely resorbed or partially resorbed. If an ultrasound exam is administered early enough, this resorption can be detected. Partial resorptions are easier to detect because they leave some remnant of the lost twin that can be identified later. Gestational sacs, empty or not, are also indicators of a vanishing twin and these, too, can be completely absorbed and/or partially absorbed. The formation of a fetus papyraceus, which is a mummified or compressed fetus formation, is another sign (Chasen & Skupski, 2001; Landy & Nies, 1995).

In addition, there are a number of abnormalities that can appear in and around the placenta that are also viable indicators of an early twin loss. These abnormalities can include either subchorionic fiber formations, which are thickening lesions that appear on the placental walls, or the formation of cysts, some of which may be connected to a slender string appearing as a blighted umbilical cord. There can be crescents of fluid outlining the intact sac, septal divisions of the amniotic cavity with one compartment empty, and/or the presence of unidentified amorphous materials (Anderson-Berry & Zach, 2004; Chasen & Skupski, 2002; Finberg & Birnholz, 1979; Jauniaux, Elkazen, Leroy, Wilkin, Rodesch, & Hustin, 1988; Kapur et al., 1991; Landy & Keith, 1998; Landy & Nies, 1995; Sampson & de Crespigny, 1992; Yoshida, 1995).

Possible Complications Arising From a Vanishing Twin

In general, the vanishing twin occurrence need not jeopardize the physical well-being of the surviving twin or the mother (Saidi, 1988). However, when complications arise, the timing of the disappearance is crucial in determining long-range ramifications. In general, the later the disappearance occurs, the greater the possibility for medical complications. This, of course, is why second- and third-trimester twin loss, which is not

the subject of this paper, is medically much more serious.

Although not as severe as later twin loss, first-trimester twin loss is associated with a few possible complications that deserve mentioning. Some research has identified a possible link between cerebral palsy in an individual and a possible vanishing twin history. This connection is believed to be greater in monozygotic, monochorionic twins than in dichorionic twins. Studies suggest a neurological impairment that usually presents as cerebral palsy or severe learning disabilities in singleton infants associated with a vanishing twin (Anderson-Berry & Zach, 2004; Pharoah, 2002). Other studies disagree with these findings and conclude that the vanishing twin syndrome is unlikely to be a cause of cerebral palsy (Newton et al., 2003).

A few more possible complications include (a) disseminated intravascular coagulation (DIC), a reversal of blood flow from the diseased twin to the viable twin, which could be a precursor to intrauterine central nervous system damage (Anderson-Berry & Zach, 2004; Newton et al., 2003; Pharoah, 2002); (b) sirenomelia, a rare congenital state that decreases vascular flow to the lower extremities, causing fused legs, feet, and death (Kapur et al., 1991); (c) a condition of blood group incompatibility that can arise during subsequent pregnancies between the mother and the new fetus (Nerlich, Wisser, & Krone, 1992); and (d) challenging issues of amnionicity and chorionicity (the amnion and chorion being the two membranes that surround the fetus) which, in multiple pregnancies of three or more, can have a dramatic impact on the well-being of the remaining twin(s), for whom greater prenatal care and management are then required (Chasen & Skupski, 2001, 2002; Kurjak, Kos, & Vecek, 2002; Manzur, Goldsman, Stone, Frederick, Balmaceda, & Asch, 1995).

Traditional Psychology Research

The vanishing twin syndrome has not been studied by traditional psychology. Rather, traditional psychology has researched twinship as a post-birth phenomenon. Attention has been given to issues of twin similarities and differences; developmental, growth, and comparative studies; physiological and biological characteristics; gene and environmental influences; cognitive abilities; personality traits; temperament; identity formation; behavioral patterns; psychopathology; and family and social influences (Macdonald, 1994; Piontelli, 2002; Sandbank, 1999; Segal, 2000). The research that has specifically focused on twin loss has been conducted with adults who are surviving twins and who have lost their twin either during or after birth. Research with children has been conducted only in terms of general sibling loss with no specific focus on twin loss (Alon, 1996; Crehan, 2004; Heiney, 1991; Paulson, 1995; Teplow, 1995).

The Nature of Twinship

In order to comprehend the impact of losing a twin, it is necessary to comprehend the nature of having a twin. Macdonald (1994) views twinship as an inherent relationship of couple-hood: "Twinship is inherently about the couple, the relationship of the couple, and how that is viewed and how it affects behavior and individual psychology and other interactions" (p. 318). The twin bond may be so profound that it possesses deep levels of intimacy and connection that cross emotional, psychological, spiritual, and even physical boundaries (Sandweiss, Sandweiss, & Fields, 1998). Brandt (2001) states that twinship is a state of being. Macdonald (1994) writes that the intrauterine experiences of twins are different from those of singletons because "they are in close proximity to a separate human being other than their mother" (p. 307). She further suggests that the process of sharing the womb may create other influential dynamics not experienced by singletons:

"Twins share a womb, and in some cases a placenta: this may have unique biological and psychological consequences" (p. 301).

Twin Bonding

When looking at developmental theory regarding twins, it is important to acknowledge the unique primary nature of the twin relationship. Research indicates that the twin bond supersedes the mother-child bond (Cox, 1994; Segal & Blozis, 2002; Tomassini, Rossina, Billari, & Skytthe, 2002). Brandt (2001) writes, "For twins, the primary bonding is between themselves and secondary bonding with their mommy" (p. 83). Macdonald (1994) concurs and adds that twins have a symbiotic relationship with each other from which they must emerge in order to become individuals.

According to Macdonald (1994), Sandweiss et al. (1998), and Segal (2000), twin connection and intimacy can be expressed in telepathy and paranormal behaviors. These authors point out that twins often have an intuitive knowing of each other's circumstances regardless of where they are; that they are often known to complete each other's sentences and have identical thoughts, get the same marks on exams, buy identical clothing, and experience sympathetic pain and sickness; that, even when they are separated at birth and do not have a conscious knowing of each other's existence, they will be known to marry spouses with the same names, have the same number of children in the same gender order, share similar likes and dislikes, and have similar speech patterns and mannerisms. Brandt (2001) elaborates on this unconscious knowing that twins can have of each other's existence even when they are separated at birth. He cites circumstances in which parents, who find it too painful to tell their surviving twin child that s/he had a twin brother or sister, will never discuss the subject. Clinical evidence suggests that these surviving twins know innately that they are a twin. Segal (2000) came

to the same conclusions in her research on twins who had been reared apart since birth. Upon being reunited, they immediately recognized each other and established a level of intimacy as if they had never been separated. "It is as if the twins 'knew each other all along' without having to be introduced" (p.111). Segal cites the example of Paul Newman, an identical twin who was reared separately from his twin brother, Jerry Levey, and upon being reunited remarked, "I am him and he is me" (p. 111).

Twin Loss and Bereavement

Data indicate that grief and bereavement are inherent experiences of twin loss. Macdonald (2002), in her research on twin loss, defines *bereavement* as, "a deprivation—the loss of a loved one and of the relationship" (p. 218). Woodward (1999) discusses the complexity of twin loss grief as being different from other forms of sibling grief because of the nature of the intimacy and self-identification that twins share. Researchers have found that a twin's sense of self is built on the concept of being a pair (Woodward, 1988, 1999). Loosing a twin can cause deep upheaval and turmoil in one's experience of self. It can challenge identity, survival strategies, and coping mechanisms and can overlay and/or underlay numerous emotional and psychological responses. These responses require sorting out and integration. Healing requires mourning, adjustment, and reordering of one's sense of self (Segal, 2002; Sussman, 2001; Withrow & Schwiebert, 2005; Woodward, 1988, 1999). Bryan (1995) argues that surviving twins can suffer so profoundly from their loss that some need lifelong support.

Joan Woodward, a psychotherapist from the United Kingdom and a surviving twin, has done extensive research on twin loss through her clinical practice with adult subjects. She has dedicated her career to the study and treatment of the emotional and psychological consequences for an adult surviving twin of having lost a twin. In 1982 she

conducted the first comprehensive study that had ever explored twin loss. During her research project, she interviewed 219 twinless twins, which at the time, was an unprecedented investigation. Her findings have contributed enormously to our understanding of the survivor twin experience and the profound effect that twin loss can have on the remaining sibling. Her research suggests that twin loss can be devastating, debilitating, and deeply wounding. It can affect one's identity, self esteem, capacity to form future meaningful relationships, and ability to trust and fully engage with life. Further, it can cause propensities toward depression, isolation, loneliness, guilt, anguish, and fear (Woodward 1988, 1999). Case (1991, 2001) and Brandt (2001), also surviving twins who have dedicated their lives to gathering data about the emotional and psychological experiences of twinship and specifically twin loss, concur.

Case (2001) looked specifically at all types of twin loss resulting from death, adoption, and estrangement. She cited a survivor's description of having lost his twin:

> I instantly ached from head to toe from an awful pain like, maybe, being under a twenty ton pile of rocks. I felt like I was being crushed from the outside in…. My voice totally disappeared.… Days passed before I could talk.… After his death I contemplated suicide thousands of times. I pleaded and prayed to God to take me too. I wanted to be with Jim more than I wanted to live. (pp. 28-29)

Brandt (2001) concludes that surviving twins often "feel incomplete, missing the other half, always searching for that twin that they bonded with in-utero" (p. 93).

Audrey Sandbank (1999), another psychotherapist from the U. K., cites evidence regarding surviving twins whose parents knew that they had lost a twin during gestation but may not have told their surviving twin. She says, "some twins appear to experience a profound sense of loss without the conscious knowledge that they had a twin" (p. 187).

However, she questions the accuracy of the memory or recollection of the loss: "It is impossible to tease out how much this sense of loss derives from real recollections of the living sensations felt in utero or from later constructions belonging to postnatal life alone" (p. 12). She did, however, look at twin loss in general, as it occurs during or after birth, and acknowledged the severity of the experience. She cites deep grief, survivor quilt, extreme feelings of vulnerability, loss of self, and identity confusion as common in surviving twins. She warns against the common situation in which those who are closest to a surviving twin, for one reason or another, do not notice the depth of the grief that their loved one is feeling. Isolation can be debilitating and undermine healing: "Even those twins who appear psychologically and socially unscathed may suffer profoundly yet silently from their bereavement" (p. 196).

Nancy Segal (2000), professor of developmental psychology and director of the Twin Studies Center at California State University, Fullerton, identifies common "lifelong feelings of depression and emptiness, and a sense that 'someone else is out there" (p. 184) among individuals who believe they were born with a twin but have no medical record of a twinship. She expounds on the emotional and physical stress that the grief of twin loss causes and the deep yearning and missing that can predominate for years. Though she did not specifically reference the vanishing twin experience, she talked about the general experience of gestational twin loss and the long-term consequences for the surviving twin: "Some twins surviving the prenatal loss of their co-twins may experience guilt, anger, frustration or sadness later in life" (p. 183).

Alessandra Piontelli (2002), a world-renowned Italian child neuropsychiatrist and researcher, has studied twins for more than 30 years. She recognizes that grief can occur from late gestational twin loss but does not acknowledge that there can be grief from an

early vanishing twin experience. Though she acknowledges the vanishing twin dynamic and says that it "occurs in as many as 50% of all twin gestations" (p. 17), she does not believe that it creates any significant psychological consequence for the surviving fetus. According to her, the only way that a twin is able to know that it has a co-twin is through the felt sense of the physical sensations of "intrapair stimulation" (p. 51). These are moments of actual physical contact that take place between fetuses in the womb. Because of the tiny size of young fetuses, the weakness of their movements and the expansive distances between them, this contact does not occur prior to nine weeks and usually not until 11 weeks. Consequently, she challenges the idea that young fetuses know that they even have a twin at all and that any aspect of the early vanishing twin experiences can become "embedded in the unconscious of a surviving twin" (p. 51).

Research indicates that twin loss bereavement has the potential to exceed, both in degree and intensity, the grief that is experienced from losing a parent, a relative, a spouse, a sibling, and even a child (Cox, 1994; Segal & Blozis, 2002; Segal & Bouchard, 1993; Segal, Wilson, Bouchard, & Gitlin, 1995; Tomassini et al., 2002). It appears that the depth of the bereavement that is felt from losing a loved one is in direct proportion to the depth of the closeness that existed in the lost relationship. Because twinship is a multifaceted relationship with many different levels of connection and closeness, it is considered by some to be the most intimate of all human relationships (Emerson, 2005). In accordance with this, researchers propose that grief is more intense in monozygotic twin loss than dyzigotic twin loss because of the extended shared intimacy of having been conceived from one egg rather than two (Cox, 1994; Segal, 2000; Segal & Blozis, 2002; Segal & Bouchard, 1993; Segal et al., 1995; Sussman, 2001).

The PPN Paradigm

PPN psychology is both the backdrop for this research and the very foundation upon which it has been designed and conducted. As such, an understanding of basic PPN principles is in order if an intelligent discussion about the vanishing twin syndrome is to become possible. This field endeavors to uncover the mysteries of our earliest beginnings from preconception through conception, gestation, birth, and the post-birth attachment phase. It seeks to understand these experiences from many points of view, especially from the perspective of the embryo, fetus, prenate, and neonate. In addition, it endeavors to learn about the influences that these experiences can have on our emotional, psychological, psycho-spiritual, and physical development. PPN psychology proposes that embryos/prenates/neonates have (a) consciousness and sentiency, (b) memory, (c) capacities for imprinting, (d) capacities for bonding and attachment, (e) capacities to form beliefs, and (e) susceptibility to traumatic imprinting (Castellino, 1995, 2000; Chamberlain, 1994, 1998a, 1998b, 2003; Findeisen, 2005; LaGoy, 1993a; Marquez, 2000; Verny, 1981, 2002).

In order to contextualize prenatal and perinatal data, an understanding of relevant terms is essential. The term *embryo* refers to life from conception through the first eight weeks of gestation, *fetus* to life from eight weeks until birth, and *neonate* to a newborn. The term *prenate* is often used interchangeably with the others. It comes from the word *prenatal*, which refers to the period of life that exists from conception, through gestation and up to the 20th week in utero. The term *perinatal* refers to the period from the 20th week of gestation through birth until the 29th day after birth (Dox et al., 1993).

The field of PPN psychology has emerged, in part, out of a weave of many other disciplines, all of which have informed the PPN knowledge base and continue to do so.

These include psychiatry, psychology, the regressive therapies (e.g., Primal Scream) the somatic body/mind therapies (e.g., Somatic Experience), trauma resolution work, attachment theory, embryology, cell biology, the neurosciences, consciousness studies, memory studies, craniosacral therapy, midwifery, and obstetrics. The convergence of these disciplines in the PPN paradigm suggests that our prenatal and perinatal beginnings actually set in place crucial imprints that influence how we develop, who we become, and how we are (or are not) able to go forward into our lives with a strong sense of self and empowerment (Emerson, 2000; Findeisen, 2005; Ham & Klomo, 2000; Levine, 1997; Lipton, 2000, 2005; Marquez, 2000; Nathanielsz, 1996, 1999; Siegel, 1999).

PPN clinical and empirical data are collected from therapy that is conducted with newborns, babies, children, and adults. Though therapeutic modalities will change according to the age of the client, the PPN lens remains the same. Techniques include regression and primal therapies (Farrant, 1986a, 1986b; Raymond, 1998; Grof, 1988; Janov, 2003; Larimore & Farrant, 1996; Noble, 1991); hypnotherapy (Chamberlain, 1990, 1999a, 1999b, 1999e; Chamberlain & Madrid, 2001; Cheek, 1986; Gabriel, 1992); somatotropic therapies (Emerson, 2002b; Levine, 1997; Rothschild, 2000); "somatic memory retrieval"® therapy (Castellino, 2001); primal therapy with infants (Emerson, 2004), play therapy and somatic story telling, reflective therapy, and various methods of self-reporting, session observations, and analysis of therapeutic work with infants, babies, children, and adults (Castellino, 2005; Emerson, 2002, 2005; McCarty, 2003a, 2003b). Findings from these therapeutic modalities have informed PPN research and have been a part of the foundation of PPN psychology.

When looking at and considering PPN research, it is important to understand that current PPN data are found in several different sources. Some of the data is described in

traditional publications such as books and articles. However, other data, which includes some of the most extensive clinical research comprising thousands of clinical hours, can only be accessed through professional venues such as trainings, workshops, and classes. Because PPN psychology is such a new field, some of its leading experts, though they are PPN published authors, have not yet documented all of their findings in traditional print. Dr. Raymond Castellino and Dr. Wendy Anne McCarty, both of whom have made major contributors to the PPN field, fall into this category. Their work is extremely pivotal to this study and so, in addition to citing their published works, I have cited their clinical findings, analyses, and interpretations from other sources such as interviews, personal communications, classes, and trainings. In the reference list those sources are cited as lectures, interviews, and seminars; the interested reader is encouraged to visit the websites of Dr. Castellino at www.castellinotraining.com and Dr. Wendy Anne McCarty at www.wondrousbeginnings.com.

Dr. Castellino's experience spans 36 years (since 1970) of working with babies, children, and families. He has taught numerous PPN trainings, seminars, advanced workshops, graduate classes, and process workshops, both nationally and internationally since 1992. He has an extensive two-year curriculum for training PPN professionals that he has used to train PPN therapists around the world since 1994. He is a faculty member of the Santa Barbara Graduate Institute and director of the BEBA PPN family clinic in Santa Barbara, California, which he co-founded with Dr. McCarty. He has been my mentor since 1995 and I have taken and assisted all of his trainings, seminars, workshops, and classes many times.

Dr. McCarty's work spans 30 years (since 1976) as an obstetrical nurse, childbirth educator, marriage and family therapist, prenatal and birth therapist, and consultant who

works with adult children and babies from a PPN perspective. She helped to found the Santa Barbara Graduate Institute and co-created its first graduate degree programs in prenatal and perinatal psychology. She was chair of the PPN department for two years and is a core faculty member at the school. She teaches and lectures both in the United States and Mexico and co-founded the BEBA PPN family clinic in Santa Barbara, California with Dr. Castellino. She is also the committee chairperson for this dissertation.

The Influence of Prenatal Life

Verny (2002), a founding father of PPN, suggests that "from the moment of conception, the experience in the womb shapes the brain and lays the groundwork for personality, emotional temperament, and the power of higher thought" (p. 29). Chilton-Pearce (2002) posits that all of our human experiences from our earliest prenatal beginnings comprise a multidimensional reality that exists both outside of the body/brain parameters as well as within. Everything that happens to us becomes a part of the total weave of who we are. McCarty (2003b) explains:

> Our earliest experiences in the womb, at birth and during infancy establish a foundational blueprint for life. This blueprint becomes the infrastructure from which we grow and experience life: physically, emotionally, mentally, relationally and spiritually. These early experiences become part of our implicit memory and autonomic functioning – below the level of our conscious awareness. (p. 3)

PPN Consciousness and Sentiency

The subject of prenatal consciousness is central to the field of PPN psychology. PPN clinical research data suggests the presence of a conscious and sentient awareness that facilitates our processing of our prenatal and perinatal experiences (Chamberlain,

1994; Emerson, 1996; Janus, 2001; McCarty, 2004; Raymond, 1998). Research data from the field of consciousness studies posits similar conclusions about the possible presence of consciousness during the prenatal period and even pre-conceptive consciousness (Bohm, 1980; Wade, 1996; Wilbur, 1998). This subject is essential to the PPN concept of the vanishing twin experience. As stated in the introduction, the PPN perspective postulates that early gestational twins have a consciousness that registers the loss of their twin and, thus, the surviving twin can be impacted by that loss.

Consciousness is defined as "the state of being aware of oneself, of one's own existence, sensations, thoughts, surroundings" (*Webster's Unabridged Dictionary of the English Language*, 2001, p. 432). In order to appreciate the perspective from which PPN psychology views consciousness and sentiency, it is important to look at modern consciousness theorists whose work informs the PPN perspective. These theorists, as they seek to understand the human experience and the nature of existence, posit that consciousness (a) exists independently of, and is not bound by our body/brain parameters, extending beyond the substrates of our physical form, and (b) that it exists prior to and after the life of the individual (Bohm, 1980; Wade, 1996; Wilbur, 1998). These concepts are reflected in PPN clinical research which suggests that even concepti, embryos, and prenates have consciousness and sentiency (Castellino, 1995; Chamberlain, 1998a; Cheek, 1986; McCarty, 2004: Verny, 1981; Wambach, 1979). This is essential to the PPN perspective of the vanishing twin syndrome which postulates that the surviving twin embryo has conscious awareness of its twin and is impacted by the loss (Emerson, 1996; Findeisen, 2005; LaGoy, 1993a, 1993b; Rose, 1996).

Wade (1996, 1998a, 1998b) postulates that there are two different kinds of consciousness—fetal and transcendent. Her research cites that the first is tied to the body

and the central nervous system and the second exists outside the physical body and pertains to an awareness that seems to be more or less independent of the body. She describes the second as "a mature, physically transcendent source of consciousness that coexists with the immature consciousness originating from the fetal body" (p. 43). Wade (1998b) further suggests that this transcendent source of consciousness

> registers thoughts, feelings and actions but is not comprised of, or very attached to, these. It is characterized by a sense of self but relatively little ego, and it seems to understand the reactions of others with compassion rather than through the lens of ego defense structures (p. 142).

Grof (2000) speaks to this same duality of consciousness and says that both have the capacity to access a deeper unconscious awareness of our earliest experiences including a broad knowledge of our archetypal and ancestral histories. McCarty (2004, 2006a, 2006b) describes this deeper knowing as an "omni-awareness that is far more expansive than the human cells and growing fetus can explain" (McCarty, 2004, p. 98). In addition, Wade (1996) suggests that consciousness is not bound by the limitations of birth and death. McCarty (2004) writes, "Our primary nature is as conscious, sentient, non-physical beings that exist prior to and beyond physical human existence" (p. 67). Chamberlain (1999d) posits that consciousness "is not a developmental trait, but an endowment of human persona" (p. 91) while Grof (1996) writes that it "is a primary attribute of existence" (p. 3). Embryologist van der Wal (2004b), who studied the embryogenesis of life, suggests that the embryo

> does not "get a soul," it is the soul manifested in human existence and human behavior…. During its total development the embryo is the expression of the presence of a being, which is able to mediate between heaven (cosmos) and earth.

(p. 1)

Wade (1998a) goes another step further by assessing the phenomenology of this nonphysical source of prenatal consciousness. She concludes that prenatal consciousness has the following broad capacities: (a) a fully mature concept of others which includes recognizing differentiation; (b) an awareness of self-boundaries that are not physical; (c) a definite awareness of spatial location relative to the mother and the fetal body; (d) a perception of a timeless present; (e) a definite attitude toward life; (f) the ability to record and process information; and (g) the capacity to facilitate being born or to self-abort.

Finally, consciousness theorists also postulate the actual physical location of consciousness. Sheldrake (1999) posits that it exists in morphic fields which are the energetic fields of space that contain the collective memory of human social groups. Dossey (2001) and Talbot (1991) argue that it is nonlocal, non-time-oriented, and exists outside of the body-brain parameters.

Consciousness Prior to Conception

Some theorists suggest that there is a prenatal consciousness prior to conception (Farrant, 1986a; Grof, 1996; Linn, Emerson, Linn, & Linn, 1999; Luminare-Rosen, 2000; McCarty, 2004; Raymond, 1998; Rose, 1996). Maiden (1998) writes that consciousness predates conception and is influenced by the consciousness of the parents during preconceptive times. Carman and Carman (1999), Hallett (1995), and Luminare-Rosen (2000) suggest that a preconceptive relationship exists between a conceptus and his or her future parents. In this period prenatal bonding can occur.

Cellular Consciousness During Conception

Emerson (1996), Farrant (1986a), McCarty (2004), and Luminare-Rosen (2000) write about the presence of consciousness at conception. Linn et al. (1999) state “at the

moment of conception, a child has a fully conscious spirit that is as sensitive, if not more so, than at any other time in life" (p. 4). Rose (1996) says that "feeling and consciousness are present at conception" (p. 4).

Emerson (1996), Farrant (1986a, 1986b), Grof (1988, 2000), Janov (1983, 2000), Larimore & Farrant (1996), Raymond (1998), and Rose (1996), all PPN clinicians who use primal and regressive therapies with their clients, have gathered data that indicate the presence of a consciousness in the egg and the sperm. They suggest that both the ovum and the sperm have consciousness before, during, and after conception and that it is this consciousness that perceives the events of one's conception, tube journey, implantation process, discovery period, and other significant events such as abortion attempts and miscarriages of a twin.

Rose (1996) cites two clients who transformed prominent life patterns after they relived the events of their conceptions during regressive therapy sessions. She described one female patient who was able to change certain patterns in her life after learning about their origins. This woman

> spent her life aloof, kind of emotionally cold, and nobody could get really close to her…. She finally relived her conception. She said, "This feels robotic. It feels mechanical, it feels totally cold. I don't know what's going on, nobody's in touch with anything." We interviewed the parents and they said that they had a fertility problem. The doctor had given them a lovemaking schedule and they were following it. So the result was this rigid, robotic, unfeeling conception, and that's how her life went too. (p. 58)

Another patient was a women who would go to social dances and invariably attract many men. However, she was terrified of them and could handle relating to only

one man at a time. Eventually she would always end up choosing someone in whom she was not even interested. Logically this made no sense. Then, in a therapy session

> she relived being an unfertilized egg, cowering, terrified of all the sperm coming towards her. Her mother did not want to get pregnant. As a result, the egg was afraid, almost shivering, and trying to hide from the onslaught of rapidly approaching sperm. To get the fear over with, she just reached out and grabbed the first sperm, not the right sperm. (p. 59)

Rose reports that once the woman "relived the terror of her cowering egg, she was able not only to dance with men she liked, but she met and married a man who was good for her (the right sperm, not the first sperm)" (p. 59).

Finally, cell biologist Bruce Lipton (2005) looks at the behaviors and capacities of the single cell, of which an ovum is one. His research indicates that cells have the capacity to respond to their environments, to be influenced by their experiences, and to choose behaviors that are proactively oriented either toward growth or toward protection.

Clinical Implications of Prenatal Consciousness

PPN clinicians are informed by these consciousness theories and are continually discovering corroborating evidence in their own clinical findings. Emerson (2000) argues that consciousness, as described above, is what enables prenates to register the events of their conception, implantation, discovery, and gestation and to discern whether or not they are wanted. Other clinicians indicate similar conclusions as their research suggests that prenates possess awareness of self, of mother and mother's state, and of the general environment that surrounds them; prenates are impacted by their experiences and have memory of the earliest of these (Castellino, 1995, 1999, 2000, 2001; Chamberlain, 1994; Emerson, 1996; Ham & Klomo, 2000; Janus, 2001; Mauger, 1998; McCarty, 2002, 2004,

2006a, 2006b; Verny, 1981).

Still others expand this concept further through their research and postulate that prenates have the ability to perceive, communicate, recognize significant others, process information, negotiate their environment, and demonstrate developed capacities for sense awareness (Castellino 2001, 2004a; Chamberlain, 1990, 1994, 1999e, 2003; Chilton-Pearce, 2002; McCarty, 2002; Noble, 1993; Righetti, 1996). "In the environment of the womb, hosts of modern studies prove that a fetus is active, responsive, and influential" (Chamberlain, 1998a, pp. 98-99). McCarty (2002) goes one step further suggesting that even our belief systems are forged during our prenatal times through our experiences of conception, pregnancy, and birth and that these early beliefs "form our blueprint for life in the physical world" (p. 357). Ham and Klomo (2000) reference this same concept of prenatal belief formation by citing the earlier works of Hull (1986) and Lake (1982), both of whom indicated similar conclusions.

PPN Memory

Any discussion about the vanishing twin experience and its impact on the surviving twin has to include an exploration of prenatal memory. As stated, PPN psychology suggests that there is a prenatal memory "online" during conception, gestation, and birth that enables a surviving twin to recall vanishing twin experiences. Modern memory theorists shed light on this possibility. Their understandings go beyond traditional theorists who localize memory in the brain structures alone. Some posit that memory exists in relationship to and also independent from body/brain parameters (Chamberlain, 1990, 1999a, 1999b, 1999d; Chilton-Pearce, 2002; Emerson, 1996; Wade, 1996). Others suggest that memory exists in the larger universal field (Sheldrake, 1996, 1999; Pribram, 1971; Schwartz & Russek, 1999).

The Multiple Nature of Memory

Chamberlain (1990) describes various forms of memory:

> short and long term memory, autobiographical memory, semantic memory, affect, perceptual and motor memory, declarative and procedural memory, 'habit' memory, recognition and recall, explicit and implicit memory, embryonic imprints, holographic or cellular memory, anniversary memory, out-of-body memory, and past-life recall. (p. 172)

He explains that evidence from these capacities indicate that "memory appears to be an innate and ageless endowment of human consciousness" (p. 171).

Wade (1998b) defines three different memory capacities: local, nonlocal, and nonphysical or transcendent. Local memory is oriented from and held within a specific locale in the body, i.e., the brain. Nonlocal memory comes out of cellular impressions which lead to complex processes of learning and knowing. These impressions result from hormonal changes that occur throughout the body in response to life experiences. Nonphysical or transcendent memory is held in the transcendent consciousness which exists outside of the body and the physiological processes. All of these collectively help explain the recurring capacities of clients to access memories that go back to their conception, early embryonic development, and even preconceptive journeys, all of which predate the formation of the brain and its substrates. Wade (1998a) reports that patients "have accurately reported incidents long before any significant brain development had occurred, in some cases before the embryonic body was even formed" (p. 255).

Cheek (1986) and Wambach (1979) hypnotized, respectively, 500 and 750 patients and their findings also suggest that there is fetal memory that can recall the events of prenatal times. Ham and Klomo (2000) hypnotized 12 mother/child pairs to

cross-reference offspring memory with maternal memory. They concluded that there is a quality of detail in the prenates' recalled perceptions of their womb experiences that is "related to awareness of self, environment, and the people within the immediate environment" (p.141).

Carman and Carman (1999) have studied and documented hundreds of preconception memories and testimonials. They "are left with the conclusion that the boundaries of memory, without a doubt, transcend our brains' limitations and that human consciousness itself exists independently of a brain and nervous system, even before the tiny fetus forms" (p. 23). Finally, Wade (1996) identifies certain experiences as being naturally prone to becoming encoded in our memories. These include the experiences of conception, discovery, and the feelings a mother and father have about being pregnant.

Implicit and Explicit Memory

No discussion of memory is complete without mentioning the differences between implicit and explicit memory, both of which exist in our human memory capacity. The first is nonsymbolic, nonverbal, nondeclarative, and unconscious. The second is symbolic, declarative, and accessible through conscious awareness (Siegel, 1999; Stern, 2004). Siegel (1999) writes that implicit memories become manifest in the body or soma. Siegel gives credit to Antonio Damasio (1994) who first identified "somatic markers" (p. 173) as body cues that hold the memories and imprints from emotional experiences. Often these markers are unconscious and subtle movements that can elicit a present time sensation of the memory. Rose (1991) refers to this form of body memory as body core feelings, states in the body that do not have easily identified components to them. Siegel explains that somatic markers are present at birth and probably before. Castellino (1995, 2001) asserts that they are present throughout the prenatal period. Somatic markers

provide important guidelines for PPN therapy.

Memory as an Expansive, Holographic, or Universal Expression

Some theorists posit that memory exists beyond the body. Sheldrake (1996, 1999) writes that memory is in the field that surrounds us. He refers to this field as a "morphic field" (Sheldrake, 1999, p. 24). Morphic fields hold together and coordinate the parts of a system in space and time and contain memory from previous similar systems. This coordination takes place with the help of morphic resonances which are the processes by which like influences like to imbue our memories with information. These morphic fields are part of nature; therefore, memory is inherent in nature.

Others suggest that memory is a holonomic and holographic phenomenon. As in any hologram, the parts contain the whole. In this model memory is held throughout the organism and shared amongst all cells, each of which has a memory of the larger experience. In addition, the holographic phenomena contain both non-local and local layers. The local layers include elements of our chemical, cellular, somatic, brain-heart dynamics and the non-local components reach beyond the limitations and boundaries of individualized body parameters (Marquez, 2000; Pribram, 1971; Talbot, 1991).

Finally, Schwarz and Russek (1999) describe an expanded memory that they refer to as the "universal living memory" (p. xix) system, a systemic memory hypothesis which postulates that all dynamic systems store information and sustain memory (p. 209). Memory exists in all things. Examples are heart cells, water molecules, and atomic systems. According to Schwarz and Russek (1999) consciousness exists in everything and unites the one mind and the universal memory.

Cellular Memory

Farrant, in an interview with Raymond (1998), defines cellular memory as "a kind

of preverbal memory contained within the physical body of experiences that occurred when we were gametes; that is to say, there is a body memory, a cellular memory of our experience as a sperm, and also of our experience as an egg" (p. 4). Larimore and Farrant (1996) clarify this concept further. *Cellular consciousness* is the complete memory that we each carry in our bodies of our earliest experiences, including conception, and the separate experiences of being a sperm and an egg (p. 1). Raymond (1998) and Verny (1981) explain that these memories can inform us about our prenatal times.

Dossey (in Wade, 1996) states that memory is transmitted through the RNA in the nuclei of cells. Cell biologists Pert (1999) and Lipton (2000) who study the biological nature of cellular memory conclude that memory is encoded and stored at the receptor level of cells. Pert (1999) goes a step further to link memory with emotions and cell functioning. She writes that "memory processes are emotion-driven and unconscious" (p. 143). Wilheim (1998, 2002) also contributes to the understanding of cell behavior and cellular memory through her concept of a basic memory matrix from which our unconscious memories are derived.

> [This] matrix contains the imprints, done by means of a cellular memory, of the whole process of our biological experience, from preconception to birth—that is, since the formation of each one of the two basic germinative cells—sperm and egg—up to the moment of birth. (p. 21).

Memory as a Neurobiological Process

Noble (1993) offers yet another framework for understanding memory. She suggests that memory has no location or fixed content in the brain. "The brain has frames of reference or maps that serve in a selective process of categorization. It is not the contents of experience that are encoded in memory, but organizational patterns that

process experience in certain ways" (p. 54). She states that the new neurobiological sciences conclude that memory involves three essential capacities: perception, storage, and retrieval. In this way memory is understood to be a process that involves several different, but mutually dependent steps, all of which are necessary for retrieving the actual memory.

PPN Bonding and Attachment

An understanding of gestational bonding and attachment is essential to appreciating gestational twin bonding and its possible disruption following a vanishing twin experience. PPN psychology clinical data parallels traditional psychology findings regarding twin bonding as it occurs after birth (discussed in the Traditional Psychological Research subsection of this chapter). Woodward (1999), noting that bonding and attachment are central to our well-being and their absence underlies our pain and agony, states that Bowlby, the father of attachment theory, thought that "our attachments engage us in the most intense emotions during their formation (falling in love), and in their steady maintenance (loving), and their disruption, or threat of disruption, causes our deepest fears, anxiety and anger" (p. 126). Emerson (2005) writes, "a prenatal twin forms the *first* [italics added] connection or attachment in life" (p. 6). Because twins form at conception a the cellular level, they begin to develop individually as they travel together until each implants in the Mother's uterine wall. In terms of attachment theory, their first attachment is formed with each other; the second attachment is formed with the Mother.

PPN research suggests that bonding and attachment begin in the womb and that the nature of these relationships can influence later relationships in life (Castellino, 1999, 2000, 2001; Emerson 1996; Linn et al., 1999; Maret, 1997; Peterson, 1997; Rigetti, 1996; Speyrer, 2005; Takikawa, 2005). Gowell (2001) posits that prenatal bonding is an

expression of altered states of consciousness coming together, communicating, and impacting each other.

From the PPN perspective our prenatal times are fertile territories for both creating and disrupting bonds and attachments. La Goy (n.d.) suggests a prenatal etiology for attachment disorders: "To understand bonding and attachment disorders, it is crucial to understand prenatal trauma—more specifically, the relationship between conception, implantation, the early loss of a twin and the umbilicus" (p. 2).

Bonding and Attachment Prior to Conception

Carman and Carman (1999), Hallett (1995), and Luminare-Rosen (2000) have, collectively, gathered hundreds of self-reports and anecdotal examples of couples who claim to have been able to communicate with their future babies prior to conception. "Invisible interactions often mark the prelude to pregnancy, contacts beginning long before the development of the first embryonic cell" (Carman & Carman, 1999, p. 9). Chamberlain (2003) writes, "A growing literature, based on parent reports, is presenting numerous cases in which 'babies' were successful in opening a dialog with their future parents before conception, a notion in total conflict with scientific materialism" (p. 96).

Twin Loss and the Bonding and Attachment Disruption

Traditional psychological research indicates that twin bonds are among the most primary forms of bonding and attachment that can be experienced and that the disruption of these bonds can cause deep loss, even greater than that of a mother losing her child (Cox, 1994; Macdonald, 1994; Segal & Blozis, 2002; Tomassini et al., 2002). PPN clinicians are gathering similar clinical evidence that also indicates that there may be significant emotional and psychological trauma from the disruption of a gestational twin bond (Emerson, 1996; Findeisen, 2005). In addition, Brandt (2001) and Segal (2000)

suggest that surviving twins, who have lost a twin sometime during or after birth, always know, at least unconsciously, that they are twins. PPN clinician Rose (1991) comes to the same conclusion regarding vanishing twin survivors. She posits that they know, consciously or unconsciously, that they are a twin.

Bonding, Twinship, and God

Other PPN clinicians hypothesize that the twin relationship is the closest relationship that we have next to our connection with God (Castellino, 1999; Emerson, 2005; Linn et al., 1999; Rose, 1991). They say that twinship approximates the intimacy that one feels in one's relationship with Source. Conversely, twin loss also approximates the deep yearning for reconnection that one might feel from one's disconnection from the Divine. Linn et al. (1999) refer to this particular yearning as "divine homesickness" (p. 31). Emerson (2005) says that "for many of us, our twin merger was the closest we got to God while in the body" (p. 45) and that "twin loss is an exacerbation of divine loss, and often confused with it" (p. 46). Rose (1991) discusses one clinical case in which the patient reported that her experience of losing her early twin felt as if she had lost her connection to God as well as her bond to the universe.

PPN Imprinting

PPN research suggests that our prenatal and perinatal experiences can leave imprints and/or influences that can effect our development and our ability to become empowered, creative, and individuated beings. These imprints can come from conception, gestation, and/or birth (Janus, 2001; Marquez, 2000; Mauger, 1998; Noble, 1993; Righetti, 1996). This is relevant to the vanishing twin syndrome which is posited by PPN psychology to have the potential to leave significant imprints in the surviving twin. An imprint is defined as "any impression or impressed effect, a mark made by pressure"

(*Webster's Unabridged Dictionary of the English Language,* 2001, p. 963).

> Larimore and Farrant (1996) write that prenatal imprinting is extensive.
>
> These early times and experiences influence us in ways that we have never before been aware of, much less understood. It is being shown more and more that we are constantly (unconsciously) and profoundly affected by these experiences in every aspect of our lives. (p.1)

Janov (2003) explains how imprints function:

> Repressed memories, which find their way into the biological system produce distorted functions. These distortions can be both organic and psychological. . . .
>
> There are two ways in which imprints are set in place. One is through the experience of a single, excruciating drama. The other is through a series of events during which certain needs remain chronically unfulfilled over a period of several years. (p. 109)

PPN findings further suggest a scope of potential influences from gestation and birth that can effect one's sense of self; ability to relate to the world; ability to trust; belief systems; survival strategies; character dynamics; sense of safety; capacities to develop relationships with others; and over-all ability to experience oneself as a creative, loving, and individualized being (Castellino, 1995, 2000, 2001, 2004a; Chamberlain, 1994, 1998a; Emerson, 1996, 2000, 2002a; Findeisen, 2005; McCarty, 2002, 2004; Janov, 1983; Ham & Klomo, 2000; Verny & Weintraub, 2002).

This concept of imprinting is mirrored in the field of embryogenesis which posits that cell generations, which are formed from earlier cells dividing and differentiating, possess knowledge about the prior cells and the holonomic experience that existed earlier. It is as if the entity subdivides itself into smaller expressions of the same one

whole (van der Bie, 2001; Blechschmidt, 2004; van der Wal, 2004a, 2004b). van der Wal (1998) states "the embryo may be considered as a continuous whole or a completely self-organized being that seems to fall apart into its bodily constituents and organs" (p. 4). In this way, imprints occur on a cellular level.

Internationally known MD and expert in the filed of embryology and anatomy, Jaap van der Wal (1998) traces the evolution of embryological gestational imprinting. He explains that the body is formed through an evolution of behaviors that propel cell differentiation and specialization. Old cells give way to new ones, and so on. As they do, they pass on imprints from their experiences. In this way, early experiences bear influence on subsequent cell generations. The experiences of early fetal development can set in place developmental patterns that continue (Findeisen & Lipton, 2004; Shea, 2007). The application of this concept to the vanishing twin occurrence suggests far-reaching consequences in terms of the long-range imprinting from the loss of a twin that occurs very early during gestation. Noble (1991) emphasizes this concept: "The earlier the loss, the more intense the imprint" (p. 74).

PPN Trauma

The concept of prenatal trauma is essential to understanding the vanishing twin syndrome from the PPN perspective. Castellino (1995) discusses the origin and nature of traumatic imprinting: "Trauma impacts can result from a single event or a series of events that, in any way, cause overwhelm to a person's spirit, psyche or physical body" (p. 5). He goes on to say that "the trauma may be psychic, emotional or physical" (Castellino, 2000, p. 34). Janov (1983) states that "What we know is that *trauma begins in the womb*" (p. 25). He continues,

The pains that are stored in the womb can be "remembered," but not in terms of

> the cognitive memory mechanisms we are familiar with. Fetal recall is a body memory. The body remembers, in its own way, and that stored "knowledge" is no less valid than intellectual recall. (p. 27)

Storage of PPN Trauma

Emerson (1999) suggests that "traumatic memories are somatically stored in cells, tissues, fluids, postures, schemas" (p. 1). Linn et al. (1999) state, "memories of unresolved trauma are stored in the energy field that surrounds the physical body" (p. 49). Pert (1999) writes that there is a molecular basis of memory in biochemical changes that occur at the receptor level of cells and that "traumatic memory is stored on the level of neuropeptide receptors, deep in the interior of the cell" (p. 271). Sequi (1995) posits that the body carries prenatal traumas in an attempt to make sense out of them and to find a way to integrate them.

General Imprints From PPN Trauma

Prenatal trauma can leave deep imprints in one's capacities for development and expectations of and ability to relate to life. Fogel (2002) states that traumatic memories can be resistant to modification by further experience and, therefore, influence perception and experience throughout the life span. Emerson (1996) writes, "early traumas shape how subsequent events will be perceived and experienced" (p. 140). Thomson (2004) explains:

> Early trauma, whether experienced pre- or postnatally, is encoded and processed at the subcortical or unconscious level. These early experiences form a rudimentary template from which all other experiences will be appraised; they profoundly influence the later forming cortical or conscious levels of processing. (p. 11)

Possible Emotional and Psychological Imprints From PPN Trauma

Grof (1988) explains, "memories of fetal traumatization seem to be among important factors underlying general emotional instability and various specific forms of psychopathology" (p. 75). Findeisen (2005) writes that "when early experiences are either physically or emotionally traumatic, they leave survival imprints that cast a dysfunctional shadow, lasting into adulthood" (p. 1). Sequi (1995) posits that the difficulties that embryos and fetuses experience in the womb are "the possible intrauterine origin of character structures and, therefore the somatopsychic core of conflicts" (p. 309). Emerson (1996) writes that "prenatal and birth traumas impair bonding at birth" (p. 6) and lead to later bonding and attachment problems.

Speyrer (2005) also references Frank Lake's concept of umbilical affect. He points out that this connection, as it exists throughout gestation, sets in place the organization of our future capacities to establish and maintain relationships. Janov (1983) suggests, "very early trauma may somehow be stored in the bodymind, expressed in psychosomatic conditions through adulthood" (p. 166). He continues, "The roots of some disease, both psychological and physical, may go beyond genetics to the prenatal and perinatal or transpersonal realms of consciousness" (p. 168). Ward (2004) summarizes this potential for prenatal trauma to leave imprints saying that these early experiences "may hold the key to subsequent adult behavior, relationships, attitudes, diseases we develop and the blocks that inhibit human potential" (p. 90).

PPN Perspectives and Research on Vanishing Twin Loss

Thus far, twin loss has been considered from the traditional psychology perspective as it occurs after birth, during the life span, and in terms of its potential emotional and psychological ramifications for the surviving twin. Traditional research

indicates that the experience of losing a twin can be profoundly traumatic (Segal, 2000; Woodward, 1999). PPN psychology looks at twin loss as it occurs along the prenatal and perinatal continuum, from conception through birth. As research continues to expand our understanding of this subject, public awareness is beginning to grow with publications like, *Untwinned* (Hayton, 2007), an anthology of twenty articles on the subject of prenatal twin loss. PPN clinical findings suggest that gestational twin loss can be as emotionally and psychologically traumatic to the surviving twin as it can be for the surviving twin who has lost a twin later in life (Rose, 1996).

Noble (1993) provides an example of one patient's experience as she relived her early twin loss during a regressive therapy session:

> Sarah went into deeper feelings, and responded that she felt as if she were "floating, dangling with a string through her middle" (such metaphors may be obvious to us, but the patient may not realize that this is the umbilical cord.) Then came grimacing and grief reactions: "It is leaving to my left", and "I'm moving this way" (she slid slowly to the left). . . . "I'm staying, I'm hanging in here. But I'm so afraid, and I don't want it to leave." I asked her if she was hanging on with her hands and feet, and she said, "I don't have hands and feet yet." Thus, I knew that her embryological development was prior to six weeks. (p. 225)

PPN Vanishing Twin Frequency

From the PPN perspective the vanishing twin dynamic occurs much earlier and more frequently than medical research indicates. Regressive therapies suggest that it occurs primarily during the first 3 weeks of life—between conception and the implantation process (Castellino, 2001; Emerson, 2005; Rose, 1996). This period is fraught with specific embryological transitions that are precarious and challenging to the

survivability of a conceptus/embryo and which could lead to the demise of a twin (Shea, 2007). Because medical research does not typically perform routine ultrasounds prior to six weeks, it would make sense, from this PPN perspective, that a conception could come and go and never be detected by medical professionals or technology (Emerson, 2005).

Again, PPN research posits that vanishing twins occur more frequently than medicine suggests. Segui (1995) argues that 50 percent of conceptions "are lost at the beginning of pregnancy, within the two or three weeks following fertilization" (p. 315). PPN oriented clinicians believe more people may have experienced twin loss than the consensus realizes. Findeisen (2005) writes, "it is estimated that 70 percent of all twins conceived do not reach term" (p. 7). Noble (1991) notes that possibly 80 percent of twin pregnancies are lost (p. 50). Emerson (2005) suggests that 30-80 percent of all conceptions are multiple, as apposed to singleton conceptions, and that 70 percent of singletons may be surviving twins. La Goy (1993a) reports that in her clinical work with children between the ages of 14 months and nine years, 23 out of 25 discovered that they had experienced a twin loss in utero.

Dr. Wendy Anne McCarty (2006) has not seen the same extensive vanishing twin percentages in her practice though she agrees that research is clearly indicating that many more individuals than previously believed seem to be survivors of a vanishing twin loss. She suggests that practitioners who are themselves twins or survivors of a twin loss, either vanishing or other, may have a greater sensitivity to the experience which could influence the nature of their receptive field to the issue. As a result, they may attract a greater client base of survivor twins into their practices and, therefore, their clinical research may reveal a greater percentage of vanishing twin survivors.

Possible Causes of Early Twin Loss

The embryological perspective. As discussed earlier, medical research claims certain causes for first-trimester twin loss. PPN expert and clinician Dr. William Emerson (2005) suggests that there are four types of circumstances that may cause early twin loss. Each is relevant to this research as each may contribute to the formation of distinct emotional and psychological imprints in the surviving twin:

1. The first type is a spontaneous twin loss that occurs from natural causes during a wanted pregnancy. The imprint for the fetus is one of being wanted. This type of twin loss is the least traumatic.
2. The second type is a spontaneous twin loss that occurs during an unwanted pregnancy. The imprint is one of not being wanted and rejected by the parent(s). This type of twin loss is more traumatic than the first.
3. The third type is a twin loss that occurs from a partially successful abortion attempt in which one twin survives. The imprint is not being wanted and also of being left alone in the womb to continue to develop on one's own. This type of twin loss can be devastating.
4. The fourth type is a twin loss that occurs through the selective reduction process that is often used in artificial reproductive technologies. The imprint is similar to failed abortion imprints but can be even more painful because there may be several twin losses to contend with, as there are often more than two fertilizations.

In addition to the above, embryology teaches that there are other challenging physiological transitions that the egg, sperm, blastocyst, and embryo must navigate through successfully, within a specific time frame, in order to survive. If there is a failure

to do so, then the new life may become threatened. They include: the fallopian tube journey, implantation, and the formation of the umbilicus (Emerson, 2005).
Noble (1993) points out that "conception, implantation, and birth present survival issues that are more of a challenge to twins than to singletons" (p. 213).

Emerson (2005) elaborates on the precariousness of implantation as a phase that is time sensitive and requires the blastocyst to implant into the uterine wall in order for the pregnancy to be viable. If implantation is premature or post mature, actual death can occur. If the embryo manages to survive a precarious implantation in which the timing is off, there can be a near-death experience that registers in the fetal consciousness as a traumatic imprint and this can affect later functioning during the lifespan. If twin loss does occur either during or right after implantation, then there is a greater possibility that there will be some form of trauma and also visible bleeding.

In addition, there are pathological circumstances in the early embryonic stages that can cause abnormal growth and development both in the placenta and the umbilical cord threatening the growth and functionality of both. Abnormalities in either could lead to the death of an embryo (Carlson, 1999). Anastomosis is another potential threat to fetal life. This is the abnormal formation of tubular structures which can occur in the blood vessels of the placenta. This causes an unequal distribution of nutrients through the vascular systems to twin embryos, potentially causing the death of one (Castellino, 2004a; Dox et al., 1993).

Womb and umbilical toxicity are also conditions that can threaten both single and, especially, multiple conceptions. In these instances, the womb and/or umbilicus become contaminated with toxic substances that get transmitted to the embryo/fetus/prenate. Toxins include all forms of environmental pollutants and deleterious substances that are

in the mother's system from smoke, drugs, alcohol, and excessive hormones due to maternal emotional, psychological and/or physical stress (Emerson, 2005; Rose, 1996; Segui, 1995). It should be noted that maternal toxicity can also come from negative responses and emotions that a mother has to being pregnant. In addition, accidents, falls, family crises such as deaths in the family, mother/father conflicts, financial worries, and moving from one living situation to another can create toxic ramifications for the fetus/prenate as well (Castellino, 2001).

Finally, because multiple conceptions require greater nutritional outlays from the mother, if her health is compromised or her resources are depleted, then she may not be able to meet the needs of her twins. This can threaten the viability of her pregnancy. Poor eating habits, maternal illness, lack of rest and/or excessive fatigue can compromise her system (Castellino, 2001, 2004a; Emerson, 2005; Rose, 1996; Segui, 1995).

The embryogenesis perspective. The above considerations are best understood from the embryological perspective which offers explanations and informs the PPN knowledge base. Embryogenesis, as previously mentioned, looks at these embryonic phases from a phenomenological point of view. It explains the nature of the four transitions which occur in the first three weeks of embryonic development that are critical for the survival of the embryo and which, if not traversed successfully, could lead to the death of the embryo. Each is a developmental nodal point that occurs in the transitions between certain primary stages of dynamic morphology and the development of form and structure (van der Bie, 2001). Shea (2007) points out that the successful completion of each stage requires the embryo to generate an enormous amount of energy and potency. If the embryo fails to do so adequately, it could die (van der Bie, 2001). The four transitions are as follows:

1. First transition: Egg and sperm merge together, join their separate identities into one, negotiate the states of polarization that occur during conception, and that comprise the conditions of fertilization (Hall, 2004).

2. Second transition: At the end of the first week, the blastocyst must free fall out of the fallopian tube into the open space of the uterus (equivalent to jumping off of a 20-story building). The blastocyst must crack open its zona pellucida shell leaving itself unprotected and exposed to the mother's immune system and float over to the uterine wall in the hope of being invited in (Blechschmidt, 1977).

3. Third transition: At the beginning of the implantation process at the end of the second week, a very complicated and multifaceted endeavor requires the blastocyst/embryo to connect its own inner and outer bodies and to the uterine wall. This includes the initiation of blood formation which carries the connective tissue necessary for connecting to the future placenta. In addition, the embryonic steps that occur during this transition give rise to the embryonic structures that will eventually become the umbilical cord. If this transition is not successfully traversed, the embryo will die (van der Wal, 1998).

4. Fourth transition: At the end of the third week begins the formation of the heart. This includes repositioning the heart from the top of the head into the heart space in the middle body. Very powerful fluid dynamics are necessary in order to equalize the pressure between the amniotic sac and the yoke sac so that these steps can take place. If any of these steps are not properly completed the consequences can be deleterious or fatal for the embryo (Shea, 2007).

Each of these four transition stages is a monumental accomplishment in and of itself. The thought of one single embryo successfully executing any of these steps is

amazing. The thought of two or more embryos successfully executing them at the same time is quite miraculous. When one understands the magnitude of these endeavors, each of which is necessary for the further solidification of life, the myriad of things that could go wrong and that could cause a twin to die become comprehensible. The inherent precariousness of these first embryonic weeks becomes apparent, the potential for a vanishing twin syndrome to occur becomes plausible, and the possibility that all of this could occur long before the medical model detects anything becomes probable.

The psychological perspective. PPN psychology posits that there are psychological and emotional influences which might lead to a vanishing twin dynamic. PPN clinical data suggests that a pregnant mother's mental, emotional, and physical condition has an impact on her offspring. Verny and Weintraub (2002) write that a pregnant mother's state influences her prenate's development and that there is "the potential for increased risk of lifelong problems for children exposed in the womb to excessive maternal stress, anxiety, and depression" (p. 37). Linn et al. (1999) find that "babies marinate in the mental, emotional, and spiritual climate of their parents' inner lives, and their consciousness is permeated by their parents' world" (p. 12). Gowell (2001) explains that "we are electromagnetic bundles of particles and waves" (p. 317) resonating with our environments. As sperm, eggs, and embryos, we are impacted and influenced by the energies that resonate in our mothers and fathers.

Based on these premises, PPN psychology posits that maternal, and possibly paternal, emotional and psychological rejection of a pregnancy can traumatize and challenge the survival of an embryo. These states can create an emotional toxicity that comes from negative feelings, maternal stress, and maternal depression. These dynamics appear to contaminate the umbilical connection and the environment of the womb which

may leave long-range imprints in the consciousness of the surviving prenate. Imprints for the surviving twin can include feelings of not being wanted, not being seen, not being worthy of being loved, and not being worthy of existing (Castellino, 2001; Emerson, 2005; Rose, 1996; Speyrer, 2005). Emerson (2005) explains that a mother's negative feelings can even unconsciously limit needed nutrients and blood supply to the embryo and thereby jeopardize its survival.

Graham Farrant, an Australian psychiatrist, refers to this same dynamic but from a slightly different angle. He talks about the power of a woman's thoughts to effect ovulation. In Noble (1991) Farrant is quoted as saying that "some women have willed their egg to split or consciously desired to release two eggs" (p.35). If this is true, then it could be extrapolated conversely that mothers and fathers who do not want to become pregnant or who, more specifically to this study, do not want to have twins, might be able to similarly effect the lack of viability for an egg split, or egg release, or perhaps even a second conception.

The Embryogenesis of Psychological and Emotional Imprinting

Embryogenesis provides explanations for the possible emotional and psychological influences that can be overlaid on the metabolic process that underlies embryonic development (Shea, 2007). Development occurs through physical and chemical changes out of which material substance is produced. The ordering principle that governs and facilitates this unique metabolism is the consciousness of the prenate which is held in the fluid dynamics of the metabolic fields (Blechschmidt, 1977, 2004; Shea, 2007). Guus van der Bie (2001) explains that "consciousness can influence metabolism. Psychological events can change the physiology of metabolism in a split second. Fear, anger, and happiness are well known for their physiological effects" (p. 47).

In this way, the emotional and psychological dynamics that are present during gestation have the potential to affect the metabolic fields in which the embryo grows and thereby affect the growth of the embryo (Shea, 2007).

Possible Long-Range Vanishing Twin Imprinting

LaGoy (1993a) explains that "the loss of a twin in utero is a significant trauma" (p. 443). A vanishing twin experience can be extremely painful and can influence how the surviving twin goes forward into his or her life. Farrant believes that '"the vanishing twin syndrome is an emerging psychiatric condition"' (as cited in Noble, 1991, p. 221). Rose (1996) explains:

> The effects of losing a twin in the womb can be devastating. People with twin loss say they're born guilty, or grieving, and have a deep sense of grief that follows them through life. Many personality characteristics can be traced to twin loss. (p. 64)

Noble (1993) expounds on this same kind of wounding: "There can be imprints from a lost twin right after conception, an experience of debilitation that one individual describes as going through life thereafter 'rowing with one arm'" (p. 224). In *Having Twins* Noble (1991) relates the words of a client who recalled the moment when her twin died in utero:

> My "other" went away for ever. From then on, my entire being, body and all, was bathed in sorrow—a deep all-encompassing despair that permeated the whole universe for me. That was *all*, that was life. It was so *physical*. I was weakened by it. (p. 72)

Common feelings that are described by vanishing twin survivors include: a deep sense of loss, despair, numbness, dissociation, sadness, generalized fear, rage, guilt,

insecurity, fear of dying, fear that the world is unsafe, dread, depression, aching loneliness that feels as if one could die from it, sleep difficulties from an anticipation of catastrophic loss, fear of abandonment, anxiety, self-destructive feelings, disorientation, and aggression (Castellino, 2001, 2004a; Emerson, 2005, 1996; Rose, 1991,1996; Woodward, 1988, 1999). These are similar to experiences described by surviving twins who have lost their twin sometime after birth and during the lifespan. Emerson (2005) also sees possible correlates between having lost a twin in utero and a generalized higher propensity for physical challenges later in life.

Frank Lake (as cited in Maret, 1997) specifically links the stages of embryological development and the accompanying transitions to the formation of personality disorders:

> We must begin at conception, through the blastocystic stage, to implantation and the events of the first trimester. It is here, in the first three months or so in the womb, that we have encountered the origins of the main personality disorders and the psychosomatic stress conditions. (p. 2)

Possible Vanishing Twin Implications for Bonding and Attachment

LaGoy (n.d.) writes, "To understand bonding and attachment disorders, it is crucial to understand prenatal trauma—more specifically, the relationship between conception, implantation, the early loss of a twin and the umbilicus" (p. 2). Emerson (2005) adds, "Most people who have lost twins have predispositonal attachment disorder" (p. 36). He explains further:

> The majority of twin trauma occurs in the first eight weeks of the prenatal period. Twin loss disrupts the attachment process. According to the most ancient cultures who studied twins over centuries, twins are bonded at the level of the soul. So

> losing a twin is losing a soul-partner and a very deep soul attachment is broken. Understandably, this trauma damages the survivor's ability (and willingness) to attach later in life. (p. 35)

Dawn (2003) researched bonding and attachment experiences in 53 surviving twin adults who had lost their twin before or at birth. Her "data clearly showed that surviving twins are lonely, feel something is missing, feel guilty, and have difficulty in intimate relationships" (p. 151). Fifty-three percent of her research subjects explicitly expressed having "difficulty in some area(s) of intimacy in general—difficulties encountered in bonding, relating, and closeness" (p.79). In addition, she found a propensity toward longing for "a special kind of closeness that remained elusive and unattainable" (p. iv). Rose (1991) suggests that the knowledge of one's lost twin is always present in the surviving twin, whether or not it is held consciously.

Emerson (2005) and Rose (1996) both discuss coping methods that they perceive in their surviving twin patients which enable the surviving twin to deal with the pain of their loss. When letting go of their twin is too painful, surviving twins will sometimes embody some of their lost twin's characteristics themselves, and/or seek others who embody similar characteristics. This enables them to prolong their connection with their loved one. When remembering their twin is too painful, surviving twins will sometimes distance themselves from the memory and choose to avoid, reject, and/or deny reminders of their twinship. Rose (1991) writes about "ghost bonding," which occurs when one is secretly dreaming of the idealized lost twin while in relationship with another. This type of bonding can go on for years and be of such a debilitating nature that the individual is not able to form other relationships. Rose posits that this kind of yearning torment can result from very early gestational twin loss.

Emerson (1996) identifies other restrictive patterns in bonding and attachment that he observes in his clinical practice. The list includes defensive withdrawal from the world, pervasive insecurity, fear and avoidance of loss, fear of making contact, and fear of abandonment. Woodward (1988, 1999) also discusses the relationship imprints that she has observed in her practice. She, like Rose and Emerson, notes deep feelings of missing and searching for one's lost twin and the influence this has on the way one searches for a partner and allows that partner in. Sometimes the missing is so intense that it prevents being truly available to the new potential partner.

Noble (1991) talks about feelings of guilt and responsibility that can haunt the surviving twin: "With intrauterine death or still birth, the survivor feels even more intimately involved and often feels directly responsible for the destruction of the twin" (p. 74). At best, the plight of losing a twin can be a precarious and challenging experience to negotiate.

Castellino (2004a) writes about his clinical experience with "double bind" imprinting relative to twin loss. He explains that a double bind is a conflicting paradoxical state in which there seems to be no possible resolution and he suggests that it can actually be a byproduct of a vanishing twin loss.

> [Double binds] are usually created by life/death situations where one can go in more than one possible direction but the outcome of each possible direction appears to be a loss. . . . [T]hey can also occur when something happens against one's will and one is actually powerless to change it. (pp. A3-A4)

If the circumstances in the womb are such that there are not enough resources to support twin fetuses, then one, or both, will die. In this scenario, the life of one is actually tied to the death of the other and vice versa. There is no solution that procures life for both. This

can be profoundly debilitating. Often this paradox becomes internalized and will "show up as an energetic and visceral experience in the organism that can manifest as complicated and conflictual tension with the person's system" (p. A4). These imprints can influence many areas of one's life, as issues of prenatal survival effect present time experience, perception, and choice. They can compromise one's capacity to create and maintain relationships and bonds, make choices in life that facilitate solutions to conflicts, and allow free self-expression. In addition, layers of survival guilt, anger, hopelessness, fear, terror, competition, and collapse add to the confusion. Often, these dynamics can be experienced as being so global that they are perceived as too big to be solved by any one individual.

Rose (1996) lists the relationship styles that she has observed that she feels can be indicative and symptomatic of having lost an early twin. These include: (a) habitually establishing relationships quickly without allowing enough time to really get to know the new person; (b) habitually ending relationships abruptly; (c) cultivating merged relationships; (d) seeking extreme states of closeness whether appropriate or not; (e) preferring one-on-one relating; (f) projecting the original attachment style that existed in the twinship onto present-time relationships; and (g) habitually choosing to live alone in order to avoid the risk of another loss.

Other consequences of twin loss that relate to attachment can include an anxious gestational attachment to the uterus, to the umbilicus, and to the mother. This anxious attachment can continue after birth and cause nursing and digestion difficulties (LaGoy, 1993b).

Identity Issues and Twin Loss

Both traditional and PPN psychology agree that twins have a unique experience of

identity that true singletons do not know. From the beginning, their experience of themselves is intimately tied into their relationship with another. Their sense of identity is embedded in the twin pairing. When one twin dies, the surviving twin must cope with the disappearance of that identity and find a new way to know self as a separate being. This can be a very difficult and complicated challenge (Castellino, 1999, 2004a; Brandt, 2001; Emerson 2005; Rose, 1996; Woodward, 1988, 1999). Castellino (1999) explains this challenge from the standpoint of merging, survival confusion, and identification. He says that prenates merge into the other and their experience can be one of "I am you. You are me. Your presence is my survival. My presence is your survival" (personal communication, February 14, 2007). In light of this, the surviving twin is faced with a huge dilemma. How can s/he survive without the other? And, even more critical, does s/he even have the right to live? Finally, if the surviving twin identified with the death of the lost twin, s/he may have difficulty realizing that s/he survived and did not die as well.

Bowlby (as cited by Woodward, 1999) states that, "Attachment lies at the heart of the development of a 'sense of self'" (p. 5). Woodward (1999) explains further that because our attachment experiences influence how we come to know and recognize ourselves, the twin attachment becomes the blueprint for one's experience of self. She cites the words of one lone twin:

> To loose a spouse is a tragedy, to lose a child perhaps the greatest tragedy most of us could imagine; but everyone had some identity before becoming a spouse or a parent. A twin is never anything but a twin until separation by death, and there is no way of untwining except by death. In that most intimate of bereavements, the surviving twin finds the foundations of his or her own identity undermined, because twin hood bestows the singular oddity of a plural identity. (p. 108)

Woodward (1999) points out that there in lies

> the deep paradox that exists in every twin relationship. This is due to the fact that their "sense of self" is built on the concept of being a "pair." They are defined as "the twins," part of a twosome, yet this definition challenges a concept of single identity. (p. 5)

In this way, claiming one's individuality can be inherently conflictual for a twin. Without the familiar parameters and definitions of the twinship, an individuated self can be difficult to find. Findeisen (2005) suggests that loving and supportive parents can help mitigate the confusion and support the discovery of a new self for "ideally, this sense is reflected back to them through their mother's loving, caring and valuation of them" (p. 5). But if that doesn't happen, then a twin must find his or her own sense of self alone, or with the help of other sources of support and assistance.

Traditional Therapy With Children

In order to gain a better understanding Sam's therapeutic process, it is necessary to understand the basic components of the PPN therapeutic approach which seeks to support individuals to access, integrate, and release their prenatal and perinatal wounds and traumatic imprinting. PPN therapy is multidimensional. Theories and techniques from many different therapeutic modalities inform the PPN process, including psychology, the regressive therapies, the somatic body/mind therapies, trauma resolution work, attachment theory, and craniosacral therapy. PPN therapy endeavors to help individuals explore, integrate, and come to terms with their prenatal and perinatal experiences. It does so by providing a very specific form of support that is essential when facing the particular kinds of traumatic imprints that occur during these early times (Castellino, 2001). As Bradshaw (1998) so aptly put it: "We know grief can naturally be

healed if we have support" (p. 138). Techniques vary depending on the age of the client, but the perceptual lens through which the therapy is conducted remains the same.

Traditional Therapeutic Modalities With Children

A number of traditional therapeutic techniques are used in PPN therapy. Some of them are

1. Play Therapy

   Children's behaviors and verbalizations are meaningful communications of underlying thoughts and feelings. Play therapy enables children between the ages of three and eleven years old to give expression to these communications while supporting them to explore resolutions to difficult issues, while they are being understood by another. Parents need to be involved in therapy with their children as they are part of the primary support system (Annunziata, 2005; Glazer, 1999). St. Thomas (2002) says that play therapy serves as a means of uniting pain and joy. From his perspective, this union is an essential step in the healing process. Play is an arena where children can express their conflicts while also expressing their joys. Where these two dynamics meet is where the possibility for resolution of pain resides. Webb (1993) writes that play is the language of children and is crucial in their healing of loss. Play therapy is a nonverbal means through which children can express grief and bereavement. It enables them to deal with their feelings in a displaced and disguised manner. When grief and bereavement are involved "most children have limited ability to *verbalize* their feelings, as well as very limited capacity to tolerate the pain generated by open recognition of their loss" (p.13).

Therapeutic play includes general play, doll play, puppet play, storytelling, board games, and individual and group therapy play.

2. Gestalt Therapy

Short-term Gestalt therapy is also a means of working with children who are dealing with issues of loss and grief (Oaklander, 2000). Gestalt therapy focuses on one's experience in present time as a means of accessing, exploring, and releasing the deeper layers of an issue or dynamic. It is phenomenologically based in the now and typically engages clients by asking them "what" and "how" questions in a way that supports them to explore their experience, understand it, take responsibility for it, and move beyond it.

Gestalt therapy, when used with children, supports them to express what it is they are feeling in the present moment and to do so with the support of the therapist through specific activities that are direct and experientially oriented. Drawing, working with clay, making up fantasies, storytelling, sand tray, music, and puppetry are all ways of supporting children to express their deeper emotions in a fun, non-threatening manner. These activities provide children with a safe means of approaching and exploring experiences that may otherwise be too challenging or overwhelming to speak about or even acknowledge. Issues of one's sense of self, the nature of one's relationships, one's awareness, and the nature of one' contact and resistant impulses can also be explored through the Gestalt approach.

3. Art Therapy

Children's artistic expressions are forms of impulses and emotions that have been transformed into images. These images can be expressive doorways during therapy (Malchiodi, 1998). Malchiodi (1998) advocates for a phenomenological approach to understanding children's drawings and a therapeutic posture that supports child-centered work. He placed an emphasis on an open perspective, a willingness to consider a variety of meanings, and a willingness to maintain a posture of "not knowing" (p. 36).

4. Jungian Sand Play

Sand play is a successful means of exploring symbolic and archetypal expressions. The tactile and visual aspects of the medium facilitate deep spontaneous and unconscious expressions that indicate a rich array of symbolism and meaning (Ryce-Menuhin, 1992; Steinhardt 1998). Emerson (2002a) states that the sand-tray represents the womb and, therefore, facilitates the expression of deep unconscious prenatal experiences.

5. Non-directive approaches

Annunziata (2005) and Carroll (1995) emphasize how important it is for therapy to be non-directive. The child takes the lead and brings forth the material that needs to be addressed. The therapist always follows and tries to invite the child to express his/her concerns through the play and talk.

The Therapeutic Alliance

According to Woodward (1999), therapeutic alliances must be based in genuine, honest, and open relating. Clients must have the right to choose and make decisions

regarding how to proceed in a session and what actions to take. Similarly, therapeutic interventions must be used from the perspective of supporting the client's intentions. Webb (1999) explains that a therapist's role with young clients is to (a) participate while always allowing the child to take the lead, (b) set limits that build the child's ego strength, and (c) make connections between the child's symbolic play and his/her real life. Finally, with regard to art therapy, (Malchiodi, 1998) identifies the therapist's roll "as one of co creator, rather than expert advisor" (p. 36). The client is considered the authority regarding his or her own experience.

PPN Therapy With Children

As stated, PPN therapy is a multifaceted therapeutic approach, the full breadth of which is beyond the scope of this study. In addition to the modalities mentioned above, there are many others that are core to the PPN therapeutic process. They will be addressed below within the context of working with children.

PPN Foundational Therapeutic Principles, Techniques, and Protocols

Emerson (2002a) says that the empathic experience is at the heart of the PPN therapy session. "The core of the treatment process is relational and depends entirely on empathic contacts between 'therapist' and their infant or child clients" (p. 32). Castellino (2004b) explains that the main purpose of PPN therapy is to provide an accurate reflection back to a child so that they can come to know themselves and find resolutions to their traumatic imprints. The need to be accurately reflected is a survival need and supports the child to integrate through his or her sensory motor system. Without it, one goes through life making up aspects of reality and creating imaginary reflections based on early imprinting. McCarty (2003b) suggests that it is the process of acknowledging what actually happened to a person, telling the truth of their experience and the events

that occurred for them, that is the essential key in PPN therapy. “Truth helps to orient us deeply within our self. When conveyed with love, compassion, and care, it can be the ‘mother’ of self-regulation and attachment” (p. 2). Truth helps families to “reconstellate a new, more coherent, harmonious pattern and relationship” (p. 2). All three of these perspectives are at the center of the PPN process.

In addition, Castellino (2001, 2005) identifies two other primary and essential principles that are key to facilitating PPN therapy with children. The first, he says, is the principle that everything that a neonate, baby, and child does and says is purposeful and is trying to communicate something. This communication, of course, usually emerges from subconscious states but, never the less, occurs as an attempt to communicate something about one’s reality to another. Second, is the principle that children will often communicate what they are feeling and experiencing by doing something that will elicit the same feeling and experience in those with whom they are trying to communicate. This means that if a child feels extremely frustrated, they will behave in ways that will cause the person with whom they are trying to communicate to feel similar states of extreme frustration.

The Somatic Experience and the Somatic Reflection

PPN therapy utilizes the somatic experience as a core therapeutic tool. Emerson (2000) writes that “prenatal and perinatal experiences are initially encoded in the body and are primarily somatic memories” (p. 48). They are expressed through “the soma—through the body—in nonverbal gestures, postures, voice tones, muscle tones, movement patterns, and other somatic dimensions” (p .48). Castellino (2005) states, “Children are creatures of movement, emotion, sequences and rhythm” (p.4) and they speak through the language of action, emotion, sound, and movement. They receive knowledge and

information through their somatic and kinesthetic experiences. That is why, in therapy, it is essential that their sensory motor system be reflected back to them by the therapist or primary caregiver. When this happens, children are able to integrate their experiences through their brainstem and cerebellum which helps them to find themselves. Castellino (2004c) emphasizes that

> Unless both children and adults are approached from that somatic place, the lower centers of the nervous system will not be included in the therapy. So in order to work with the lower centers of development, and the earlier developmental sequences, we have to go to the body level. (p. 10)

This somatic component is also essential for the resolution of trauma. Emerson (2002b) explains that "trauma is not only a central nervous system memory, but a somatic memory as well. . . . When catharsis without somatic technique is finished, the tonic patterns, trauma postures, and trauma movements still remain" (p.7).

The Need to Tell One's Story and/or Reveal It Somatically

Children are always telling and showing us their stories, and they will tell and show them over and over again until they are complete with the experience (Castellino, 1999; Emerson, 2002a; McCarty, 2004). McCarty (2004) explains that what is most important, relative to our children's communications, is that we hold their stories as sacred. Even when we don't understand the meaning of what they are saying or showing us, we sit with the mystery and wonderment of what they might be telling us and wait until the answers unfold and make themselves apparent. Marc et al. (cited in Wilheim, 2002) states that "the child doesn't say 'this is what happened to me in my prenatal life', but it expresses it spontaneously as something that its body sets into images. . . [and] it does it over again, in the sense of repeating" (p. 20). Castellino (2004c) says that children

tell and show their stories "with their body, their symbolic play, and how they sequence their emotions" (p.10). Meanings will unfold if we are willing to be curious and wait without imposing an interpretation. Fosha (2002) explains that the need to tell one's story over and over again is part of the process of "fighting against the obliteration of the self. . . . The telling detail reveals the humanity of the person that trauma threatens to wipe out" (p. 10). Woodward (1999) orients this story telling to the needs of the surviving twin. From her experience, surviving twins need to be able to share their story over and over again with someone who genuinely understands and feels deep compassion for their plight and their grief. This is an essential part of the process of coming to terms with their loss.

Attuned and Coherent Relationships

It is important that a child's experience be reflected back by a therapist who is in harmonic resonance with him or her. Harmonic relationships are relationships that are attuned on the level of the nervous system's functioning and pacing. They facilitate the establishment of a coherent relational exchange with another individual, with oneself, and also with one's past. Children who are met in this way will experience a somatic settling that allows the issues to be processed and released on a body level, and this enables the material to be integrated as a coherent whole (Castellino, 2004c; Siegel & Hartzell, 2003).

PPN Counter Transference

PPN counter transferences can have additional components to them that do not occur in traditional therapy (Castellino, 2004b). Because PPN material is preverbal, it is held in our implicit and somatic memories requiring a form of processing that understands the PPN mechanisms. A therapist's own conception, gestation, birth, and

post birth experiences can come to the surface very quickly and can require additional support and supervision. For this reason, it is important that PPN therapists do their own personal work and have a broad understanding of (a) how PPN dynamics can show themselves, (b) the origins of prenatal trauma, (c) the nature of PPN imprinting, (d) how PPN experiences can manifest in individual and family unit functioning, and (e) how to support the acknowledgement, integration, and healing of these early imprints/wounds (Castellino, 2004b).

Symbolic and Somatic Interpretations

When trying to understand a particular behavior or sequence of behaviors, a PPN therapist must pay attention to the felt sensation of what is happening, as well as to the symbolic meaning. The somatic experience actually informs the intellect and tells the story from a different perspective. In this way the understanding comes from the bottom up and inside out. When a therapist includes the sensation of the experience, the symbolic nature of things comes into view through the sequence and sensation of what is happening. Then the intuitive right brain becomes connected and included in the awareness. This leads to a deeper and more comprehensive understanding of what is being communicated (Castellino, 2004d).

When a therapist just seeks the meaning of a behavior (a left brain analytical activity), s/he can become distracted from the unique expression of that child. If a therapist suspends judgment and focuses on being present with the experience, the discovery of the symbolic nature of that child's expression will emerge. From this perspective, understanding symbology is really about connecting with the client in a more expansive way (Castellino, 2004d).

Possible Indications of Traumatic Imprints

Castellino (1999) posits that babies and children demonstrate the imprints from their prenatal and perinatal times through their behaviors. When they do this, he explains, they also show us the sequencing in which these events occurred. Both traumatic and non-traumatic imprints can show up in any given sequence of events. Traumatic imprints, specifically, can leave holes, disconnects, and dissociated spaces in the expression of these sequences. A PPN therapist values being able to perceive these holes and knows how to reflect them and support the client to integrate them at appropriate times and in appropriate ways. In this way, shock imprints, which take the form of lapses in continuity or dissociation, can be released and moved through.

McCarty (2002) describes several therapeutic vignettes from her professional practice in which she and Dr. Castellino successfully supported young babies to integrate and release PPN traumatic imprints. Following is a brief outline of two of them: (1) Angelika, a three and a half month old baby, was often getting herself into stuck places that she could not get out of and she would behave as if she were stuck even when lying freely in the middle of the floor. She would get frustrated and escalate into an activated state. Her birth history included 36 hours of active first stage labor during which time she could not move forward because the cervix had not completely dilated. Doctors McCarty and Castellino co-facilitated PPN therapy with Angelika during which, among other things, they slowed the pacing down and gave Angelika accurate reflection and acknowledgement of what had happened to her. She began to orient herself and discover new options for herself and finally found her empowerment to become unstuck and mobile. She found new joy and freedom in moving her body and taking herself where she wanted to go. (2) Sky, a 6 week old infant, was not able to nurse. Every time he came to

his mother's breast, his head would jerk back and away from her in a very specific movement pattern. His birth history included rigorous suctioning for meconium immediately after birth with his head pulled back to open his airways. The movement pattern that he exhibited when trying to nurse was similar to that of being rigorously suctioned. In addition, the sensation of the bulb syringe entering his mouth had become coupled with the sensation of his mother's nipple entering his mouth. Again, Doctors McCarty and Castellino, among other things, slowed down the pacing, accurately reflected and acknowledged what had happened to him, and supported him to find a new relationship with his mother's breast. He successfully explored his painful history, released it, and became a fully nursing baby.

The Role of Parents

Parents play an important role in the PPN therapeutic process with children, and one or both of them is always present during therapy sessions. The child/parent relationship is a key component in PPN healing. The family unit as a whole and the individual relationships within the family are seen as fundamental sources of love, empathy, support for authentic expression, and resolution of trauma (Castellino, 2004b, 2004c).

When working with twin loss, the parent is seen as an essential player in the healing process of early wounding and grief. Woodward (1999) refers to her experiences with surviving twins: "I still maintain that it is the attitude of the parents of the surviving twin that has the most profound effect on their feelings concerning themselves" (p. 17). Noble (1993) says, "Loving, healthy parents have great power to ease and correct prenatal and perinatal losses and traumas of all kinds" (p. 8). When parents confirm the experience of loss, they affirm the presence of the surviving twin, his or her inherent

basic goodness, and his or her right to life (Noble, 1991). Surviving twins need this acknowledgement, especially from their mothers. They must be seen, accepted, and embraced as they truly are, with their grief, if true healing is to take place. This recognition further helps to offset earlier prenatal fears that someone or something is still going to try to take them away too. In addition, we must remember that the twin who dies is a family member. It is important that s/he be honored. As Noble (1993) notes, "A baby who has died remains part of a family, and this needs to be acknowledged, accepted, and experienced" (p. 7).

Dawn (2003) writes that the actual circumstance of a twin's death is not what causes the greatest distress for the surviving twin. Rather, it is whether or not the parents can acknowledge what they have experienced. What matters most for a surviving twin is whether their internal truth was seen, whether they were heard, and whether they were validated in this highly intuitive and inner sense of loss, grief, and longing.

The Therapeutic Alliance

From the PPN perspective, the therapist provides a loving safe container in which the client can experience empathy, accurate reflection, acknowledgment of the truth, support, and guidance. The client must always be supported to choose what her or she wants to do. This is crucial, because PPN therapy seeks to support newborn infants, babies, children, or adults towards ownership of their authentic impulses, intentions, needs, and desires. This is an integral part of the repatterning protocol that aspires to help reestablish self-empowerment for the forgotten little prenate/infant who lived through those early times and still lives them as a grown individual. This is vital because of the propensity for early life events to occur, such that the embryo, prenate, neonate, and baby has no control or power over what happens to him or her (Castellino, 1999). With regard

to the specific issues facing a lost twin, Castellino (1999) discusses the necessity for the therapist to be able to acknowledge the void that was created by the loss. He explains that the surviving twin needs someone to accurately reflect the void in a resourced way so that s/he can come into relationship with it and move through it.

Basic PPN Therapeutic Protocols, Skills, and Interventions

As stated earlier, Dr. William Emerson, Dr. Ray Castellino, and Dr. Wendy Anne McCarty are three leading PPN clinicians who have written and taught about PPN therapy. Although they all have discussed aspects of the same basic therapeutic concepts and principles, they emphasize them in different ways. Below is an outline of many concepts and protocols as perceived, referenced, and used by each.

Dr. William Emerson

Dr. Emerson (2000, 2002a, 2005) lists the following as important parts of the PPN therapeutic process:

1. Therapy is a connecting experience of understanding and compassion.
2. The healing process has two parts—"accurate conceptualization of the child's psyche and its expressions, and catharsis of feelings that are associated with traumatic events" (2000, p. 28).
3. Play therapies are effective modalities for accessing and releasing PPN material.
4. Sand tray therapies are important venues for symbolic expression and healing.
    a. They are suited for spiritual expression and can help a child connect with self.
    b. They enable missing aspects of the psyche to come forward.

c. They support non-verbal and non-rational exploration and healing.

d. A therapist's inner conceptualization of the pictures is key.

5. Simulating and reenactment games of prenatal and birth experiences are effective ways of accessing and releasing PPN material and trauma.

6. Evocative techniques in which parents dialogue about their experiences of traumatic events can be effective in supporting babies/children to access and heal their own experiences around those events.

7. Individual empathic and consciousness work for all family members enables them to come to terms with their own unacknowledged material and thereby enable them to perceive their baby/child's material without distortion.

8. Prenatal and perinatal schemas, or movement engrams, are ways of identifying, slowing down and releasing movement patterns that hold a freeze response to early trauma.

9. Video reflection therapy allows children to watch their own sessions and become witnesses to themselves enabling them to come into a different relationship and healing with their history.

10. Age progression games are games that take a child back to an experience from an earlier time in their history and then supports them to progress forward from that age to their present-time age in a way that helps integrate and heal the past.

11. Naming the history is important as it acknowledges what took place.

12. Specific lost twin protocols which include the use of stuffed animals and dolls to represent the lost twin; the use of clay to sculpt the lost twin.

Dr. Raymond Castellino

Dr. Castellino (1999, 2004a, 2004b, 2004c, 2004d, 2005) lists the following as important parts of the PPN therapeutic process:

1. Pay attention to the quality of and the energy between all members of the nuclear family. The relationships in the nuclear family are paramount.
2. Maintain the therapy as a family centered and infant/child centered experience.
3. Support healthy connections between all members of the family.
4. Make sure that the child is never the "identified" client.
5. Support harmonic resonance and rhythmic attunement within all relationships of the family which supports settling and safety for healing.
6. Provide accurate reflection. The need to be accurately reflected is a survival need and supports the child to integrate through his or her sensory motor system. Without it, one goes through life making up aspects of reality and creating imaginary reflections based on early imprinting.
7. Support each individual's intention for coming to therapy.
8. Enhance and support mother/father connection.
9. Enhance and support the bonding and attachment processes.
10. Support self-regulatory, self-reflective, and self-expressive skills for all family members. This decompresses traumatized forces.
11. Support the family unit into a state of empathy, compassion, and loving understanding for what each family member is going through.
12. Establish pacing and tempos that meet the infant/baby/child's needs. Support the tempo or pace of the baby. Support the rhythm that allows

each family member to integrate their present time experience.

13. Differentiate whose material is whose.
14. Differentiate past from present.
15. Identify and support resources.
16. Maintain the session as a child-lead experience.
17. Address and include the little prenate, which still lives on within the client. Bringing the little one along is essential for the full integration and release of traumatic wounding.
18. Support prenatal and birth somatic story telling and play.
19. Establish practitioner self-referencing and self-regulatory skills.
20. Learn how to use one's own activations for the betterment of the session.
21. Maintain a curiosity and wait for the mystery to unfold.
22. Observe early imprinting behaviors.
23. Observe and track symbolic sequences through symbolic play.
24. Follow the *Interpretive Intuition®* protocol (described on pages 76-77).
25. Establish an authentic relationship with the infant/baby/child/parent that is based in truth.
26. Coach parents to be with their children in attuned and effective ways that Match developmental needs.
27. Somatically support the resolution of oppositional states between parents and children.
28. Support parents in assuming the "alpha" position in the family.
29. Set and hold appropriate limits and boundaries.
30. Maintain and support safety and child-centered protection.

31. Tease apart the double binds in specific twin dynamics when required.

32. Maintain supervision support for the therapist.

Dr. Wendy Anne McCarty

Dr. McCarty (2000, 2002, 2003a, 2003b, 2004, 2006b) lists the following as important aspects of the therapist's role in the PPN therapeutic process:

1. Hold the client's wholeness in one's consciousness. When we focus in on wholeness and away from fragmentation, the relatedness of everything heals. Consciousness organizes around illness in an attempt to organize wholeness (2003a).
2. Listen empathically and offer appropriate heartfelt expressions of sorrow. The process of "acknowledging what happened to a person, empathizing and feeling that sense of remorse or sorrow that he or she had experienced the earlier difficult or trauma, is an important aspect of healing" (2004, p. 21).
3. Support parents to hear and respond to their children from an integrated and attuned place within themselves.
4. Support parents to protect their children.
5. Help clients track their sensations and then name them. This creates an integrative narrative which is an extreme state of healing.
6. Hold the vision of the client's history and all of his or her capacities from conception onward. McCarty (2004) explained why this is important, as she describes her own experience:

> When I hold the vision of babies from pre-conception on as multidimensional beings, having the integrity of transcendent and

> human perspectives, processes, abilities, and capacities, I come into resonance with more of who they are. I am expanding my awareness to come into relationship with their expanded spectrum of awareness and being. (p. 122)

7. Find the right pacing for the baby/child/client.
8. Reflect what the baby/child is doing.
9. Acknowledge what is being communicated.
10. Orient between past and present.
11. Differentiate who's who.
12. Name what is really going on.
13. Hold boundaries.
14. Pay attention to how one shifts one's focus.
15. Slow things down.
16. Approach the baby/child with respect.
17. Ask for permission.
18. Tell the baby/child ahead of time what will happen.
19 Notice, acknowledge, and support the child's reactions and expressions.
20. Respond to the baby/child/client's communications, whether verbal, gestural, somatic, or energetic.
21. Communicate what you are feeling.
22. Perceive the baby/child/client as primary consciousness.
23. Perceive the baby/child/client as an active and primary member of the session.
24. Maintain the intention to support healing rather than to treat.

25. Bring and express caring, compassion, and love. Love is the greatest healer.

A Phenomenological Approach to the Therapist's Experience

New trends within the field of psychology, consciousness studies, and quantum field theory are reevaluating aspects of the nature of the therapist's experience. Research from these disciplines is expanding our understanding of intersubjectivity and the relational dynamics that take place between therapist and client.

The Lived-Body Experience

Shaw (2003) believes that the therapist's lived-body or somatic experience could be a tool with which to understand the client's reality. "The lived-body paradigm is a means of acknowledging that our perception of the world, and how we interpret the world via our bodies, is the starting point in acquiring knowledge" (p. 39). From this perspective, "our subjective experience is primarily a somatic event" (p. 43) and "the therapist's body is an actively present agent and highly tuned to receiving sensitive information" (p. 24). The therapist's ability to track his or her own body sensations is a needed awareness that is essential for understanding the session and gathering potential information about the client's experience. "The therapist's body can be seen as a vehicle for conveying something of the intersubjective nature of the therapeutic relationship" (p. 143).

Shaw (2003) warns, however, that it is problematic to interpret the therapist's lived-body experience as a definitive statement about the client's experience. He suggests that the embodied therapeutic relationship, which is alive and subjectively interactive and which evokes aspects of the therapist's own lived experiences, be utilized to inform the therapeutic encounter. He notes:

> Being a therapist requires that one become fully and thoughtfully involved. It is as if one is engaged in a dance moving forward and moving back: one steps closer and steps away, has an effect and is affected, all as an embodied being. (p. 149)

Being in the Present Moment

Stern (2004) considers the phenomenological nature of the present moment in the therapeutic process and what happens between a therapist and client as they create the moments between them: "The present moment, as it unfolds, is an implicit process" (p. 122) that expresses "the subjective now" (p. 14) and our intersubjective nature.

Present moments are largely nonverbal experiences. They are holistic and temporally dynamic happenings. They are experiential, last for a short duration, have a psychological function, require awareness or consciousness as well as a sense of self, and contain components that are unpredictable. Within these moments, the minds and emotions of individuals interact and influence each other, creating a high level of intersubjectivity. Stern (2004) further elaborates, "Our feelings are shaped by the intentions, thoughts, and feelings of others" (p. 77). This state is characterized by a certain degree of co-created reality. It is important for a therapist to understand the components of the present moment in order to recognize and utilize them to support the therapeutic process and relationship. A therapist must know him- or herself well enough as a differentiated being in order to make sure that "the boundaries between self and others remain clear but are more permeable" (p. 77).

Interpretive Intuition®

Interpretive Intuition® is a structured protocol designed by Dr. Castellino (personal communication, February 14, 2007) that helps practitioners and clients discover the meaning behind various therapeutic incidents, behaviors, statements, expressions, etc.

It supports them to use their own experiences, perceptions, understandings, and intuition, relative to the therapeutic work, as part of the analysis process. When something occurs in a session and the practitioner or client wonders what it means, it is helpful to do the following:

1. Identify the wonderment and allow it to formulate itself into a question.
2. Translate that question into a statement.
3. Sit with the statement and settle quietly inside.
4. Notice the sensation of how the energy of the statement feels. That sensation will give the practitioner or client the felt sense of the truth of the statement or not. When the statement feels true there will be an experience of settling, surety, spreading, and an open felt sense that will contribute to the coherence of the person's story.

The Neurological Components of Psychotherapy

In a two-day seminar entitled "The Science of the Art of Psychotherapy" presented at University of California Los Angeles School of Medicine, Allan N. Schore (February 2-3, 2007) discussed the neuroscience of the art of psychotherapy and the components that underlie the essential therapist/client relationship. He cited attuned intersubjective right brain functioning as a primary source of communication between the two. This right brain communication facilitates implicit levels of knowing on the part of the skilled therapist and informs his or her intuition, capacity for empathic listening, clinical sensitivity, and ability to receive and express nonverbal communications. Bugental (quoted by Schore, February 2, 2007) refers to the way in which the psychotherapist utilizes this subtle neurological exchange.

The psychotherapist must refine his capacity to pick up faint hints of emotions, to

> intuit changes in his client's intentions even as they are occurring, to sense what his client is ready to hear and use and what will be rejected, and in short, to be the fine resonating instrument.

These concepts are integrated into the PPN therapeutic approach and are referenced throughout the portraits of this research.

Therapeutic Dynamics of Somatic Empathy

Rothschild (2005) discusses the neuroscience of conscious and unconscious somatic empathy and its clinical implications for therapists. Somatic empathy is distinct from cognitive and emotional empathy. It is a different form of knowing, experiencing, and connecting with one's client and is oriented in body sensation. These somatic cues are an outgrowth of the function of mirror neurons which create a physical resonance between a client and a therapist. Schore (February 2-3, 2007) explores these somatic cues in terms of the interrelated dynamic that occurs between the functioning of the autonomic nervous systems (ANS) in both the client and the therapist. They represent a form of physiologic counter-transference that signals shifts in the patient's ANS.

Both Rothschild (2005) and Schore (February, 2-3, 2007) encourage therapists to learn to use their body sensations as indicators of the nature of their connection with their client. These cues can help them understand their clients better and also avoid vicarious traumatization. Therapists need to accurately understand what they are feeling relative to (a) information about their client's experiences, (b) their own counter transferences, (c) merged states that they may have entered with their client, and (d) the differentiated aspects of their own material.

Rothschild (2005) talks about specific techniques designed to support a therapist to establish a state of healthy empathy with clear differentiated boundaries so that s/he

can more deeply connect with their client and yet not take on their client's material. All of these concepts are integrated in the PPN therapeutic approach and appear in the portraits of this research.

Field Theory and Consciousness Studies

Research in quantum field theory and consciousness studies are expanding our Western understanding of reality and the capacity for consciousness to cross time/space barriers between human beings through different forms of communication. Quantum field theory, which emerges directly out of physics, is suggesting that fields of energy surround us and that in them there is a "domain of influence" (Feinstein, 1998, p. 2) which carries information and effects consciousness and behavior.

Data from consciousness studies is broadening our concepts of existence and communication. It is expanding our understanding of the abilities of consciousness to transcend physical dimensions, to have knowing, and to communicate through the quantum energy fields that are beyond the realm of physical matter (Sheldrake, 1999; Talbot, 1991; Wade, 1996). New dimensions of expression and communication are being explored through a variety of inter-psychic, telepathic, paranormal, non-local, holographic, and non-ordinary states of consciousness. Included is evidence substantiating the power of long distance healing through mind, prayer, and intention (Dossey, 1999).

This research has implications for our understanding of the ways in which therapists and clients communicate with each other and suggests that there is a fuller pallet of information that is available to them which is held in the field. This also places a potential new value on the therapist's intuition, instinct, and/or sense of knowing (Sheldrake, 1999). McCarty (2006a, 2006b) bridges these findings with current research

data from medicine and healing disciplines to suggest that there are therapeutic approaches that "utilize consciousness as the integrating principle" (p. 1). She has coined the term the "*Integrated PPN Practitioner*" (p. 1): one who uses a broad spectrum of therapeutic modalities including local and non-local forms of knowing that emerge directly from the data discussed above.

Biodynamic Craniosacral Therapy.

Biodynamic Craniosacral Therapy is a healing therapy that is grounded in the subtle ebb and flow of the breath of life as it travels through the body. A PPN therapist trained as a biodynamic craniosacral therapist will use this modality to help track unresolved PPN experiences in the client, to support their own self-corrective process, and then to identify the harmonic, balanced state of resolve. The breath of life is the essential and palpable expression of our life force.

Sills (2001) defines the breath of life as "the divine or universal intention in action . . . the unseen Presence that orchestrates the unfoldment of the form and function of the universe" (p. 12). It embodies an intelligence and ordering capacity that is present even in the fluids of our embryonic beginning and that continues to express itself throughout the lifespan. The cerebral spinal fluid caries this dynamic presence and expresses it in a variety of rhythms that move through the cranial, boney, and soft tissue structures of the body. The nature and quality of these rhythms, as they move through the body, help to identify one's health and/or lack of health by revealing essential states of balance and coherency, or disruption and interference as expressed through breaks in continuity and disturbances in the flow (Becker, 1997; Shea, 2007). The accumulated imprints from one's history, including one's PPN experiences, as well as one's responses to present time events, influence the flow of the breath of life which carries within itself the

capacity for self correction and a return to a balanced state.

The primal midline is a central matrix in this biodynamic craniosacral system and one that is also important to the PPN therapy process. It is an "ordering axes around which the fluid, cellular, and tissue worlds orient" (Sills, 2001, p. 70) and an axis along which the breath of life can be palpated. Shea (2007) explains that it originates in the formation of our embryonic notochord. The midline can provide an immediate means of identifying a client's inherent state of coherency or constriction including the presence of possible PPN trauma imprints. Again, a PPN therapist who is trained in biodynamic craniosacral therapy can use their palpation skills to enhance and support the therapeutic process. They can track the movement of the breath of life along the midline as it occurs in relationship to everything that is happening in a session and identify constriction, blocks, and breaks in continuity and flow, or states of essential balance, harmony, and coherency. Then basic biodynamic craniosacral skills can be used to help support self-correction and a return to a balanced healing state.

Trauma Resolution Therapy

Trauma resolution therapy, such as Somatic Experiencing, is a form of therapy that supports the exploration, integration, and release of traumatic experiences. It is based on the biological responses and mechanisms that occur in the body during and in response to trauma. Traumatic experiences can create imprints and blocks in our physical, psychological, and emotional bodies that can cause us to shut down and then organize our functionality around those imprints. This can limit one's capacity to live fully (Levine, 1997; Rothschild, 2000).

Trauma resolution therapy uses the functioning of the autonomic nervous system (ANS) as a means of supporting the client to identify traumatic imprints, come into

relationship with them, and transform them so that they can be released. A trauma resolution therapist must be trained in identifying and tracking ANS cycling and expression (Levine, 1997; Rothschild, 2000). This is an essential skill when working with prenatal and perinatal imprints that often reveal themselves through the subtle ways that the ANS functions. The articulation and slowing down of ANS cycling is also an important and integral part of the repatterning process needed to release prenatal and perinatal imprints.

Summary

This literature review has looked at a variety of theories, concepts, and research that is relevant to the subject of vanishing twin loss and its possible consequences for the surviving twin. Findings from the fields of medicine, embryology, traditional psychology, and PPN psychology have been discussed. Five main areas have been explored: (a) twin gestation from a medical and embryological stand point, (b) twinship as an emotional, psychological, and identity construct, (c) twin loss and bereavement, (d) the PPN paradigm in terms of prenatal consciousness, sentiency, memory, bonding and attachment, imprinting, early trauma, and current PPN vanishing twin research; and (e) therapy with children. The intention has been to establish a foundation and frame of reference that support the approach, understanding, and evaluation of the research of this case study.

Chapter III: Methodology

Research Question and Methods

My intention as a researcher was to explore and portray the holistic nature of Sam's PPN therapy sessions as it may relate to a potential vanishing twin loss. This study asked the question: "How might the therapeutic behaviors of a three-year-old child be indicative of a potential vanishing twin loss"? Focus was given to the evolution of Sam's behaviors and behavioral sequences. PPN psychology was the lens through which I looked at this material and analyzed it.

It is important to understand that this type of PPN therapy is an organic therapeutic process that unfolds through a multidimensional weave of different essential components. It is an emerging gestalt, not a linear process, and, therefore, it really needs to be experienced in order to understand how it functions. Because of this, I decided that the most appropriate way to discuss this case study was through a phenomenological research approach that was qualitative in nature and that used portraiture as the main methodology. In this way, I felt that I could provide the reader with a possible felt sense of what Sam's therapy was like. This would enable the reader to feel into Sam's experience while assessing his behaviors in terms of the research question.

The research methods that I have chosen are all reflective inquiries into the human condition and each is oriented towards expressing the lived human experience and fundamental nature of its interior dynamics. Each is dynamically positioned to explore Sam's therapeutic phenomenon and to try to discern possible meanings rather than to quantify findings; to gather observations rather than to collect statistical data; and to offer possibilities rather than to prove facts.

The intention for this research was to explore Sam's behaviors through rigorous phenomenological methods and to discern if they contained plausible indications that suggest a vanishing twin history. To this end, this research looked at (1) eighteen of his nineteen sessions as part of one complete therapeutic gestalt which facilitated the evolution of his state of being (note that the eighteenth of the 19 sessions, which was a family session, was not included in this research because it introduced elements outside of the parameters of Sam's personal therapy), (2) the major over-arching behaviors that he exhibited throughout his process, (3) the possible symbolic nature of those behaviors with respect to a possible vanishing twin loss as perceived through the PPN lens, and (4) my own responses to Sam's behaviors as a means of further understanding my role as therapist and the experiences that informed my perceptions and assessments. Again, this study does not seek to prove facts, quantify data, or argue on behalf of an absolute vanishing twin conclusion.

Methodology Overview

Qualitative Research

Qualitative research seeks to understand the nature of experience from a holistic perspective. Data can be gathered from observation, documentation (chart notes, videos, publications, etc.), interviews, and subjective experience. Qualitative research uses descriptions in order to provide detailed information about the process, aesthetics, and qualities of any given experience (Kenny & Wheeler, 2005). Its structure, though rigorous, is flexible to accommodate the unique demands of each specific inquiry (Patton, 2002; Piantanida & Garman, 1999; Kenny & Wheeler, 2005; Schwandt, 1997).

Qualitative research can explore a subject from a broad view which provides a wide understanding or a narrowly focused view that provides an in-depth comprehension

of a single element. Both are valid (Patton, 2002; Piantanida & Garman, 1999). My intention was to do a combination of both. Though I wanted to study the overall essence of Sam's therapeutic process through portraiture, the breadth of the material that was contained in his 19 sessions was beyond the scope of this study. Therefore, I designed a study that tracks the broad progression of his process by focusing on specific aspects of the five most pivotal sessions and their sequential significance in his evolution. By doing this, I intended to communicate a felt sense of what his experience might have been and support the consideration that his over-all journey may have been an attempt to express, integrate, and come to terms with a possible vanishing twin loss.

Orientational Qualitative Inquiry

Orientational Qualitative Inquiry is a perspective that further clarifies the nature of the researcher's "theoretical or ideological perspective" (Patton, 2002, p. 129). This clearly stipulates the conceptual framework that guided the fieldwork and the interpretation of findings. It suggests that it is not possible to arrive at a completely unbiased perspective and that every study is actually conducted from an explicit theoretical point of view. My theoretical perspective is that of prenatal and perinatal psychology.

The Postmodern Context

Postmodernism is another underpinning of this research. Articulated and accepted in the 1980's, it is a particular worldview and perspective regarding the nature of existence and the nature of research. It believes that knowledge cannot be objectified because experience is not objective (Grenz, 1996). According to Grenz, "The universe is not mechanistic and dualistic but rather historical, relational, and personal" (p.7). In contrast to the modernistic view—which links truth with rationality, reason, and logic—

the postmodern view is that "there is no absolute truth; rather, truth is relative to the community in which we participate" (p. 8). Humor, emotion, perception, intuition, nonrational awareness, and the ability to dream are all necessary and important components of postmodern experience and knowing (Grenz, 1996; Lyotard, 1993; Sim, 1999).

Phenomenology as the Philosophical Foundation for this Inquiry

Phenomenology is the philosophical genre that provides the foundational underpinnings for this human science inquiry. Founded by the Austrian mathematician Edmond Husserl (1859-1938), phenomenology endeavors to understand meaning and reality by reaching into new realms of awareness. It seeks to "take into account the experiencing person and the connection between human consciousness and the objects that exist in the material world" (Moustakas, 1994, p. 43). It looks at behaviors, themes, patterns, the unfolding of process, self-reflective disclosure, and the lived-body experience from a perspective of suspended judgment. It uses textural descriptions to convey these dynamics (Mickunas & Stewart, 1990; Moustakas, 1994). It also endeavors to explore the nature of consciousness. Moustakas says, "What appears in consciousness is the phenomenon . . . . Phenomena are the building blocks of human science and the basis for all knowledge" (p. 26). Phenomenologists believe that

> the very appearance of something makes it a phenomenon. The challenge is to explicate the phenomenon in terms of its constituents and possible meanings, thus discerning the features of consciousness and arriving at an understanding of the essences of the experience. (p. 49)

Expounding on this broader understanding of phenomenology, van Manen (2006) explains that it does not attempt to produce empirical or theoretical observations or

accounts. Rather, it seeks to describe the experience of space, time, body, and human relations as we live and know them.

Transcendental vs. Existential Phenomenological Research

There are two different schools of thought in phenomenology which govern how the researcher relates to self and positions him/herself as the observer. Though they both follow the same guidelines, they do so from different perspectives: transcendental and existential. Both approaches will be used in this research because both are present within the philosophy and methodology of prenatal and perinatal psychology.

The transcendental perspective sees the researcher as an objective observer who endeavors to describe the "lived-world" (Mickunas & Stewart, 1990, p. 64) from a place of detachment. He/she "engages in disciplined and systematic efforts to set aside prejudgments regarding the phenomenon being investigated" (Moustakas, 1994, p. 22). The goal is to keep the observations free of preconceived ideas, beliefs, and expectations and to create as much separation and objectivity as possible.

The existential perspective, on the other hand, sees the researcher as one who "cannot separate him/herself from the world" (Mickunas & Stewart, 1990, p. 64). He/she participates in events and makes his/her observations from a place of "being-in-the-world" (p.64). The experiences of life are understood as arising out of a fundamental inter-subjectivity and interconnectedness between objects and subjects. The researcher and his/her experiences are a part of reality and actually inform the understanding of that reality. The researcher's "thinking, intuiting, reflecting and judging are regarded as the primary evidences of scientific investigation" (p. 59). Therefore, a full understanding of meaning or essence includes the researcher who must become adept at knowing him/herself in relationship to what is happening.

Key Phenomenological Research Principles

There are eight key theoretical principles that constitute the foundation of phenomenological research and which are relevant to this study. They help to clarify the postural orientation from which I participated as therapist and some of the key components which helped to inform that participation.

1. Intentionality: Our intentionality is an essential component in the discovery of reality and meaning. It is the natural intent of consciousness to direct its focus towards something which ultimately constitutes meaning. Moustakas (1994) says, “We are always intentionally conscious of something; our consciousness points to a direction and has meaning" (p. 59).
2. Intuition: What we see intuitively supports and contributes to the discovery of essential meaning (Moustakas, 1994).
3. Perception: Our perceptions constitute primary sources of knowledge and cannot be doubted. They are formed in the convergence of our intentions and our sensations where objects emerge with full-bodied presence (Moustakas, 1994).
4. Intersubjectivity: Objects and subjects cannot be separated. Being with oneself and with others, together, constitutes the whole of an experience and the union between the two is essential for finding the meaning and essence of a phenomenon (Moustakas, 1994).
5. *Wonder:* Life continues to unfold in the presence of wonder which is an essential dynamic that enables perceptions to continue to bring forth new perspectives to consciousness (Moustakas, 1994).

6. Objects, context, and meaning: The meaning of objects and actions lies in the awareness of the context and the relationship which constitutes actual or potential being (Welton, 2000).
7. Wholeness: Meaning is held in the wholeness of the experience, in the relationship of all the component parts, and in the recognition that the self and the world, together, are essential components of meaning (Moustakas, 1994).
8. The body: The body is illuminated by consciousness. It is the substance that provides the orientation through which consciousness can know itself and other in this world (Mickunas & Stewart, 1990).

Portraiture

Portraiture is a research methodology that uses narrative descriptions to communicate the research process and findings. The researcher makes empirical observations that are arrived at through rigorous attention to, and notation of, the details of the researched experience or phenomenon which is then described through aesthetic narrative expressions. It focuses on behavior, meaning, context, content, and relationship (Lawrence-Lightfoot & Hoffman Davis, 1997). I have chosen this method because it best mirrors the PPN therapeutic process. PPN therapy unfolds as an ebb and flow of dynamics. The dance between these dynamics is the "juice" that supports movement forward. Moment-to-moment the relationships between the different aspects of a session well up into the inspiration that is essential for the progression of the work (McCarty, 2003a). Sam's sessions are examples of this. In the relationship between his behaviors and my reactions and the felt sense of the field, his process unfolded. Portraiture celebrates this multidimensionality.

The portraitist functions both as participant and observer. The portraitist's voice is the research instrument and is used to portray what is happening through "a disciplined, empirical process of description, interpretation, analysis, and synthesis—and an aesthetic process of narrative development" (Lawrence-Lightfoot & Hoffman Davis, 1997, p. 185). This voice speaks from any and all of the following perspectives: (a) as the witness and discerning observer, (b) as an interpreter who searches for meaning, (c) as an expression of the researchers professional and personal orientation, and (d) as a participant in dialogue with other voices. In addition, the tapestry of the portrait emerges from (a) the conception of the overarching story, (b) the structure of the sequencing and layering of emergent themes, (c) the unfolding form of the narrative as it moves forward, and (d) the coherent evolution of all of the component parts (Lawrence-Lightfoot & Hoffman Davis, 1997). To create a portrait is to paint a composition that exists within a context and that consists of relationships, behaviors, themes, patterns, sequencing, and the dynamics of the field.

Research Structure

Reasons for Conducting a Case Study

Case study inquiry is a form of research that is organized around one circumstance, person, or event. Its intention is to develop an exploration of a single subject as defined by the research question. Methodologies and orientations are established based on their capacity to help reveal, understand, and learn about the chosen research focus (Patton, 2002; Stake, 1995; Yin, 2003).

My reasons for choosing a case study design were threefold: (a) I felt that the case study format, which focuses on one specific area, would provide me with the best means with which to explore the multilayers of the vanishing twin phenomenon; (b) I felt that it

would enable my reader and me to enter an intimate experience together while expanding our understanding and appreciation for the vanishing twin syndrome; and (c) because I love children, I felt that it would enable me to share one child's very courageous healing process in the hopes of contributing to our understanding of children and their experiences.

I chose a client from my own client base because I wanted to include the level of intimacy that results from being personally involved in therapy sessions. I choose Sam's story because it depicts the clearest example I have of a therapeutic process that explores possible vanishing twin material from a PPN perspective. It also exemplifies therapeutic interventions that may have contributed to my client's healing. In addition, Sam's therapeutic process took place between March 2000 and September 2000. That was six years ago; the time and distance between then and now has helped me to differentiate between my past role as his therapeutic practitioner and my current role as academic researcher.

Brief Outline of Sam's Therapy

Sam and I began to work together in March 2000 when he was three years and six months old. His presenting issues included withdrawn behavior, unwillingness to communicate, and an inability to look people other than his parents in the eyes when they were leaving. By the time he finished his last session, he had emerged as a much more positive, relational, communicative, and self-empowered little boy.

All of the sessions were facilitated by me at the BEBA clinic (see Appendix A) in Santa Barbara, California. Questionnaires were filled out by Sam's parents for key family members regarding conception, birth, and post-birth histories as well as a detailed description of presenting issues. In addition, I conducted an intake phone call with both

parents prior to beginning therapy and after reading through the questionnaires. The purpose was to clarify and gather more information. The work that Sam and I did together was based on prenatal and perinatal principles, therapeutic approaches, and strategies that I learned while studying and working with Dr. Raymond Castellino.

Sam and I met once a week for seven months except during holidays and vacations. One or both of his parents were always present and participated in the sessions. Sam's total therapy process consisted of 19 face-to-face sessions that were each approximately one hour long and eight phone consultations with one or both of his parents that lasted from 15 to 50 minutes. The purpose of the calls was to give his parents a chance to debrief the sessions, to ask questions, to receive coaching from me, and to let me know of any important shifts or activations that might be occurring in Sam's behaviors. Seven sessions were conducted with both parents present and participating; seven were conducted with Sam and his mother, Katherine; three were conducted with Sam and his father, Paul; one took place at Sam's home in his bedroom; and one session, which was the second to last, was conducted with the entire family present (i.e. his mother, father, and his younger sister, Emily). It is important to note that this session has not been included in this research because it existed outside of the parameters of Sam's personal work. Both of his parents were present in his final face-to-face session which occurred eight days before his fourth birthday.

All sessions were originally videotaped and documented in extensive chart notes. After each session I hand wrote an immediate set of notes and then transcribed them in the evenings. This practice improved my recall of each session, permitted additional impressions to be added, and provided an opportunity to further reflect on Sam's behavior and progress. Ten of the sessions were videotaped with a videographer present

and nine were videotaped with the camera placed on a tripod. A total of six volunteer videographers shared the videotaping. Each was a graduate of Dr. Castellino's two-year Prenatal and Birth Foundation Training, and each was participating as a researcher/witness/observer.

The room where the sessions took place was large and sunny. It contained a sofa, two futon mattresses on the floor, five 4 by 8 foot by 1 inch flexible floor mats that covered part of the floor, a 4 foot long by 2 1/4 foot wide hard rolling tunnel lined with carpet, a 6 foot long spiral cloth tunnel, lots of pillows, drawing pads and pens, and numerous toys. The toys were typical of those that are found in a prenatal and perinatal toy chest including, but not limited to, balls of all sizes, lots of different kinds of dolls, a wide variety of stuffed and plastic miniature land animals, dinosaurs, insects, water creatures and fish, a toy ambulance, miniature hospital figures, and other miscellaneous objects including a variety of ropes/cords.

The Body of the Research

As stated earlier, my intention for this research was to do an over-arching analysis of Sam's behaviors during his therapy and to assess them in terms of their potential indication that he may have been suffering from a vanishing twin loss. This meant looking at a broad view of his behavioral evolution throughout his nineteen sessions (not including the eighteenth which was a family session). The original intake call with his parents, the subsequent eight phone calls with them during sessions, the chart notes, and initial clinic questionnaires were also included as research data.

Eighteen hours of sessions is an enormous body of work to analyze and write about. Not only is the breadth of the material vast, but the possibilities for assessment are varied. Research could have been conducted from any number of perspectives such as

Sam's behaviors, his relationship with himself, his relationship with his parents (collectively or individually), or his relationship with me. I chose to explore Sam's therapeutic process through the evolution of his basic behaviors and behavioral sequences as they might relate to an early twin loss.

After analyzing all eighteen sessions from that perspective, I found that there were twelve essential behaviors that he exhibited through out. I have referred to all twelve as his "signature behaviors". This is because they not only comprised his entire behavioral repertoire but defined the essential signature elements of his work. Eight of them, in my opinion, related directly to a possible vanishing twin history and, therefore, have comprised the body of my research. The other four, which I felt were birth and post-birth related, were not included in my study but are noted in Appendix B.

I performed the following six sequential research steps:

1. Reviewed all eighteen videos in order to identity Sam's primary behaviors, his key behavioral sequences, and my own responses. I identified twelve signature behaviors, of which eight were relevant to this study. I wrote a brand new set of notes while reviewing the videos in order to establish a baseline for my current perceptions. I waited to review my old notes until after I had completed this initial step.
2. Designed a research chart with which to log all twelve of Sam's key behaviors in each session, analyzed them from the PPN perspective, and assessed which were relevant to the research question.
3. Reread all of my original chart notes and the questionnaires that were filled out by Sam's parents upon entering the BEBA clinic and compared them with the new set of notes that I had just written.

4. Spent numerous hours re-watching the key video sequences and reviewing and reassessing the data from my notes and my research chart. It was common for me to look at a chosen video segment three or four times. My goal was twofold: (1) to create an ever refined assessment of Sam's process and to reduce the complexities of his behavioral sequences to their essential elemental components and textures, and (2) to remember and identify my own experiences during the sessions and my responses to his work so that I could include them. I found that the more I watched the videos, observed my reactions, listened to my words and the tone of my voice which could be heard in the videos, and sat in the memory field, the more I began to re-experience the sessions with the accompanying body sensations and thoughts that I had.
5. Logged all relevant data from video watching and multiple sets of notes onto the research chart and made extemporaneous notes.
6. Wrote the portraits of the key sessions and key signature behaviors.

There are four essential portraits that form the body of this research. Each portrait is a composite portrayal that describes either a group of key behaviors or a collection of significant therapeutic sequences. The behaviors and sequences that are depicted were chosen because they suggest a possible vanishing twin history. They have been grouped according to the following subjects: (1) the establishment of our therapeutic alliance, (2) the eight signature behaviors that were relevant to a vanishing twin hypothesis, (3) key symbolic play sequences which are actually a subset of the eight signature behaviors, and (4) Sam's last session.

The writing of the portraits was conducted from my role as researcher/participant. While doing my research and reviewing all the data from many different angles, I did my

best to suspend the prior judgment that I had formulated when I completed my work with Sam. My intention was to continually see something new and different, learn more about Sam from a fresh perspective, and remember my own experience as therapist as well. I was continually amazed at how much I was able to go back into my experience and recall my responses to his work. Since phenomenology and portraiture include the experience of the researcher as observer/researcher, each portrait is an integrated portrayal of Sam's observable behaviors, my participation in his sessions, and my own professional and personal experience of him and what he did. In addition, this study includes an exploration of Sam's relevant history, his presenting behaviors, and a description of his chiropractor's diagnosis together with the diagnostic methodology that she used to arrive at her original vanishing twin diagnosis.

Analysis and Interpretation

The clinical analysis and interpretation chapter of this dissertation was written from my role as the researcher/observer. The intention was to evaluate the plausibility that Sam may have experienced an early vanishing twin loss. Two primary steps were taken. First, a review of Sam's relevant history in terms of its possible relationship to a vanishing twin history was assessed. Second, an analysis of Sam's signature behaviors, their possible meanings in terms of a vanishing twin loss, and their relationship to the changes in Sam's presenting behaviors was appraised. The convergence of these two assessments is where the answer to the research question lies.

Chapter IV: Relevant History

Relevant history is important when looking at case study. It provides the historic backdrop that supports the research. This study, because it is a qualitative phenomenological exploration and, thereby, includes the therapist's experience, has two relevant histories: one pertains to Sam and one pertains to me as therapist.

Sam's Relevant History

Sam's Conception

Sam was conceived when his parents, Katherine and Paul, were both twenty-five years old. They were thrilled to become pregnant. Twins ran in Paul's family and both he and Katherine suspected that they might have twins. Because Katherine was in graduate school, this thought overwhelmed them, and so they actively hoped that they would not be the ones in their family to have twins. They only wanted to have one child at that time.

Sam's Gestation

Paul was very supportive of Katherine throughout her pregnancy. During the first seven months she was preoccupied and stressed with graduate school and student teaching but focused on her pregnancy after that. She didn't have an appetite and Paul had to make her eat at night. She lost some weight in the first trimester but ultimately gained a total of 18 pounds. She was anemic in the third trimester. At no time during the pregnancy did she have any bleeding nor does she remember any particular cramping in the beginning of her pregnancy, both of which could have been symptoms of a vanishing twin. However, she suffered from such horrible cramps during her menstrual cycles prior to becoming pregnant that she feels that she would not have noticed any minor cramping during the early stages of her pregnancy.

Sam's Birth

Sam was born November 2, 1996. His birth took place in a hospital and was drug free. Katherine labored at home for 24 hours with a doula. There were no complications. Then she was transported to the hospital for a planned hospital delivery. When she arrived at the hospital her labor ceased to progress and Sam got stuck in transition. It took approximately seven more hours in the hospital before Katherine was fully dilated. Then, after 20 minutes of pushing, Sam was born.

Katherine described herself as hemorrhaging very seriously after the birth. The placenta would not release. The doctor had to pull it out which caused it to come apart in pieces. Afterwards, he did an immediate dilation and curettage (D & C). He thought that he removed it all but one month later Katherine delivered one final piece. After Birth, Sam immediately went to the breast and nursed. There is no birth record of a nuchal chord. This is a situation when a prenate rotates in the womb during gestation or during the birth process causing the umbilical chord to wrap around the prenate's neck (Oxorn, 1986).

Sam's First Year

Sam nursed until he was one year old and then lost interest. When he started eating food at five months old, he began experiencing extreme constipation. Sometimes he would not have a bowel movement for ten days, and Katherine would have to give him a suppository or enema a couple of times. He saw many doctors from the age of six months and was first diagnosed with Hirschsprung's Disease, a congenital intestinal disorder, for which a surgical removal of part of his intestine was suggested. A second opinion identified him as having a weak digestive track that would require a primary diet of nursing and which would correct itself by the age of one, which it did. At one he

developed chronic and severe sinus infections which were first diagnosed as asthma and then as severe environmental allergies especially to mites and grasses. Sam's chronic sinus infections persisted until he was seven years old when he finally began to outgrow them. Around the time that Sam began to crawl, he started having difficulty with relationships. He did not want to be with anyone other than the key people in his life—his mother, father, and grandparents. He began avoiding everyone else and expressing an unwillingness to participate in activities.

Sam's Presenting Behaviors

When Sam came to the BEBA clinic he had a series of presenting behaviors that, according to Katherine, restricted his self expression, relationships, and ability to engage in his life. She described them as: (1) having a hard time in new situations, (2) taking a long time to warm up to people, (3) never looking people in the eye when they left, (4) sometimes not communicating when spoken to, (5) difficulty trusting and feeling safe, (6) not being willing to participate in various activities, (7) remaining closed and inward with people he did not know *really well*, and (8) being extremely sensitive in his responses to things.

Dr. Bunis' Original Vanishing Twin Assessment

In the beginning of the year 2000, Katherine took Sam to see their family chiropractor, Dr. Sobyl Bunis of Santa Barbara, California, for help with his allergies and sinus infections. According to Katherine, Dr. Bunis had suggested that Sam may have been suffering from a lost twin experience which she suspected may have happened during the first month of gestation. She also assessed that he was struggling with issues of feeling unsafe in the world and was having difficulty trusting people. She referred Sam to the BEBA clinic for prenatal and perinatal therapy in the hopes that he would be able to

come to terms with this loss. All of this information about Dr. Bunis was given to me by Katherine when Sam first came to BEBA.

After my research was completely finished, I interviewed Dr. Bunis myself to find out what methods she had used to assess Sam. The result of that interview is pertinent to this study. Dr. Bunis' professional expertise includes chiropractics, nutrition, homeopathy, kinesiology, and Neuroemotional Technique (NET)®. Her assessment of Sam's condition was conducted with NET® and kinesiology methodologies. NET® uses muscle testing and a particular protocol to help identify specific traumatic imprints that are held and locked in the body as a result of overwhelming trauma. These techniques are now being used by medical doctors, chiropractors, therapists and a variety of other professionals throughout the United States.

Dr. Bunis, who has been assessing potential vanishing twin syndromes for 15 years, feels that patterns that are chronic and have a global dynamic to them often originate in the womb. She uses NET® specifically to help identify emotional trauma that may have possibly originated in utero. After muscle testing Sam, in accordance with the NET® protocols, Dr. Bunis suggested that he was suffering from a vanishing twin loss which may have occurred in the first three to four weeks of gestation. This assessment came out of a complex analysis process which looked at the emotional states that Sam was experiencing in relationship to meridians and other energy pathways in the body. She assessed three emotional states that he seemed to be suffering from and which were contributing to his presenting behaviors. The first was over-sympathy, which is an extreme sensitivity to other people's strong emotions due to the inability to have healthy, personal boundaries around other individuals. This condition, according to Dr. Bunis, often originates during gestation and can result from, among other things, an extreme

connection between an embryo, fetus, or prenate and its mother's state. Sam's over-sympathetic state, however, tested negative as having anything to do with his mother. She also identified Sam as struggling with frustration, insecurity, and unrequited love. In addition, he was having difficulty in school; Dr. Bunis identified the presence of a particular fear in him that was concerned with what might happen to other kids.

Sam's Parents' Relationship to Therapy

Sam's parents, Katherine and Paul, actively participated in his therapeutic process. They were both deeply loving, caring, and attentive parents who adored their son and were dedicated to supporting him to do whatever he needed to do in order to find his way through the issues that were challenging him. They eagerly embraced the therapy, coaching, and feedback that I gave them. They also confronted aspects of their own challenging material in order to differentiate it from Sam and, thereby, create more space and greater possibilities for him and his world.

Katherine immediately accepted Dr. Bunis' vanishing twin assessment which fit into her own personal cosmology. Paul, on the other hand, found the concept very foreign and had a harder time integrating it. However, as soon as he realized how important the sessions were to Sam and saw how Sam's behaviors at home began to change, he committed himself fully to participating and supporting his son in whatever way was needed. He continued to do so even though the actual vanishing twin concept remained a challenging one for him to fully integrate.

Situating Myself as the Researcher

My PPN Bias

PPN psychology is my passion. It is one of the lenses through which I look at life. It is a paradigm that ignites my intellect, challenges my capacity to know others and

myself, and supports me to find ever-expanding ways to grow and embody my own life. It is the doorway through which I have faced and have come to terms with many of my own personal prenatal wounds, be they psychological, emotional, physical, and/or ancestral.

For me, a PPN therapy session is a living sculpture that rises from the depths of the human experience and unfolds to reveal itself. It is a multidimensional creation that has mass, form, and balance. It moves in all directions through space while also passing through past, present, and future time. PPN therapy emerges from consciousness. It rises out of the morphic field (Sheldrake, 1996) of the session and all of the tangible and intangible dynamics that are present. It is forged from the very beginning of the client's life and shaped with the materials of emotion, psyche, identity, imprinting, relationship, movement, timing, ancestry, and consciousness. Each session is a monument to life: the client's life and his/her essential search for health, well-being, and self-empowerment.

I believe that our PPN experiences help to set in place our character structure, sense of self, survival strategies, relational capacities, belief systems, perceptions, and expectations of the world. As a practitioner, I always hold the PPN perspective as a possible underlying blueprint that is relevant to present-time issues with all clients regardless of age or presenting issues.

In my clinical work as a PPN practitioner, I incorporate many of the theories, techniques, and skills that historically and currently inform the field of PPN psychology. These are discussed in the section entitled "The PPN Paradigm." In addition, my predominant perspective and approach to doing therapy comes from my training and work with Dr. Castellino. His clinical approach and research have informed the structure and therapeutic posture that supports and guides me through assessment, tracking,

intervention choice points, and symbolic acknowledgement. I also utilize my skills as a certified biodynamic craniosacral therapist to more accurately track my client's autonomic nervous system in terms of its cycling, fluidity, breaks in continuity, and resourcing shifts, all of which can reveal different aspects of traumatic imprinting.

My interest in twinship, specifically the vanishing twin syndrome, comes from two dynamics: (a) the fact that my mother is an identical twin and I grew up in an extended family where the larger belief structures about identity were influenced by the stereotypical concepts of sameness and identicality that are so often associated with twinship and that made individuation for the rest of us very difficult; and (b) the fact that I believe that I had both a vanishing twin brother and a vanishing twin sister and have spent quite a bit of time healing those wounds. My interest in researching a case study with a child was a direct outgrowth of my deep love of children and my commitment to be their advocate.

Finally, in assessing the inherent challenges of this research, I feel that my biggest challenge was to open myself and let go of the conclusions that I had formed in 2000 when Sam and I worked together; and to allow myself to find a fresh and new relationship with him, his sessions, and his amazing journey. This process required that I try to mentally let go of any preconceived ideas and expectations about Sam as I began to watch each video. I continually tried to witness him as if I was meeting him for the first time. Of course, this was an imperfect process, especially because my own memories and body sensations of being in the sessions began to surface as I watched the videos. Nonetheless, I sought to allow those sensations and recollections emerge without conclusions attached to them. I believe that I was fairly successful at this because

ultimately I saw new and different things in Sam and his work and came to new conclusions about the meanings of some of his behaviors.

My Own Vanishing Twin Experience

I believe that one of my own vanishing twin experiences might shed light on the subject of vanishing twin imprinting. I first discovered that I had a vanishing twin history in 1997 during a PPN Womb Surround Process Workshops® with Dr. Castellino. I continued to explore this dynamic in subsequent processes during which I began to have memories of a twin brother *and* a twin sister both of whom left sometime around implantation.

In one particular workshop, I set my intention to explore how my twin brother had left and to create a different relationship with that loss. In the beginning of my session I told Dr. Castellino that I was sure that his leaving had left a gaping hole in my right side. I explained that throughout the years I had had the occasional sensation that I could not hold onto my life force because it felt as if it was spilling out of this hole. The conclusion that I had come to in my naivety had been that my brother and I had been conjoined twins and that we had been joined physically somewhere in the area of my gut on my right side. I thought that this would explain the sensation of the creation of a tear and the resulting hole when he left. Dr. Castellino told me that we could not have been conjoined because only same-sex twins are conjoined. This was disturbing feedback because it meant that either I was wrong about this twin being a boy or wrong about the sensation of the tear and the hole.

During the session, I discovered additional memories that reaffirmed that this twin had been a brother and, in addition, I discovered that he had been positioned next to me on my right side where the hole was. I also learned that something had happened to

him at the beginning of his implantation and that he suddenly decided to leave. It was clearly his choice. He turned and left very quickly—without warning and before I could even say goodbye. His leaving was unexpected, deeply painful for me, and created a tearing sensation in my right gut.

Of course, this tear can be understood as a symbolic expression of the traumatic emotional and psychological ripping that happened when he left. My identification with him certainly could explain the feeling of my life force leaving through this hole, almost as if it were following him as he went away. I think this interpretation has some validity. However, the most important thing that I learned during that session was that I did have a very distinct physical sensation of a tear that was quite different from the emotional and psychological wrenching that I had experienced from his leaving.

During the remainder of the session, I did a series of visualizations in which I repaired the rupture and sealed it up. From that point forward, I began to experience my life force as staying within my body and as being available to me in a more consistent and potent way. My confusion, however, as to what that tear really was and what caused it, persisted throughout the years. Then this year, while researching the PPN clinical literature on vanishing twin loss for this dissertation, I came upon a paragraph in Dr. William Emerson's (2005) unpublished manuscript entitled "Twin Loss: Intimacy in Retrospect". In it, he discusses some of his clinical findings regarding the connections that can exist between prenatal twins. In those findings I found my answer.

> Twins in the womb lie together in various positions or shapes and their super causal or subtle bodies are about 95% interwoven or overlapped with each other. When one twin dies, the death leaves a hole in the super causal body of the surviving twin. Through energy palpation you can detect that hole or energy

vortex in the super causal body. (p.38)

Dr. Emerson added that he has found that as many as 80 percent of surviving twins can have large, easily detectable holes in their super causal bodies.

When I read this paragraph I burst into tears. They were tears of sadness and also deep relief. My entire body let go. I knew instantly that Dr. Emerson's observations were correct, at least as far as my experience goes. I recognized the truth in his words and realized that my own inner knowledge about the actual connection that I had with my brother had been correct. His leaving had created a tear in my right side and that tear had left a gaping hole. What I had not understood previously was that my sensations were not of my material form, but rather of my energetic, super causal body which surrounds me. I felt grateful to Dr. Emerson for his clinical observations. He had given me the explanation that I had been searching for but which had eluded me for years.

I realize that it could be argued by some that, when I am in a therapy session and believe that my client may be expressing a vanishing twin experience, I could be projecting my own vanishing twin material onto him. I think that this question of projection could be asked of any therapist who sits with the exploration of vulnerable and/or intimate material. I believe that both preverbal and psycho-spiritual material, by virtue of their very nature, have a unique propensity for creating projections in the therapist. This must be addressed in the way that a therapist holds boundaries. However, the positive effect of a therapist's own personal material is that it can create, in that therapist, a proclivity and sensitivity towards that material enabling him or her to hold a receptive container for similar experiences and material to surface in others if need be.

What is important is that therapists do their best to understand their own material, to become familiar with the ways in which their material surfaces, and to be very careful

to differentiate it from their clients'. Checking one's personal agendas, projections, and expectations is an on-going and integral aspect of being a therapist and is necessary in order to maintain safety and the integrity of empathy. For me, this has always been a primary focus and component in my work. Ultimately, I believe that my own felt sense of the vanishing twin experience enables me to provide a positive and receptive therapeutic field for this material to surface in my clients if it is present in the first place, and if it needs to reveal itself. The key is to hold a wonderment, curiosity, and non-judgmental welcoming for anything and everything to express itself. From this perspective, it may be no accident that Sam and I worked together.

Chapter V: The Portraits

Orientating the Research

PPN therapy facilitates the exploration of early gestational and post-gestational experiences. As stated in Chapter II, it seeks to support individuals to access, integrate, and release their prenatal and perinatal wounding and traumatic imprinting. Though it is conducted in present time, it creates a space for memories, somatic imprinting, and belief structures from prenatal and perinatal times, particularly those that indicate some form of early trauma, to emerge. It enables clients to express these dynamics while receiving accurate reflection and support for self-regulation which ultimately leads to integration, resolution, and healing.

I believe that the therapeutic work that Sam did with me became the road map with which he explored and came to terms with certain aspects of his prenatal and perinatal history. The difference between his presenting behaviors at the onset of his therapy and those at the end of his therapy clearly indicate that some kind of significant evolution occurred for him during that process. In the beginning of his therapy he was (1) inwardly withdrawn, (2) reluctant to express himself, (3) had difficulty being in relationships, (4) had difficulty trusting and feeling safe, (5) was reluctant to engage in many activities, and (6) was unable to maintain eye contact when saying goodbye. At the end of his therapy, he was (1) self-empowered, (2) outwardly self-expressive, (3) able to enjoy new relationships with friends and relatives, (4) much less timid and more secure, (5) able to participate in and enjoy new activities, and (6) was able to maintain eye contact when saying goodbye.

This study analyzes that therapeutic journey and does so with the intention of ascertaining whether Sam's therapeutic process may have involved the exploration and,

perhaps, resolution of a vanishing twin wound. It does so by exploring the possible nature and symbolic meaning of his behaviors relative to the research question and through the specific lens of PPN psychology. The question being asked is, "How might the therapeutic behaviors of a three-year-old child be indicative of a potential vanishing twin loss?" As stated in the methods section, this study does not seek to compare interdisciplinary interpretations nor does it seek to prove facts, quantify data, or argue on behalf of an absolute vanishing twin conclusion. Rather it looks for new possibilities regarding interpretation and understanding, and endeavors to support meaning and symbology to reveal itself.

Eighteen of Sam's nineteen sessions comprise the body of this research. The family session, which was the second to the last, has not been included as it introduced elements which were outside of the parameters of Sam's individual and personal work. This research looks at two components. The first and primary component is the nature of Sam's signature behaviors and key behavioral sequences which indicate a possible vanishing twin dynamic and which I have objectively described. The second is the nature of my own responses to those behaviors which I have subjectively described. Though the latter is not the main focus of this study, it has been included because it was an integral part of Sam's therapy. My responses to his work were an essential component of the therapeutic weave that he and I created together. They informed the inter-subjective dynamic that existed between us and helped establish the therapeutic container that I held for Sam.

Each of these components has been portrayed in this study according to strict phenomenological and portraiture research guidelines. Both of these methodologies require the researcher to function as an observer and as a participant. A review of these

research parameters follows, as well as a brief overview of my own process as therapist, as a means of orienting the reader to the nature of my participation which ultimately informed my assessment of Sam's therapy.

Phenomenology and Portraiture

As noted in the literature review, the researcher in phenomenological methodologies functions both as a transcendental and an existential participant. In the first approach the researcher describes the lived world as objectively as possible while, in the second, she describes her own experience which cannot be separated from that lived world (Mickunas & Stewart, 1990). Perception is deemed as an essential source of knowledge that cannot be doubted. Perception arises from the researcher/participant who must remain present with herself within the dynamics of the lived world that is being described. In addition, the self and the world are believed to be inseparable components of meaning. Meaning is held in the wholeness of the experience and in the relationship of all the component parts which cannot be separated from each other or their context (Moustakas, 1994; Welton, 2000). In this way, my experience as therapist is a component part of this research.

Similarly, in portraiture, the researcher also functions as observer and as participant. The portraitist's voice is the research instrument and speaks from any of the following perspectives: as the observer who witnesses; as the interpreter who makes interpretations; as a participant who engages with the subject during dialogue; and as the voice which gives expression to the researcher's professional and personal orientation. The researcher carefully assesses the research as a whole and then combines empirical observations with aesthetic narrative expressions. Behavior, meaning, context, and relationship are the focus (Lawrence-Lightfoot & Hoffman Davis, 1997).

My Process as Therapist

As therapist I incorporated a number of understandings, approaches, and techniques in my work. These practices informed my own unique way of perceiving, interpreting significance, identifying possible meaning, sensing truth, and making choices. These have been discussed in the literature review in Chapter II, sections "PPN Therapy with Children" and "A Phenomenological Approach to the Therapist's Experience," and in Chapter III, section "*Key Phenomenological Research Principles*." Collectively they provided guidelines for my coming into relationship with early prenatal and perinatal material and for tracking stories, traumatic imprinting, autonomic nervous system cycling, and reading energies in the field.

The essential principles and techniques discussed in Chapter II, section "PPN Therapy With Children" that I followed included: (1) creating an open, accepting, and loving field for therapy; (2) maintaining an ongoing curiosity and wonderment about Sam, his needs, and the story that he was telling while also waiting for the mystery to unfold; (3) perceiving Sam's primary consciousness and feeling its presence; (4) supporting him to lead the session and coaching his parents to do the same; (5) listening and watching attentively to all of his communications whether verbal, gestural, somatic, or energetic and responding appropriately; (6) observing and tracking symbolic sequences through symbolic play; (7) meeting him in the moment and giving him an accurate reflection about what he was doing, saying, or showing; (8) identifying and supporting resources; (9) supporting prenatal and birth somatic storytelling and play; (10) encouraging the expression of whatever needed to come up by noticing, acknowledging, and supporting Sam's reactions and expressions; (11) maintaining the intention to support healing rather than to treat; (12) noting the objects and toys that he played with and the

ways in which he used them and related to them; (13) watching and tracking his movements, behaviors, and the expressions of his nervous system individually; (14) tracking the tempo, sequencing, intensity, and timing of his movements, behaviors, and expressions of his nervous system; (15) tracking his relational behaviors as expressed through his relationship with me and his parents at any given moment in the sessions; (16) holding a receptive field for vanishing twin material to surface and acknowledging potential elements as they surfaced; and (17) tracking my own responses and behaviors and deciding how and when to use them for the betterment of the session.

The essential principles and techniques discussed in Chapter II, section "A Phenomenological Approach to the Therapist's Experience" that I followed included:(1) staying connected to "the lived-body" (Shaw, 2003, p. 39) experience;(2) staying in "present moment" (Stern, 2004, p. 122) awareness; (3) using Dr. Castellino's Interpretive Intuition® protocol; (4) tracking somatic empathy (Rothschild, 2005); (5) tracking the full pallet of information that is available in the field of energy or "domain of influence" (Feinstein, 1998, p. 2) that surrounds us, that carries information, and that informs us; (6) using biodynamic craniosacral therapy (Sills, 2001) to track cranial rhythms and primary midline coherence, and to support the resolution of disturbances in the essential flow of the life force; and (7) using trauma resolution techniques to identify and support the resolution of traumatic imprints as revealed through the functioning of the autonomic nervous system. In addition, my perceptions, assessments, and choices relative to a possible vanishing twin were also informed by my experiences with other clients regarding this subject, the collective and historic experiences of other PPN therapists regarding this subject, and my own vanishing twin history.

The essential principles discussed in Chapter III, section "*Key Phenomenological*

Research Principles" that I followed included the basic phenomenological principles of: (1) intentionality, (2) intuition, (3) perception, (4) intersubjectivity, (5) wonder, (6) objects, context, and meaning, (7) wholeness, and (8) the body.

As I moved through each session I used my trained therapeutic skills in conjunction with my whole self, including my mind, my ability to sense information, my own emotional body, and my own somatic experience to help me understand what might be going on. My responses to the material were part of my internal barometer that assisted me in identifying coherency, breaks in continuity, and the configurations of story telling. I was inspired by my experience of the energy in the field, by my own felt sense of truth, and by my own personal experiential repertoire which I continually tried to identify and differentiate from Sam's material. In this way my experience was more likely to become an asset that could inform the session rather than an unconscious projection that could complicate and cloud the session. The more I became aware of the specifics of my own experience, the more I was able to use it as information to set in place wonderment and intention, and to broaden the field to make room for whatever Sam needed to bring forward. For this reason, I have included aspects of my own responses to Sam's work as a means of providing the reader with a more comprehensive portrayal of the phenomenon that became Sam's therapeutic process with me and the dynamics that influenced my own role as therapist.

Finally, from a simpler and more direct orientation, I attempted to keep my relationship with Sam alive and in the moment. In every session I could feel his courage and commitment to himself. I could feel a larger part of him at play, his consciousness, so to speak, as it was present and participating. Sam came in with different levels of courage and essential potency each day but I could always feel the presence of a larger intention

and deliberateness at work. I would meet Sam at the beginning of each session and say hello to him verbally. In my heart and thoughts, I would say hello to his little child self and his larger consciousness self, and wonder what was planned for the day.

Breakdown of Research Steps

As discussed in the methods section of my literature review, I chose to analyze Sam's entire therapeutic process, minus the family session, and to do so from the perspective of his behaviors and his key behavioral sequences. This is reported in Chapter V: The Portraits. My goal was to look at the possible meanings and symbolic content of these behaviors to see if there were any over-arching indications that could withstand research scrutiny and support the hypothesis that he may have experienced a vanishing twin loss.

My research involved the following four steps: (1) assessing all of his eighteen personal sessions and treating them as one complete therapeutic gestalt which facilitated the evolution of his state of being, (2) analyzing the major over-arching behaviors that he exhibited throughout his process and which expressed the essential phenomenon of his growth, (3) employing a PPN lens to explore the potential symbolic nature of those behaviors in terms of their literal and energetic dynamics with respect to a possible vanishing twin loss, and (4) noting and exploring my own responses to Sam's behaviors as a means of further understanding my role as therapist and the experiences which informed my perceptions and my assessments. After reviewing and analyzing all the data, I found that there were key aspects of his therapeutic process that might directly relate to a potential vanishing twin loss.

These dynamics are explored in four separate portraits, each of which is a composite of related behaviors and sequences. Each portrait contains a description and

an assessment section. The assessment section identifies my wonderments regarding the possible associations and symbolic content of Sam's behaviors as they occurred to me during the therapy process. In this way, the reader will be introduced to the material and then immediately given a context with which I held and understood it. Later, in Chapter VII: Analysis and Interpretation, these assessments are revisited again from a broader perspective in order to perceive the larger interrelational and contextual nature of Sam's symbology as it may relate to a possible vanishing twin.

General emotional tones and references to phone calls are also included, though there is a specific section which describes the phone calls in more detail. These calls occurred as needed and enabled me to communicate with Sam's parents privately to explore questions and answers and to track Sam's experiences and behaviors outside of therapy.

Brief Description of the Portraits

Portrait One: Our Therapeutic Alliance

Sam's process of establishing his therapeutic relationship with me was extremely unique and contained elements which could possibly relate to an early twin loss. He used his first and third sessions to create this alliance, each of which is explored in Portrait One. These sessions also introduced Sam and exemplified the specific ways in which he communicated, told his stories, and moved through his material.

Portrait Two: Signature Behaviors—Panoramic View

Sam exhibited 12 major behavioral patterns and significant behavior sequences which together comprised his essential therapeutic process and which he exhibited over and over again throughout his therapy. As stated earlier, I refer to them as his

"signature behaviors." Each signature behavior enabled him to express himself, explore his material, and find integration and resolution. Eight of them appeared to speak directly to a possible vanishing twin history and the other four appeared to speak to issues of birth and birth-related dynamics. This research focuses on the eight that relate to a possible vanishing twin history. The other four have been briefly referenced in Appendix B.

Portrait Three: Symbolic Play With Dolls—A Signature Behaviors Subset

The third portrait focuses on one particular significant subset of the eight signature behaviors, namely, Sam's symbolic play with dolls. There are three categories in this portrait: play with cords and dolls; play that disconnects and separates; and play that tapes up dolls. From a PPN perspective these doll sequences could be literal depictions of a twin loss dynamic.

Portrait Four: Sam's Last Session

The fourth portrait is a description of Sam's final session. In it he demonstrated resolution and integration of the key behaviors and symbolic issues that he originally presented and explored during therapy.

During the course of Sam's therapy, his presenting behaviors, as exhibited inside and outside of therapy, continued to evolve and change. By the sixth session he was already stepping out into his life with more confidence and with a greater willingness to be expressive, relational, and communicative. His basic routine at home and at school remained the same throughout his work with me with one exception. In the middle of his therapy, his father quit his job and started a new business. This was difficult, stressful, and challenging for everyone in the family. Sam expressed some feelings about this in a few minor places in his therapy. His predominant work, though, always seemed very

focused on the themes that were expressed through his signature behaviors. He continually explored them and they seemed to progressively support him through his material and toward greater and greater freedom, expansion, and capacity to engage with his life.

Portrait One: Our Therapeutic Alliance

Sam had a very specific way of creating his therapeutic alliance with me. He allied with me in two steps. Sessions 1 and 3 each comprised different aspects of that process. Session 1 set in place our initial agreement to work with each other. Session 3 set in place the full spectrum of that alliance. I believe that in Session 3 Sam unconsciously tested me to see how committed I was to meeting him and learning about him, and how capable I was of perceiving him no matter how confusing things might get on the outside.

Sam's First Session

Sam's first session was an introduction for both of us. In it, I believe that he allowed me to get a glimpse of his pain and some of the key issues with which he was dealing. I also allowed him to experience aspects of me. He barely looked directly at me but I could feel him watching me carefully with his peripheral vision throughout the session. It felt as if he were assessing me and trying to decide whether or not I had whatever it was that he needed me to have in order to work together. He appeared to be deciding whether or not he wanted to let me go on his journey with him. At the end of the session he looked directly into my eyes and, in that look, I felt that he told me that he had decided that we could proceed.

Description

I believe that Sam's first session actually began in the driveway outside the

therapy room. As he approached the door of the BEBA clinic he tripped and stubbed his toe. When he and his parents entered the room, his physical pain was in the forefront of his experience and the process of dealing with it became the focal point of the first ten minutes of his session. I remember feeling his retraction into his pain. He felt so vulnerable to me. I had the distinct sense that it was no accident that he had hurt himself. As I allowed myself to focus on his toe, I sensed the presence of a bigger pain in him, as if his hurt toe was just a window through which to get a glimpse of a larger dynamic that he was holding within himself. I was filled with tenderness for what I perceived as his willingness to let me see him and to look into his world from the very moment that we met.

After he entered the room, Sam hugged his mother's leg. Katherine picked him up and held him in her arms. He did not look at me as we all stood by the door and introduced ourselves but I had the distinct feeling that he was tracking me. He clearly wanted to be in the room even though he felt pain in his toe. Katherine crossed the room to the sofa in the far corner, still holding Sam, and sat down. He cuddled into her lap with his legs straddling her waist and his chest hugging her chest. Paul sat next them. Sam kept his back to me and, though he turned his head to the right side in my direction, he did not look at me. I felt that his body language was communicating that he really did not want me to come too close. As I scanned the room for a place to sit down, I focused my attention toward him and did my best to tune into his specific communication to me. I felt that, without words, he was saying, "I need you to stay over there. I'm not ready for you to come toward me." I acknowledged him and what it was that I thought he was saying to me silently. I chose a spot on the floor that was a distance from him and as I sat down I said out loud, "I'll stay over here." As he heard my words he suddenly lifted his

eyes and looked directly at me. It was the first time that he allowed our eyes to really meet. In that look, I felt that he was clearly acknowledging that we had successfully communicated with each other. Then he broke the eye contact and stared past me toward the wall.

Katherine stroked Sam's hair and gave him little kisses on his cheek. The room felt warm with the deep caring of his parents concern and love. We all sat quietly in the pause of his resting space for perhaps three to four minutes, just waiting for him to find his way. He never cried but rather nestled deeply into his mother's armpit, safely between his mother and his father. We just sat quietly together and waited. I felt a softness fill the room as a resonance seemed to emerge among all four of us as Katherine, Paul, and I sat holding Sam's space. Sam's energy began to shift. He slowly moved his body like a child waking up from sleep. He turned his head and torso to the left and looked at his scraped left toe.

I took this opportunity to check in with him and see if I could come closer by asking, "Can I come over and look at your toe?" Again, he did not use words but looked at me for a brief moment. He had a warmth and receptivity in his eyes that I felt was beckoning me to initiate closer contact so I began to crawl very slowly towards him. As I did I said, "You might not want me to come over, and you'll find your way to tell me that if you don't want me to." I paused after I moved a little closer and was barely close enough to see his toe. I asked, "What do you think? Can I look?" He nodded no.

Then a second later, he nodded yes. I began to move closer and, as I did, I said, "I'm going to come over very slowly and if you want me to stop you let me know." He kept looking past me with a soft stare but I could feel him watching me through his peripheral vision and even settling as I came closer. He reached over and touched his own

toe with his left hand and then he began to open and extend his fingers toward me. I felt as if he were beckoning me closer and, as I continued to approach, he kept reaching toward me with his fingers. I kept using my craniosacral skills to sense into and track the underlying breath of life rhythms that were being expressed through the functioning of his autonomic nervous system. These rhythms, from a biodynamic craniosacral perspective, can indicate the state of one's health and balance as well as a lack of health and balance. I wanted to be sure that there were no subtle body signs indicating that he might want me to stop or any display of an active alert in his system that might indicate fear or activation. There was not. When I got close enough to see his toe, I bent toward it and said in a curious, loving voice, "What did you do to your foot?" He peeked out at me. "There's a little peek," I said. He peeked out again. "And another," I said again. He smiled. I sat down on the floor next to his toe.

The room settled. There was another long pause. I felt Sam begin to let go of the place inside that had been activated and unnerved by his stubbed toe. He turned around on Katherine's lap to face outward and into the room. There was a shuffling of positions, talking and interacting, and the energy in the session began to percolate. Slowly, Sam's attention began to move out into the room. He looked around noticing the videographer behind the camera and then the toys. Soon he was engaging with me as I started talking to him about the trip to the zoo that he had taken earlier before the session. I knew about this because his father had asked him questions about it during the beginning of the session.

Within a few minutes Sam was climbing off the sofa and heading for the toys. There was no further sign that he was concerned about his stubbed toe. The session had fully transitioned. From that point forward, Sam engaged with the room and the toys and

began his process of telling us his story. In this first session, he introduced eight of the twelve signature behaviors that would comprise his primary behavioral repertoire. These behaviors both supported him to express himself, tell his story, and find his way to healing. They were also the expressions themselves. Each of these will be discussed later.

Throughout the session Sam kept minimal eye contact with me. He looked at me occasionally with fleeting glances but did not really allow me to look back into his eyes for any length of time. Regardless of where he placed his eyes, though, I could feel him paying attention to me. It was as if his energy kept coming toward me. I felt that my every move was being noticed and that Sam was watching how carefully I paid attention to him and the things that he did.

At the very end of the session, after saying goodbye and as I walked to the door, he looked up at me with what felt like his first real willingness to make extended eye contact with me. He allowed me to really look back into his eyes and meet him for more than just a second. I felt that he was letting me see him, that he was peeking out and showing me the part of himself that really wanted to come forth but that was still far away. In that moment, it seemed as if he were showing me that place where one's deep yearning to make contact gets caught between fear and uncertainty; then one is left with the ultimate question, "How do I do this?" I perceived the expression on his face as asking that question as he looked at me, and I felt my heart get warm as I looked back at him. I said to him silently with my thoughts, without audible words, "Thank you for letting me see you. I will hold this space for as long as you need me to and in whatever way you need." I had the feeling that he heard me because of the way he looked back at me and because I began to feel a warm connection between us in my own center. I could feel my own sense of the primal midline (defined on page 80) of my being come alive,

and I also had the sense that I could feel his primal midline come alive too. I turned slowly away with a final soft goodbye and left the room. In my experience of the truth of that culminating look between us, I believe that we had finally and mutually agreed to work together.

Assessment

As we begin the first of the contextual discussions of Sam's work, I think it is very important to reiterate one of the core PPN principles introduced in the section of Chapter II entitled "PPN Foundational Principles, Techniques, and Protocols." This principle states that everything that a baby and child does has significance and purpose and is part of a communication process. In my experience working with babies, children, and adults, I have found this to be true. In addition, first sessions often serve as introductions, not only with respect to introducing the key participants to each other, but also with respect to laying out the essential issues to be dealt with and the blueprint for healing. First sessions also establish the initial therapeutic agreement that has to exist between client and therapist before the therapy can really begin.

Sam's first session is an excellent example of all three. To begin with, I believe that everything that he did was imbued with meaning, albeit unconscious or semiconscious, and was a form of specific and implicit communication. This is exemplified, in my opinion, by his stubbing his toe a few minutes prior to the session. As Sam was walking to the door he hurt himself so when he came into the room he was dealing with actual real pain. I remember my experience when he came in and stood next to Katherine while she explained what had happened. I had the distinct feeling that hurting his toe, though it appeared to be an unrelated incident, really had purposefulness in terms of communicating something important about Sam. I felt that through the

physical pain in his foot he was accessing a deeper level of pain that he held inside. It felt as if his toe simply allowed him to bring a piece of that deeper experience into the session and let me get a glimpse of it. I was deeply touched by the vulnerability that I perceived in him and the accessibility of his hurt feelings.

Also, during his first session, Sam introduced eight of his twelve signature or key behaviors that he used throughout his therapy. These will be described in the second portrait. Each one laid out a different piece of his story and opened a different window through which to observe one of his dynamics. Each provided possible meanings and indicated a possible direction for him to take in order to find his healing. I relate to key issues as clues that can provide potential directions that can lead to healing. I believe that if we listen carefully to the pain, it can inform us and tell us where we need to go and what we need to do in order to find our way through.

Finally, Sam's session established the foundation for our therapeutic relationship. Though Sam was initially distracted with his painful toe—the kind of experience that can often cause a child to want to leave a session immediately—he never asked to leave. I always felt that he wanted to be there. Initially, Sam needed to get a sense of me and my abilities to meet him, and then he needed to choose to let me in. This I believe took place on a semiconscious level. During the session he told his story and, as he did, I could feel him using his fleeting glances and his peripheral vision to track my responses and assess my general ability to follow him, see him, and understand him. When, in the end, he allowed both of us to meet each other in an extended moment of eye contact, I felt that he had chosen to take another step towards me and to let me in. My experience of that moment was that we both acknowledged and committed our mutual therapeutic intention to each other and, in that commitment, the initial foundation for our relationship was laid.

Sam's Third Session

I believe that Sam's third session solidified and broadened our therapeutic alliance in a way that was essential in order for his therapy to deepen. During and after the third session I could feel that the material that was surfacing was very significant but I could not tell exactly why. It was not until after I completed this research that the importance of this session came into focus. I believe that before fully proceeding into his therapy, Sam had to do two things. He had to set in place certain safety parameters, and he had to make sure that I was capable of staying connected with him no matter what. I believe that he needed to be sure that I would not allow myself to be distracted from him and that I could meet him in his material no matter how confusing things might get. Though I believe that these were unconscious needs of his, I feel that he satisfied them during his third session. When the session was over our therapeutic relationship had shifted from being one that had just begun to one that had become fully rooted and poised as a reliable container in which his material could surface.

In order to discuss Sam's third session it is first necessary to go back to something that he said to his mother after his first session with me. He expressed that he really wanted to have a session in his bedroom. During our second session together two things happened relative to this. She reported his request to me, and he asked the question again so I could hear it. I did not know how to respond initially. I knew that BEBA did house calls for newborns but I was not sure about the protocol for home visits for older children. I also was afraid to set a precedent that could cause a conflict later on if Sam wanted to do more in his own house.

I took a moment and quietly settled myself. I focused my attention inwardly and connected to my own sense of my core and primal midline (defined on page 80) and,

from there, I listened very carefully to Sam's request. I sensed that his request was coming from a deep need inside of him and not from some frivolous whim. I had no idea what it was that he was reaching toward but I had the feeling that there was something very important that had to happen in his home. I had the strange feeling that he wanted this to happen so much that he was almost begging me to go. So, with some trepidation, I committed to doing the next session at his house. This was a challenging decision for me because I was a young therapist and had no idea what the ramifications could be from such a choice. I just felt deeply that I needed to go and decided to trust that impulse. The session was so successful in my opinion that I came away with a renewed willingness to trust my instincts and allow my intuition to play a greater role in my work.

Description

Sam's third session began when I knocked at the front door of his home. Though he and his mom opened it together, Sam barely looked at me. Katherine communicated that Sam wanted to show me his bicycle and that he wanted to ride around his neighborhood with me. I was glad that he was so clear about his desires and intentions but I was surprised by this unusual request. Again, my instincts told me that there was an important reason for his wanting to take me on this little journey and so I agreed to go.

The first fifteen minutes of the session were spent going around the block, with Sam on his bike and Katherine and me walking slightly behind him. He barely spoke to me and never really looked at me. I had the feeling, as I had in the first session, that he was watching my every move and noticing how I responded to him. He kept the lead, sometimes peddling very fast but never letting himself get too far ahead. Marlene, his grandmother, also came along and she wheeled Emily, Sam's 18-month-old sister, in a stroller behind all of us. We went around the block and all the while I had the distinct

impression that Sam was deliberately showing me the parameters of his neighborhood. I kept feeling that he wanted me to walk this specific path with him, notice it, take it in, and hold something about it in my awareness.

We traveled in a big circle and ended up back at his front door. Sam quickly jumped off his bike and wanted to take me immediately into the house and up to his room. Katherine came with us as we went upstairs. She asked Sam if he wanted her to stay in the session with us and he said "no." So she left the room and closed the door behind her. Then, something very unusual happened. Sam, who had barely spoken to me that day or even in the previous sessions, for that matter, suddenly became talkative and outgoing. His voice, which had traditionally been very quiet in my presence, was now loud and clear. He was enthusiastically relational and interactive with me and also maintained good, direct, and continual eye contact with me. This, too, was unusual because in his first two sessions, he barely looked at me. When he did look at me, it was very fleeting. Truly, this session introduced me to a new side of Sam that I had not yet experienced.

Sam jumped on the bed and I set up the camera. Then his cat jumped on the bed and, when I was done with the camera, Sam said that I could sit on his bed too. From that moment forward, Sam began to tell me a story that felt very significant. I believe that it was a challenging story for him to reveal and that it was also essential to his therapeutic process. Though I did not have enough information about Sam's overall issues at the time to confidently interpret the meaning, I did feel that he was telling me a story about issues of identity and identity confusion and that there was something about that that he needed me to know in order to take the next step in his therapy.

Sam began the story by picking up his cat and saying, “Sometimes, Emily [his sister] isn’t nice to her [the cat] and she [the cat] doesn’t know who it was, so she [the cat] bites both of us.”

I reflected back to him what I heard him saying, “So, sometimes Emily is the one who’s not very nice to her [the cat], but she [the cat] doesn’t know it’s not you.”

He nodded yes and then said, “She [the cat] thinks it’s both of us.”

I thought that it was very interesting that the first story that Sam told me in his bedroom was about how his identity had gotten confused with his sister’s identity and how he had gotten blamed for something that she had done but that he had not done. I flagged this awareness for myself during the session by making a mental note to keep it in the forefront of my thoughts. I could feel the power of this information but, even after the session was over, I could not achieve a substantial understanding of how it was important. Then, while I was watching the videos as part of this research, I began to understand what might have been going on. I think that I was accurate in my original assessment that this story had something to do with identity. However, I now believe that the specific issues that he was exploring were the questions, “Who is who? Whose is whose? And who is doing what and to whom?”

When Sam finished the cat story, he reached over to a bowl of “treasures” on his nightstand and took out a small piece of smooth, colored glass. He gave it to me and said that I could keep it. This took me aback because typically he had been so reserved with me. I never expected him to want to give me anything. I asked him to clarify if he meant for me to keep it. He nodded yes and said that it was beach glass. We continued to sit on the bed and I continued to appreciate the glass. Then, as I reached to put it safely away in my pocket, explaining that I had a special place in my office where I kept treasures and

where I would keep this one. Sam said, in a barely audible voice, "That's one of my sister's."

"What's one of your sister's?" I asked, not understanding what he was talking about.

"That," he said nodding in the direction of the glass in my hand.

"This is one of your sister's?" I asked.

"Yup," he said while nodding yes.

"Do you think it's okay with her that you gave it to me?"

"But it's mine now," he explained.

"Oh, it's yours now," I repeated. I paused for a second as I attempted to open the space for further disclosure. But he changed the subject and began to tell me about his two dogs. Clearly, he did not want to continue the discussion. I decided to go with his transition and talk about his dogs. All the while I was holding the glass in my hand, curious about the significance of what had just happened and wondering how we would come around again to talk about it. I felt disoriented with this new information. I had just been given a gift and then told that it did not belong to the person who had given it to me. I could feel something powerful happening. I felt caught in the strange warp that Sam's behaviors had just spun and that was clouding the field between us. I felt confused and believed that Sam wanted me to experience something about this kind of confusion so that I could better understand him.

This interpretation is derived from a very important therapeutic principle discussed in the section of Chapter II entitled "*PPN Foundational Principles, Techniques and Protocols."* This principle states that children will often communicate what they are feeling and experiencing by doing something that will elicit the same feeling and

experience in those with whom they are trying to communicate. In this way, I felt that Sam was creating, probably unconsciously, a situation that would give me an experience of confusion similar to some form of confusion that he knew in his own reality and that may have had something to do with identity confusion regarding himself or someone else.

Sam proceeded to take a photo album from his bookshelf and, as we looked through the pages together, he suddenly admitted, "Emily didn't know that I stole—sneaked it out." Then he began to tell me how a friend of theirs had given it to Emily and how she did not know where it was.

"So this is really Emily's, right? [pause] If Emily had this, where would she keep it right now? If she knew that it was right here, where would she keep it?"

"I don't know. She doesn't know it's right here," he responded.

I got off the bed and kneeled in front of Sam on the floor. "So you know what, Sam? I'm going to move down here so you can look into my eyes. [Sam looked into my eyes.] I really know how much you want to give this to me, and I really feel like I'm receiving this, and I'm also wondering if maybe we should give this back to Emily because it's really hers. And then, later on, if you have something that's yours or that you made and you want to give it to me, then you can give it to me. [long pause] And I really get that you want to give me something. I can really feel that in my heart and I think that maybe you should give this back to Emily." I wanted to be sure that Sam felt loved and appreciated for wanting to give it to me and also not shamed for taking it from Emily. I was also trying to illicit his agreement to return it. He thought for a moment and then said, "I want to give you something and I've got some treasure in here." Sam jumped off the bed and went to his bookcase and took a stone out of a container on the shelf.

"Are those your treasures?" I asked.

He nodded yes.

"Okay," I said.

"There's a lot!" he said with excitement.

"Oh, can I see?" I asked.

"Yeah, you can have one." Sam handed me a piece of beach glass.

"Oh, this one I can have? Wow, these are your treasures, [pause] right?" I wanted to be sure that it was his.

"Yeah," he nodded assuredly. Sam was filled with a renewed excitement and joy as I received his gift.

I told him that I wanted to look at it under the lamp. "Come and look at it with me," I said. Together we moved over to the nightstand. "Look at how it spins and how clear it is," I noticed. The two of us huddled under the lamp, just reveling in the beauty of his treasure glass. Then a few minutes later, I looked him in the eye and said very deliberately, "Okay, I'm going to put this in my pocket and when I get home I'm going to put it in my treasure box. I'm going to put this deep down in my pocket, all the way down, so I don't lose it." I had a strong feeling that procuring safety for this gift was important to Sam and that doing so held a broader significance that I would only begin to understand later. I put it down into my pocket. Then there was a very long pause and I held out Emily's stone to him and said, "I'm going to give this one back to you, and you can give it back to Emily; and then I'll keep this one." Sam seemed happy and relieved. A few seconds later he asked me if I wanted to see Emily's room and jumped off the bed. I said that I did. He joyfully walked to the door, opened it, and took me into the hall. He

showed me both Emily's room and his parents' room where the session ended. Katherine and Sam walked me downstairs and we said our goodbyes.

As I walked down the front path toward my car, I glanced up at the house and saw that Sam and Katherine had come out onto the second balcony and were watching me. I waved and said goodbye again to Sam and reminded him that I would see him the next week. He looked directly into my eyes, smiled, and waved back. He remained on the balcony and watched me as I pulled out of the driveway and drove away. My ride home was filled with a sense of awe and deep appreciation for Sam, his choices, and also my own instincts. Though I did not understand it all yet, I could feel brilliance at play and was grateful that I had allowed the session to take place in his home.

While driving home and reviewing the session in my mind, I was amazed at the particular dynamics of confusion and disorientation that had occurred. I could still feel the confusion in my own body sensations. My perception, once again, was that the confusion was a piece of Sam's material. I also had the strange feeling that somehow I had just been tested. I felt that Sam had subconsciously needed to reassure himself that my intention was to be in relationship with him and not somebody else. I sensed that he needed to be sure that I would not allow myself to be distracted away from him by someone else's reality or someone else's beautiful beach glass. I felt that I had passed his test and that as a result our relationship had shifted; that our therapeutic alliance had deepened and that Sam had made a final decision to fully take me inside and show me his world.

Assessment

I had a sense that this was a powerful session but it was not until I did this research that my full appreciation of it came into focus. My feeling is that four important

dynamics were established during this session.

1. I believe that Sam's request to do a session in his bedroom was his way of asking me if I really wanted to go with him into his world no matter how far I had to travel to get there.
2. My sense of Sam's initial bike ride around his block was that it was his way of marking or scribing the outer perimeters of his existence for me. I think that he needed me to see those boundaries and then to mark them in my own consciousness before he could take his next step in his therapy. I had the distinct feeling that he needed to set those landmarks in place so that no matter how far into his material he might go, I would always be able to guide him back out to his starting point and the world that he knew and on which he relied.
3. The stories that Sam told about being blamed for doing something that Emily had done to the cat, and the confusion about which piece of beach glass belonged to whom were both stories about identity confusion. They are issues which fundamentally ask the questions: Who is who? Whose is whose? Who is doing what and to whom? These are questions that seek to explore issues of individuation, individual action, and individual possession. They are similar to identity issues which can face twins, as discussed in the literature review. I believe that Sam further explored these fundamental issues of individuation, along with issues of connection and belonging, in his later sessions during his hide-and-seek games with small balls. These will be discussed in the next portrait.
4. I am still not completely clear why Sam chose to introduce me to his

empowered, confident self as he did in this session. It is interesting to note that, in the next session, he retracted into the shyer, quieter, and more contained persona that he had exhibited in the first two sessions. In each session thereafter, however, he progressively came forward more and more until, in the last session, he emerged once again, as his confident, self-assured, expressive, and empowered self. Perhaps the third session needed to happen the way that it did because, in order for us to really establish the full breadth of our therapeutic relationship, Sam needed us to come together in our fully empowered selves. Or perhaps he was just marking and letting me see that part of himself that he subconsciously wanted to move toward and ultimately set free through his therapy.

Portrait Two: Signature Behaviors—A Panoramic View

As Sam's therapy progressed it became apparent that he expressed himself through 12 basic behaviors. Each of these was a behavior that he initiated from his own impulses. Though he expressed other behaviors as well, these 12 comprised his essential behavioral repertoire and were repeated over and over again throughout his therapy. Though some were done more often than others and for greater periods of time, depending on the session, all were very specific. They so consistently formed the primary body of his therapeutic activities that I refer to them as signature behaviors. Eight of them seemed to address themes that spoke more directly to the development of multiple embryos and to a possible vanishing twin history. They depicted several different themes including: certain embryological stages that occur during healthy development of an embryo(s); certain precarious embryological transitions that can lead to the death of a twin; and scenarios with dolls that could be interpreted as actual depictions of a twin loss.

Each of these themes laid down a different aspect of Sam's story and a different expression of something that he held inside and about which he needed to talk. The other four behaviors were equally important expressions of something that Sam held inside, but they seemed to depict birth themes and are listed in Appendix B.

Behavior # 1: Playing With Fruit and Balls

Sam used small balls and/or small plastic round fruit toys in 15 of his sessions. There were four ways in which he played with them:

Putting Plastic Fruit in His Mouth

In the beginning of his therapy Sam would stuff small plastic grapes, strawberries, or apples into his mouth and, then, with a big puff of air, spit them out so that they made a popping sound as they were shot out into the room. Sometimes he would spit them at his mom. As I watched this and held the energies of pre- and perinatal time lines, I was continually reminded of an ovum as it is released from or popped out of an ovary just before conception.

Putting Plastic Fruit in His Mother's Hair

Sam would take the plastic strawberries and/or one-inch colored balls and bury them into the folds of his mother's hair. He kept trying to hide them underneath and in between the strands. Children will often play with their mother's hair. It is a way of connecting and holding on. It can be very soothing and comforting to do so.

Sam's behavior felt significant, particularly because he was not just playing with her hair. He was deliberately trying to hide the balls in and under her strands. It felt as if he was showing us, almost in literal terms, the process of implanting. For me, the imagery was again of a blastocyst burying itself into the layers of the uterine wall.

Playing Hide-and-Seek With Balls

The most significant thing that Sam did with the three 1-inch balls was to play hide-and-seek with them. He would play this game over and over again in many sessions and sometimes for long periods of time. Each ball had a different color and was designated as belonging to the same person: the yellow one was his mom's, the orange, his dad's, and the green one was his. Each would be hidden either behind or under a pillow or the futon. Once or twice he hid them in a plant.

Sam would hide all three at the same time, but try to place them each in slightly different hiding places. He seemed to relate to them as if they belonged together and yet it also seemed important to him that they had clear, differentiated, and separate identities. He even assigned them family positions. The yellow one always belonged to his mother, the orange one to his father, and the green one to him. He generally instructed his mother to find them. If the session ended and all the balls had not been found, he would leave the remaining balls in their hiding places until the beginning of the next session when he would pick up the game where he left off. Sam would get happy when each ball was found, but he would get gleeful when all three were finally found.

Because Sam played this game so many times, I knew that I really needed to take it in. As I sat with myself, I started to wonder about a multiple conceptive history. His treatment of the balls as a group that became hidden in the underfolds of the futons and pillows reminded me of multiple fertilized ova that get implanted at the same time. I thought it was interesting that he hid three balls and wanted his mother to find them. Was he showing us something about a multiple conception that, perhaps, he knew about but she did not, and he wanted her to find out about it? Or was his focus more on differentiating the balls from each other and making sure that even in their connectedness, each had its own experience of being hidden and of being found

individually? Could this have been related to the identity issues that he presented in his third session which took place in his house? During that session there was a lack of differentiation between him and his sister, between his beach glass and hers. In the beach glass sequence, he had difficulty discerning "who was who" and "whose was whose?"

Finally, could his need to hide the three balls, have had nothing to do with differentiation, and instead was way of exploring the triadic relationship that he had with his mother and his father? After all, the assignment of each of the colored balls to represent each of them was a significant part of his story. What parts of Sam was he expressing and working out in these games?

Playing Other Games With Balls

Sam occasionally played a game of catch with all of us. We would sit together on the floor and toss a ball around for a significantly long time. He would play with a three-inch or six-inch ball that was covered with many nipple-like knobs, or he would kick, throw, or push around a large green exercise ball that stood about one-and-a-half feet high. I still do not have a clear sense of what he was expressing through this game other than the fact that it was an activity that brought us all together with a shared intention to play with and focus on one specific ball. Was he asking us to orient our attention towards one singular entity? Could the ball have been representative of him and could he have been expressing his desire/need to be held, focused on, and surrounded as a single individual? In addition, occasionally he would kick around the big green exercise ball which he generally did only with his dad.

Behavior # 2: Playing Hide-and-Seek

Sam played hide-and-seek in many of his sessions and loved to play it. It was a source of excitement and glee for him. He played it over and over again and sometimes

for long periods of time. There were two versions of the game. One involved hiding the one-inch balls as described above. The other involved hiding those of us who were present with him in his session.

Sam played the game with those of us who were present in his session only during his last four sessions (not including the family session). In each, he played the game for long periods of time. In three of the sessions he teamed himself with his father and he had me play opposite both of them. In the last session, he teamed himself with his father again and had his mother and me play opposite them. During this last session, in the second to last round, he also chose to hide by himself. The teams took turns hiding and seeking. Hiding places included going behind or under blankets, pillows, balls, futons, doors, tunnels, and sofas. From a PPN perspective, these hiding and finding games can be expressions of dynamics that occurred during the discovery period after conception when parents first discover the presence of their new little one and realize that they are pregnant.

As I sat and observed these games, I wondered about Sam's discovery period and what he was looking for while playing them so many times. Two possibilities came to mind, both of which I think were at play. First, I think that he had a need for us to experience being hidden and then being found so that we could understand more about him. He spent a lot of time in his sessions showing us these dynamics. I believe that there were experiences which occurred during his own discovery period that he needed us to experience too. Second, I think that he actually had his own need, having nothing to do with the rest of us, to re-experience being found over and over again. It was as if there was something in that moment of being discovered that he craved and loved. Perhaps he was showing us something about the way it had been, or, perhaps, he was creating a new

version of the way he wanted it to be.

Behavior # 3: Playing in the Tunnels

In twelve of Sam's sessions he played with tunnels. The BEBA clinic has a hard tunnel that is 2 1/4 feet wide, four feet long, and lined with carpet. It also has a soft, coiled tunnel that is 1 1/2 feet wide, six feet long, and flexible. Most of the time, Sam played with the hard one.

Sam rarely played in the tunnels by himself. He used them mostly in conjunction with other people and or in conjunction with toys. He threw toys through the tunnel, over it, at it, and even placed them on it. He would hold balls or small figurines in his hands and crawl through it, roll in it, climb over it, or sit on it. Sometimes he would connect the two tunnels together and crawl through them or hide in them with his father. A few times he turned the hard tunnel upright on its side and instructed his mother, father, me to crawl into it with him, two at a time. Once, in the last session, he hid in the hard tunnel by himself.

As I watched Sam engage with the tunnel, I felt into the context and timing of each sequence, and took into consideration the other images and behaviors that were at play at the time. I was often moved by many images of the tube journey process that flooded my mind. From a PPN perspective, tunnels often symbolize birth canals or fallopian tubes. Only once or twice did I sense that his tunnel symbology had anything to do with birth. The reason for this had to do with the context and the energetics of the sequences. There was a multiplicity of balls, toys, and people that always seemed to gather in or pass through the tunnels. This reminded me more of the activity of several ova as they travel down the fallopian tube making their way from the ovaries to the uterine cavity.

Behavior #4: Drawing

Sam drew pictures in 12 of his 19 sessions. His drawing behaviors comprised prominent therapeutic sequences that were specific, lengthy, unusual, and significant. Though about one-fourth of his drawings contained some fluid circles and squiggles, especially in the last sessions, most of them were comprised of poking and pounding the pen onto the paper, penetrating it, and creating multiple holes and perforations. Typically, Sam would sit on the floor; hold the pen tightly in either hand, and pound numerous times onto the paper causing multiple breaks in the surface. He would dig the point of his pen down through the perforations and into the underneath layers of the paper sheets below. Sometimes he squiggled the pen down through the top layer of paper, pushing it and eventually creating tears. Sometimes he even tore up the drawings at the end, ripping them into pieces and throwing the pieces into the room. It was not uncommon for him to draw anywhere from seven to fifteen drawings in one session. Occasionally, he would also make tracings of his hands. During several sessions he even drew lines and squiggles on his legs and arms, and on those of his parents as well. In session eight, he covered himself with numerous pen marks on his arms and legs. That evening Katherine called (phone call # 4) to tell me that after our session, Sam refused to go to his swimming class, telling his mom, "I don't want my pens to come off my arms!"

Sam seemed driven to dig down into the underneath sheets of paper. Sometimes his movements felt angry. But they also seemed to express an urgency to reach below, to descend into the deepest layers and touch them with the point of his pen. As I sat watching him, I kept being reminded of how an animal will burrow down into the earth towards a destination. I had the feeling that he was reaching down to a specific spot, almost as if he could not stop to rest until he found it. He had a determination that caused

me to feel that there was something very important in what he was showing us.

As I continued to watch him, images of two embryological stages filled my mind. First, and most predominantly, I could feel the energies of implantation. I could envision the blastocyst as it penetrates the uterine wall, burrowing down into the connective tissues of the endometrium. Then its cells begin to proliferate and extend out. This image kept coming to mind in many sessions, and I continually wondered about Sam's implantation experiences and what it was that he might really be trying to tell us about that. Second, as I watched him squiggle the pen down into the paper, I could feel the energies and movements of the conception sperm as it squiggles and digs through the crowd of other sperm and then penetrates through the egg wall into the body of the egg. Finally, as I watched him during his moments of aggressively pounding, I could not help but wonder about some of the feelings that he might have towards some of the dynamics that he was showing us.

Behavior # 5: Hiding Objects in Cracks Between the Mats

In eight of Sam's sessions he did short sequences in which he played with the floor mats in the room. More specifically, he played with the cracks between the floor mats where the edges and corners of the mats met and abutted one another. He would lift up the edge of a mat or the corner of a mat and slide something under it. Often he would push the object far enough back so that it was barely visible or out of sight completely. Sometimes he stuck his fingers or feet into the cracks and under the mats. A few times he even crawled under the mats and hid. In the very last session he took the 15 colored pencils that he had been drawing with and put each one methodically and deliberately down into the cracks.

For me, this behavior again evoked images and the physical sensation of being

buried below the top layer of something, of being hidden beneath and burrowing down. Again, I was reminded of the process of implantation when the blastocyst buries itself into the layers of the mother's uterine wall and its presence often goes unnoticed.

Behavior # 6: Playing With Cords

In fourteen sessions Sam used cords in his play. He appeared to use cords as a means of creating and sustaining connection or as an expression of the failure to create connection. He used cords to connect and attach to his parents. He would wrap one around their necks, bodies, or torsos. Sometimes he would first attach the cord to them and then stretch it across the room between his parents and himself or use it to pull his parents across the room to wherever he was. This play was usually joyous and sometimes serious. The connections with his parents always felt solid. I had the feeling that he was reaffirming and declaring his attachment to his parents in those sequences.

Then there were other cord sequences which did not feel like joyous statements of connection but rather like statements of isolation, strangulation, and disconnection. In Sam's fourth session he tied one end of a cord around a giraffe's neck and, as if it were a leash, pulled the giraffe around the room. Then he wound the cord, with the giraffe still attached to it, around the hard tunnel. Finally, he rolled the tunnel back and forth over the giraffe while the giraffe was dangling by its neck. For me there was a quality of strangulation in the way that the giraffe hung, rolled forward and backwards around the tunnel, and then disappeared under it.

In addition, there were two other sequences in which Sam used cords with dolls. They are described in the forthcoming section entitled "Symbolic Play With Dolls." In these sequences, Sam wrapped cords around the body of a doll, the head and neck of a skeleton, and the neck and bodies of other stuffed animals. It seemed that the cords were

used to create some kind of knotted mass that caused strangulation or envelopment.

Sam's emotional tone during these sequences had levels of anger in it, but often there seemed to be a predominant expression of disconnection and discard. I, again, had the distinct feeling that he was trying to show us something that he knew about and that he wanted us to know about too. Was he telling us something about his own cord attachment or that of someone else's?

Behavior # 7: Playing With the Futon

At the beginning of each session, one of the two futons in the room was folded up and used as a table upon which and against which the toys were lined up and displayed. Sam used this futon in every session, and he used it in the same way. It was part of a ritual that he enacted. At some point in the first half of each session, he would remove all of the toys from the futon, either by pushing them off or aggressively throwing them off, and then unfold it. Once unfolded it became an empty platform upon which he walked, ran, sat, rolled, played with cords, did birth sequences, and hugged his parents, depending on the session. In the last four sessions (not including the family session), during which he played hide-and-seek with those of us who were present, he also used it as something to either hide under or into which he would roll up.

His use of the futon was always very deliberate. As I watched him engage with it, I often had the feeling that his ritual of removing the toys and unfolding the futon was part of his way of making it his own and starting afresh. It felt as if he needed to get rid of the things that existed on it before him so that he could turn it into a new foundation upon which to build something different for himself. He would invite his parents to join him on it and their engagements together there were always loving and filled with lots of physical contact.

The futon, once it was cleared and opened, felt like a large, flat, and essential resource for him. It became a platform upon which he could express himself and explore new parts of himself. He loved playing on it and chose to be on it at specific times and in specific ways. The activities that he did on it felt particularly orienting for him. He seemed to be able to call upon something supportive and resourcing for himself whenever he was on it. In this way, I often thought of the futon as a symbolic placenta. It appeared to provide a foundation upon which Sam was able to grow more into himself, the way that a placenta supports and facilitates a fetus to grow more into itself.

Behavior # 8: Playing Symbolically With Dolls

Sam played with dolls in eight of his sessions. However, in two of the sessions, his mother initiated the play, chose the dolls, and brought them to him. Those sequences are not included in this research because they originated from her impulses, not his.

In the six sequences that Sam did initiate, his play with dolls was powerful, specific, and deliberate. The storytelling that he depicted with them felt so intentional and precise that it almost seemed as if they were literal portrayals. The dolls seemed to provide Sam with a dynamic means of communicating something specific. The stories that he told with them felt significant, especially in relationship to everything else that he did in his therapy. His doll themes seemed to talk about loss, the lack of connection, insufficient attachment, the yearning not to be left behind, and the desire to take a relationship home. These sequences will all be described in detail below in Portrait Three which looks specifically at Sam's doll signature behaviors.

As I sat with Sam in his sessions and then watched the videos later, I kept feeling that his play with dolls was telling us about something that had really happened, something that only he knew about, and something that he could no longer hold by

himself. All of the symbolic imagery that was expressed in his use of dolls caused me to begin to seriously believe that he very well may have experienced a vanishing twin loss.

I believe that these behaviors with dolls are extraordinary windows into Sam's world. If we let ourselves feel into them as energetic and symbolic expressions, they can guide us toward an understanding of how Sam communicated and what he might have been trying to say. Clearly, each could become a study unto itself, and each is comprised of many components that could be explored more deeply and in greater detail. This research has looked at them from an overarching perspective that assesses their general structure. In the seventh chapter, entitled "Analysis and Interpretation," their relationship to each other, as mutual expressions of Sam and his material, will be assessed relative to their indication of a possible vanishing twin history.

In the following section Sam's play with dolls is categorized. Within each category described below, the specific dolls that he chose and the character of his play with those dolls is portrayed. Sam's behavior with the dolls is first described and then assessed. The format for each characterization is the same: a description followed by my assessment.

Portrait Three: Symbolic Play With Dolls—A Signature Behaviors Subset

Sam played with dolls in very specific ways. There are only six sessions in which he initiated playing with dolls (including one skeleton), and they all speak to powerful symbolic images of separation, loss, and yearning. Sam's doll play seemed to fall into three categories: (a) "*Play That Involves Dolls and Cords*" during which Sam used cords to tie dolls up and then discard them; (b) "*Play That Disconnects and Separates*," during which Sam depicted scenarios of separation and relationships lost; and (c) "*Play That*

Involves Taping Up Dolls," during which Sam wrapped up dolls with paper and tape in what appeared to be an attempt to secure them inside the package.

In the third category, Sam asked me twice if he could take the dolls home after his sessions. In both situations, I allowed my instincts to direct me. I sensed that there was something very important in his request, so I gave him permission to do so. Of the three dolls that he took home, two were eventually returned. The third could not be found and was never returned.

Play That Involves Dolls and Cords

During two of the sessions Sam took pieces of cord and attempted to attach them, in one way or another, to a specific part of a doll's body. In one segment he was successful; in one he was not. He eventually came to a place where his relationship with each doll suddenly shifted and he discarded it either by throwing it or pushing it away. Then he directed his attention elsewhere and began to play with other toys.

The Soft Cloth Doll

Description. In his first session, Sam picked up an 18-inch flexible cloth doll that is used for teaching purposes in obstetrics and midwifery. He began to study and touch the small metal snap that was sewn onto the abdomen where the umbilicus would be. He picked up a three-foot piece of cord that was on the floor next to him and tried to attach it to the snap. He made several failed attempts to connect the two, and then even tried to wrap the cord around the doll's belly. When he did not succeed with either, he quickly, and somewhat angrily, discarded both the doll and the cord by flinging them behind him.

This play segment was the first to introduce us to a particular kind of attachment/connection/disconnection/loss issue that would become a prominent theme in Sam's doll play. It is important to note that these attachment issues did not seem to

implicate his relationship with either of his parents. His connections with them were consistently loving and filled with much physical contact, expressiveness, and joy. His parents remained attentive to Sam throughout.

Assessment. From a PPN perspective, cords and ropes are often seen as symbolizing the umbilical cord, especially when they are used either as a means of facilitating connection and attachment, or as a means with which attachment is broken. The umbilical cord's primary function is to connect the fetus to its mother, deliver needed nutrients, and remove waste products. Umbilical cords literally keep the fetus connected to his or her life. Sam tried to establish an attachment at the doll's umbilicus but failed to do so.

I believe that Sam's play suggests a symbolic scenario that represents some inability to form an umbilical connection. He displayed a desire to connect the doll to the cord, or the cord to the doll, at the site of the umbilicus. When he failed to do so, he abruptly and angrily discarded them both behind him and turned his attention elsewhere. For me, this kind of play was a flag because it happened in the first therapy session which is often a time when children express some of their key issues. I began to wonder about what Sam might be expressing about unrealized attachment.

The White Rubber Skeleton

Description. In his ninth session, Sam picked up the white rubber 12-inch skeleton that was lying next to him in a pile of toys and an eight-foot thin brown cord that was tangled in the same pile. He untangled part of it and began to wrap it around the neck of the skeleton. He made many loops, and as the neck disappeared beneath the layers of cord, he shifted and began to wrap it around the head and torso. Within a few minutes he was holding a mass of wrapped cord and skeleton limbs. While he was wrapping, he sang

the following song, making up the tune and lyrics as he went:

Wrap it around your neck.

Wrap it around your neck.

Wrap it around your neck.

Wrap it around your neck.

Wrap all this around your neck.

All it, all it, all it around your neck.

All it, all it, all it around your neck.

All it around your neck, neck, neck.

You're all wrapped up and you go into the garbage.

When Sam completed this last line of his song, he suddenly picked up the cord with the skeleton bound up inside of it and threw the bundle up in the air. He let it fall with a disinterested and, again, discarding attitude. He paused, and then reached for a small, stuffed monkey that was lying on the floor in front of him. He picked it up, untangled another section of the cord that was also on the floor in front of him and wrapped it around the monkey. As he did, he sang, "And the monkey gets in and it wraps around him." Once done, he reached for some other small stuffed animals on the floor, wrapped them up too, and sang, "And then all the other animals get wrapped around and go into the garbage." With the word *garbage*, the song and wrapping ended. Sam scooped up the toys and the cord that enveloped them, stood up, and threw them onto the sofa.

Assessment. It is interesting that skeletons symbolize the remains of a dead person. Sam chose to use this image and to wrap its neck, head, and torso many times with a cord until an undifferentiated mass of cord and limbs was created. This mass was

then scooped up and thrown "into the garbage." The same ritual was then enacted with a small monkey and other small animals. Again, the mass of wrapped animals and cord were discarded—thrown "into the garbage."

Cords, discussed above, are a means of establishing connection and support. However, Sam used them to create a knotted pile of undifferentiated mass which he threw "into the garbage." His imagery suggested death, strangulation, and even suffocation. There are embryological scenarios in which cords and blood vessels can strangulate and/or fail to deliver needed nutrients to the embryo/fetus causing death. Malformed umbilical cords and abnormal placental growth can lead to undifferentiated masses of nonfunctioning cells. I think that what is important is that Sam told us this story because somewhere inside of himself he knows about it and carries the story. He portrayed it three times, so I believe that there must have been something important that he wanted us to know about it too.

Play That Involves Disconnecting and Separating

In this category of play, Sam explored issues of failed connection, separation, and loss. In his fifth session he depicted a short sequence in which he used all his might to break off the head of the soft doll.

Breaking Off the Doll's Head

Description. Sam had a short sequence in which he was sitting on the floor and reached for the soft cloth doll that was next to him. He began to bend the head vigorously forward with all of his strength. It appeared that he was trying to break it off. When bending it forward did not separate the head from the body, he tried to pull it off. He used all of his might again, but eventually gave up because it would not break off.

Assessment. There was something determined and even angry in Sam's demeanor.

He really seemed to want to separate the head from the body. There was even a touch of violence in the way that he vigorously bent it all the way forward until it was practically touching the chest. I just kept feeling that he was showing me the story of demise and how the "whole" of something was decapitated into the "parts" of that something.

Separating the Skateboarder From the Skateboard

In his sixth session Sam presented a long sequence that explored feelings of deep yearning and his desire not to be left behind. Before describing this segment, it is important to briefly talk about a phone call (Phone Call Two) that I received from Katherine the night before this session. She called to ask for support because Sam was expressing a lot of rage and she was having difficulty handling it. She reported that he was explosive and that they never knew what would set him off. "Sam loses it and goes ballistic," she said. She and Paul were continually on the alert when Sam was at school or with friends in order to deter him from getting triggered into rage.

I supported her to take a step back and to look at his behaviors both within the specific context of each outburst and also within the larger context of his work in therapy. We framed his anger as an expression of something much deeper that was surfacing which gave her a different perspective from which to relate to his rage. This made it less frightening and helped her to neutralize and normalize the situation. Then we talked about ways to meet and support Sam through this period. I reminded her of the importance of giving him accurate reflection and space, of slowing things down, of supporting him to express his feelings in safe surroundings and not at other children, and of going with him into the places that he needed to show her. She expressed that she felt relieved at the end of our conversation because she had been shown some tools with which to support Sam.

Description. In his sixth session, Sam came into the session sucking on a miniature three-inch toy skateboard and holding a six-inch male doll. He had planned on bringing these toys to the session but had forgotten them at home, so on the way they had to go back to get them. During the first ten minutes, Sam lifted them both into the air (about eye level), showed us how the man stood on the skateboard, and then let both drop to the floor. He did this several times with an air of disregard and disinterest. When he was done, he crawled into the hard tunnel with them, rolled back and forth in it for three or four minutes, then climbed out, laid them on the floor near the wall and began playing with other toys.

About 20 minutes later he dropped what he was doing and went back to the man and the skateboard. He picked them up again, stood on one side of the tunnel, placed them on the tunnel which was lying on its side, and stood the man on the skateboard. The skateboard slipped loose and slid down the other side of the tunnel to the floor. Sam reached forward over the tunnel and down the other side with the man still in his hand. He called out in a quiet, wispy voice, "Wait for me; wait for me." He reached so far forward that he slid over the side of the tunnel too with the doll still in his hand and landed head first on the mats. He righted himself and then tried for about two minutes to affix the man to the skateboard so that they would not come apart. He could not figure out how to get them to stay connected, so Katherine suggested scotch tape. I went into the other room, got some tape, and she helped Sam tape the doll in a standing position onto the skateboard.

Sam tested their ability to stick together by deliberately letting them fall off the edge of the tunnel several times. They actually stayed together. Suddenly, however, his demeanor changed. He tore off the tape and began to pound and throw both of them at the

tunnel. While he was doing this, the skateboard somehow flipped up and landed on top of the tunnel. Sam reached up and deliberately gave it a little push, just enough to make it fall to the ground. As it did, he repeated with the same quiet, wispy voice that he had used earlier: “Wait for me; wait for me.” Then he fell forward onto the floor, extending his arms toward the fallen skateboard.

Sam’s movements forward seemed to express both a collapse and a desire to reconnect with the skateboard. I became aware of a sense of yearning and sadness that seemed to fill the room. Sam reached with his hand for the skateboard and the man which had fallen a little way away, grasped them, and sat up. He placed both of them up against the topside of the tunnel and then—very methodically—let them go. They fell to the ground and he picked them up again, placed them in the same position on the tunnel again, and let them fall. He repeated this eight times, each time picking them up off the ground, returning them to the top of the tunnel, and then letting them fall again. His attention was focused with what seemed to be a curious desire to let them go and watch them fall. It was as if he had decided to consciously watch this scenario over and over again, as if he wanted to come to terms with it. He appeared calm and centered.

This sequence ended with Sam throwing both the skateboard and man through the tunnel, picking them up, placing them on top of the tunnel again, trying a few more times to get the figure to stand on the skateboard, and then finally releasing them, letting them just slide off the edge. He reached after them with an extended arm and then slid over the side of the tunnel too. He sat up, shifted his attention to some other toys in the room, and moved on to other play.

Assessment. This was a dynamic sequence, rich with intricacies and possible meanings. I believe that it spoke to issues of connection, loss of connection, and the

yearning that can arise as a result of such a loss. Sam's images seemed to express his desire for a specific kind of attachment and connection. This desire was demonstrated by his efforts to get the male figure to stand on the skateboard and remain attached to it. He also seemed to express this desire when he reached for the falling skateboard, plaintively calling out, "Wait for me."

In my opinion, these images seem to be indicative of a disrupted relationship. Sam's story depicts a failed relationship between a man and his skateboard, the support object upon which he was supposed to stand. Their attachment was not strong enough to prevent separation. As a result, they became disconnected from each other and also from Sam. Sam was left with a feeling of loss and a deep yearning not to be left behind when they fell away. Of all the segments, this one most comprehensively suggests the possibility of a vanishing twin history.

Could the skateboard have symbolized a form of essential support without which one cannot stand? Could this symbolic function have been similar to that of a placenta or the futon that Sam used in every session? Was Sam telling us about a loss that he had actually experienced and that had occurred because of a failed attachment, one that was not strong enough to keep the connection? Could this loss have been a vanishing twin? Clearly, we don't have answers to these questions. However, we do know that Sam knew this scenario so well within his being that he was able to create this beautifully woven depiction of it.

Finally, in assessing this segment fully, it is also important to acknowledge how challenging this material may have been for Sam to address. In light of the magnitude of his depictions, it is possible that his prior expressions of rage and anger may have been indications of the degree to which this material was challenging for him to approach. It is

my experience as a therapist that strong emotions often surface either right before or right after a powerful session in which significant material is uncovered. This is part of the healing process and could explain Sam's strong emotions in the days leading up to the session.

In addition, Sam presented his story in stages which also indicates that the material may have been challenging for him. He first introduced us to the man and the skateboard briefly in the beginning of the session and then set them aside on the floor. Later, when he was ready, he returned to them, picked them up, and used them to dramatically tell us his story. This form of titration, which in PPN terms is the process of coming into relationship with material in stages or through its constituent parts, can be indicative of material that is difficult and challenging to process and that needs to be approached carefully and slowly.

Play That Involves Taping Up Dolls

In two segments, Sam sandwiched dolls between two pieces of paper and then wrapped them with tape. In each sequence he was intending to take them home. He wanted to make sure that they would remain safe and not fall out in the car. After watching these segments many times, it seems that they depict, among other issues, a concerted effort to provide safety and protection for the dolls in the face of making a major transition from one location to another. It is interesting to note that, from a PPN perspective, vanishing twin loss is believed to occur most frequently during certain precarious early embryological transitions that are major evolutionary steps and that occur when the embryo moves from one primary state of organization into another.

The First Girl Doll

Description. In Sam's twelfth session he completed a series of drawings. When he

was done he deliberately pushed the drawings away. They came to rest in close proximity to a four-inch girl doll that he picked up and carefully laid down in between two of the drawings.

"She takes care of them," he said as he arranged the drawings so that she was completely sandwiched between them and no longer visible. "Now we must glue this together so she's in it," he added.

"So she's in between this piece of paper and this piece of paper. [pause] I can't even see her," I commented. I did not have any glue but I knew that I had scotch tape. I got up to get it and as I returned and gave it to him, I said, "You know, Sam, what's amazing is that if you didn't tell me that she was there, I wouldn't have known it because I can't see her, and you're telling us that she is there." He did not respond but began to tear off pieces of tape. He lifted the top piece of paper as he reached to tape it to the bottom piece, and as he did, she slipped forward. He could see her between the sheets, though no one else could.

"I can see her," he said.

"Yea, you picked it up and I think you're the only one who knew that she was there," I added.

"Cause I put her in."

"Because you put her in there, right. Did your mommy know she was there?" I wondered.

"I don't know."

"Mommy didn't know until you told her," Katherine explained.

"Did your daddy know she was there?" I asked.

"No." [pause]

"You knew she was there. [pause] Did Emily know she was there?" I inquired.

"No."

"No. [long pause] How old is she?" I asked.

"One."

"She's one. [pause] Does she have a name?" I wondered.

"No. [pause] That's why I'm wrapping her up."

"Oh, that's why you're wrapping her up. Because she doesn't have a name," I commented.

"No, 'cause she doesn't have a Mommy."

"Oh, she doesn't have a Mommy, so you're wrapping her up inside the paper. [pause] How come she doesn't have a Mommy?" I asked.

"I don't know. She doesn't," he responded.

"She just doesn't. [long pause]

"Hmm," I said, then added, "What is she going to do in there?"

"Play," he said matter-of-factly.

"Play. [pause] Does she have anybody in there to play with?"

After a long pause he said, "No,"

"So, she doesn't have a name, and she doesn't have a mommy, and she's going to play in there by herself. And you're the only one who knew she was there. [pause] How did you know she was there?" I inquired.

"Cause I put her in! [pause] The doctor doesn't know that her baby is in there." [long pause as Sam continues to break off tape and attach it to the papers].

I finally commented, "Yeah, [pause] so nobody knew that she was in there, did they?"

"Only me knew and Mommy," he answered.

"But Nancy and I only knew cause you told us," Katherine responded.

There was another long pause as Sam continued to tear off pieces of scotch tape and tape the papers together. His head was bent the entire time, looking down, and he did not make eye contact with anyone. After quite a while, I said, "What's going to happen to her?"

"Die in there. She's going to die in there and then we're going to throw the paper away," Sam said.

"So she's going to die in there and then you're going to throw the paper away. Did I get it right?" I asked. He looked up at me and nodded yes [long pause].

"Sam, would you look at me? [Pause, then Sam looks at me.] I'm sorry. [long pause] I feel really sad that you knew she was there and I feel really sad that she died," I said.

Katherine moved forward over to where Sam was sitting. She began to talk with him about the things that he was saying and as they were talking, he said to her, "She doesn't have a way to come out." A few minutes later he asked his mom, "What does the garbage man do?"

Katherine explained how the garbage man comes and takes away the trash. Then she asked Sam "Is that what's going to happen to her?"

Sam paused and then said, "No, I'm going to keep her at home."

Sam and Katherine began to talk about family events. Sam continued tearing off pieces of scotch tape and using them to tape the two pieces of paper together. The doll was not visible at all. Several times he picked up the papers to see if he could see the doll

through the cracks of the two sheets. It seemed important to him to seal her in completely so that no one could see her and so that she would not fall out.

He had difficulty closing some of the sides, so Katherine showed him how to wrap the tape around the edges of the papers. At some point toward the end of his taping I asked him, "So, Sam, what are you going to do with her when you get her home?"

"I'm going to unwrap her," he answered.

"And then what are you going to do with her?" I inquired.

"Play with her. [pause] My toy."

"So you're going to take her home and play with her. [pause] And then what are you going to do with her?" I inquired again. [pause]

"Throw her in the garbage," he said.

"Hmm, throw her in the garbage. [pause] I wonder what it's going to feel like to be thrown into the garbage? Do you think she's going to like that?" I wondered.

He didn't answer. Then Katherine reflected to him, "You're very busy wrapping her up."

"So she doesn't fall out of the car," he said. [pause]

"Where do you want her to get to?" Katherine asked.

"I want her to get to home," he said.

Sam continued to wrap the doll for another five minutes, very carefully sealing up all the cracks. Katherine helped him. When he was done, he just put the package down on the floor and shifted his attention to another area in the room. He moved away to some other group of toys and the session transitioned. It ended about 15 minutes later. I gave Sam permission to take the wrapped doll home.

Assessment. I think that when a child tells an elaborate story like this one, it is important to listen on several levels. To understand a child's tale, one must perceive the whole gestalt of what they are presenting. Children's words have definite meanings, but they often do not use them the same way that adults do. In order to really understand their meanings, one must listen to their words both in literal terms and also as energetic expressions while, at the same time, feeling and seeing how they are being themselves and what they are doing as they communicate.

Sam told a very particular story. Through the woven experience of his actions and words, and the image of a girl doll, he showed us something important. On a literal level, he showed us a girl doll whose existence was hidden from everyone but himself. Only he knew where she was. He wanted to take her home and play with her. To this end, he worked very hard to wrap her up in paper and tape so that her safety would be secured. Then, once at home and having played with her, he was going to throw her into the garbage.

On a deeper, energetic level, I believe that Sam was showing and telling us about the process of becoming hidden between layers, of existing without being seen or recognized, of a relationship that had deep meaning, of his wish to procure safety for that relationship, and of the eventual choice to discard that which was once wanted but had died.

Sam's intentions felt deliberate to me during this segment and his choices seemed specific. I experienced him to be in continual relationship with me though he barely made any eye contact. His awareness seemed to move between several places. First, he seemed focused on what he was doing in the moment. In addition, he also seemed to have his

attention somewhere far away and also deep inside. I could not help but feel that he was tracking something that only he could see and feel.

Of course, it is impossible to know for sure who or what this doll symbolized for Sam or what all of the nuances of his story meant. We can only do our best to suggest a possible meaning by assessing how he used her in relationship to the session, to his other behaviors, and to his entire therapeutic process. I feel, however, that we can be sure that what he showed us was an expression of an aspect of himself and something that he knew so much about that he needed and chose to tell us about it too.

The Second Girl Doll and the Doctor doll.

Description. Sam played a monster game in his 16th session, in which I was the monster. He and his father alternated between trying to hide from me and also trying to catch me. At one point they did catch me. Then Sam grabbed my arm and began pulling me toward him. Paul asked him what he wanted to do with me, and he said that he wanted to take me home and roll me up in paper. I told him that I did not have a big enough piece of paper for that. He and I started to remember the doll four sessions earlier that he had wrapped up and taken home. Paul asked him if he knew where the doll was. He said that he did not and that he wanted to roll a doll up in paper again. So he picked up a six-inch male doctor doll wearing a white coat and announced that he wanted to take him home. He took two pieces of blank paper, placed the doctor between them and began taping the edges together exactly as he had done with the girl doll in session 12. He asked his dad for help and together they diligently taped the edges closed.

At one point, I asked, “So Sam, what are you going to do with him when you get him home?”

“Take him out,” he said,

"And then what are you going to do?" I persisted.

"Keep him in the house."

Sam continued to tape for another five or six minutes. Then his eyes fell on another girl doll that was lying on the floor. She, too, was wearing an orange dress just like the doll he had wrapped up several weeks before. He picked her up and said that he wanted to wrap her up too. There were plenty of sheets of paper, so he chose two more, sandwiched her between them, and began taping. Paul helped with this doll too, and together they used numerous pieces of tape to make sure that all the edges were sealed.

When she was securely wrapped up, Sam taped the two packages together—the one containing the doctor doll and the one with the girl doll. I commented several times on how carefully he was wrapping the dolls up and how he was using a lot of tape to make sure that neither of them would fall out. Sam did not look at me once during the entire wrapping sequence. His focus was intently on what he was doing and also on his dad with whom he was strategizing where and how to put the pieces of tape. Together they guided each other and cooperatively worked as a team.

Sam took five additional pieces of paper and placed them one at a time at specific locations around the first two packages. Sam continued to use a lot of tape, as he made sure that all the pieces were strongly attached.

"So we have two dolls attached to pieces of paper and they're all securely scotched taped in," I observed.

Sam and Paul kept taping and then Paul asked, "Are they all stuck together now Sam, or do we need to put more tape?"

"More tape," he said.

I watched them work together, tearing the tape, untangling it when the strips were

really long, and figuring out where and how to place them.

Then I commented, “Yeah, it takes a lot to hold them all together. [very long pause] And I see how you’re getting to do it the way you want to Sam. [pause] This time it’s your way. There’s no way these guys are coming apart.”

Paul kept checking in with his son to be sure that Sam was getting it exactly the way he wanted it. I believe that he would have continued to add more paper but we came to the end of our session. When it was time to stop, I told Sam the he could add one last piece of tape.

“Where do you want to put that last one?” Paul asked him. Sam decided that he wanted his father to add the last piece.

“You’re the last,” he said.

“I’m the last one?” Paul asked. Sam nodded his head yes.

“Yeah, that’s important. You need to be the last one to secure it all together,” I mirrored.

“Where do you think we need to put this last one?” Paul asked.

“Right there,” Sam pointed to the center seam connecting the two packaged with the added piece of paper and deliberately showed his dad exactly where and how to lay the scotch tape down. Once the tape was on, Sam let out a big sigh and a huge smile came across his face. He sat back and just scanned what he had created. Both Paul and I congratulated him on a job well done. Paul asked him if he was going to take it home and he said, “Yes.” Together they got up and carefully lifted all the sheets of paper. They kept them in the same extended configuration that they had been in while on the floor and were very careful not to bend or crease the papers. Sam carried them over to the door where he put them down so he could put on his shoes. He was happy and seemed to be

very pleased with himself and his creation. When his sneakers were on, he lifted up the entire creation again and carefully carried it outside to the car.

Assessment. This was an exceptionally moving and powerful segment for me to witness and be a part of. There was something that felt sacred about the way that Sam wrapped up these dolls, connected them to each other, and then surrounded them with five additional sheets of paper. On a literal level, as in the 12th session, Sam, engaged in a process of carefully sandwiching dolls between sheets of paper and sealing them in with tape. He secured each in its own package so that no part could fall out or even be seen; and then he attached both packages together with a lot of tape so that their connection was firmly established. Then he surrounded them with five additional sheets of paper which he firmly attached to secure a larger perimeter. Sam expressed his intention to take the doctor home, unwrap him, and then keep him at home. He said nothing about the girl doll. Finally, when he was done, he lifted the entire large package up and carried it out to his car.

This session was both similar and dissimilar to the 12th session in which Sam wrapped and taped the first doll. Sam's wrapping and taping behaviors were similar, but he spoke less in this session. Also, this time, he used blank pieces of paper whereas in the earlier session he used his drawings as wrapping paper. Sam's demeanor this time was also different. He felt more present, peaceful, and centered. He appeared less preoccupied than in the 12th session. He also seemed to have fun with his dad, and was available and interactive with him. He was thoughtful and deliberate about his choices and clear about what he wanted to accomplish. Unfortunately, the session ended prematurely for Sam. When we came to the end of our time together he had to stop adding papers and taping. Because of this, we will never know what his final creation might have been had he had

the time to finish it the way that he wanted to.

On a symbolic and energetic level, I believe that this session was very healing for Sam. The assessment that I arrived at in 2000, regarding the possible symbolic meaning of this sequence, was slightly different from the one that I arrived at after analyzing his work for this research. In 2000, I walked away with the sense was that his behaviors were very much like a ritualistic burial rite. There was a quality to the way that he taped the dolls under one sheet of paper, sealed them in, and then surrounded them with an outer secure perimeter of papers that felt as if he were laying them to rest. He seemed to behave like someone would when burying a loved one, laying them down into the ground.

However, after reviewing the tapes for this research, I came to a more expanded and slightly different conclusion about what Sam might have been doing. I now believe that in addition to the possibility that he may have been laying something to rest, he may also have been gathering something together. Perhaps we was gathering and integrating some of the disconnected parts of himself that he had explored during his therapy. His process of wrapping and taping the dolls may have been his way of integrating whatever it was that they represented to him and bringing it all together into one complete whole. Perhaps his desire to take the dolls home was his unconscious intention to bring them all back into himself where he could finally find a place to let them be.

Portrait Four: Sam's Last Session

The process of deciding when and how to terminate therapy is a very individual one. People stop for many different reasons, under different circumstances, and in different ways. Sam entered therapy because Katherine and Paul wanted to support him to come to terms with and resolve issues that were causing him to struggle in his life. After working together for five and a half months, his parents expressed that they were

very pleased with his progress and were feeling ready to bring his therapeutic process to a close. His behaviors had gone through a significant evolution and he was able to engage with his life from a place of empowerment, self-expression, and joy. Sam was also about to begin a new school year so his parents felt the timing was right to discontinue therapy. We picked the day that would be Sam's final session which gave me several weeks to talk with him about closure and prepare him for our last meeting. Of course, both Sam and his parents understood that they could always come back at any time should they want to.

The last session was extraordinary. Except for the first ten minutes, which I will describe momentarily, Sam was communicative, intentional, and self-assured. He was deeply loving toward his parents and the entire session was punctuated with many moments of his jumping into their laps with a lot of hugging and joyous laughter. He remained connected with both of them throughout the session. He was present, relational, and interactive. His behaviors indicated that he had achieved resolution with many of the key issues that he had presented in therapy six months earlier.

This session felt like a culminating expression of integration, acceptance, and wholeness. There were so many levels of completion and new imprinting. It was a beautiful demonstration of the growth that Sam had achieved for himself and the self-confidence that he had found. He was clear about the things that he wanted to do and facilitated getting them done. His emotional and psychological demeanor was declarative. He was very different from the way he had been in his first session during which he was tenuous, retracted, quiet, and cautious. His last session seemed to be both a literal and symbolic expression of the new empowerment and possibilities that he had created and embraced for himself.

Finally, in order to fully appreciate a discussion about the very end of his last session, it is necessary to describe the therapeutic intervention that I had introduced in the second session and had used to bring closure to 10 of 16 sessions. It was a game that I made up as our second session was coming to an end. I called it "The Backwards Game." I created it to help Sam consciously engage with the endings of our sessions because he had so much difficulty saying goodbye and looking at people when they left.

This game consisted of my saying goodbye to him and then exiting the room by walking backwards toward the door. This allowed me to continue to face Sam and maintain eye contact with him. We made it fun and, as I walked backwards, I would remind him that we were saying goodbye and that we would see each other again the next week. Sam enjoyed this game. It enabled him to play with his discomfort with farewells, develop the ability to perceive the moment of farewell, and to trust the continuity of our connection over time. He was generally eager to play it, though occasionally he refused.

The last session began as Sam and Katherine entered the room and returned one of the girl dolls that Sam had taken home. Katherine explained that they had not yet found the other two, though she and Sam had looked everywhere for them. Sam just could not remember where he had put them. I suggested that perhaps there was something about them that needed to stay in the house and that there was a reason why they could not be found. Perhaps Sam needed one or both of them to stay and not be taken away. Ironically, in the evening after our last session, Katherine left me a message saying that they had found the doctor doll and would drop it by, but that they still could not find the other girl doll. They never did.

As we began our session, I acknowledged, once again, that this was going to be our last time together. During the first ten minutes of the session, Sam would neither look

me in the eyes nor face me. I had expected this and understood it. I kept acknowledging silently to him that I could feel how much he did not want to look at me. He felt tenuous, shy, and even a little mad. I could feel him tracking me while, at the same time, keeping himself away from me. He tried to keep his back to me as much as possible even when he started to do his first drawing.

"I'm aware of how you're not looking at me and you're giving me your back," I reflected. Within a few minutes of my saying that, he moved over to me and deliberately leaned his back against my leg. The moment we had physical contact he softened and I could feel him relax. I felt him open his heart to me and my heart felt warm. It was as if the naming of his state and the contact with my leg enabled him to trust the reliability and continuity of our connection again, especially in the face of this being our last session. From that point forward, the energy opened up. Sam became talkative, relational, and actively involved. He proceeded to create four distinct categories of play, each of which clearly indicated a resolution to certain issues. The categories consisted of four activities: drawing, playing hide-and-seek, playing with cords, and saying our final goodbye.

Drawing

Description

Sam began a short drawing sequence that was quite unlike any of his other drawing sequences. He laid out a bunch of colored pencils and paper on the floor, chose a pencil, and began to draw. He drew two pictures. He did not pound as he had throughout his earlier sessions, though he did make two puncture holes. He was more interested in drawing lines than digging holes. He drew with one hand for a few moments and then picked up another pencil in the other hand and began drawing simultaneously with both hands on the same paper.

When this was completed, he gathered up all 15 pencils and deliberately organized them so that he was holding all of them with his left hand. Katherine commented, “Look at that. Your hands are big enough to hold all of those pencils.” I added, “Yea, organizing all the pieces, bringing all the pieces together and putting them in order.” He tried to draw a little with these pencils in his left hand and then switched them to his right. It was somewhat difficult, so he held the pencils with both hands together and drew with the entire bunch. “Drawing with all the pieces at once. Everything is together participating,” I reflected. Then the pencils fell loose, and he began to pick each one up and place it deliberately into the cracks between the floor mats. When he had completed arranging them, he jumped into his dad’s lap and hugged him.

Assessment

This sequence clearly shows that Sam’s relationship to his drawing had shifted. No longer was he pounding holes and digging down into the underneath layers of the paper. He was now showing us squiggles that moved fluidly across the page. The pen marks that had once penetrated his earlier drawings were gone. In their place was a drawing made up of multicolored lines and curves that had coherency and that stayed on the top surface of the paper. I think that this demonstrated that Sam no longer needed to express the feelings that he did in his previous drawings during therapy. He had different choices available to him now and could engage with the colors, marks, and paper to express new and different parts of himself.

I believe that it was significant that Sam held all the pencils together, first in his left hand, then in his right, and then in both hands. This seemed to indicate an ambidextrous ability to grasp his chosen pieces from his left or his right side and to also merge the two sides of himself to form one functioning whole. Symbolically, this

ambidextrous dynamic also seemed to indicate an absence of restriction and/or limitation in the ways in which he was able to express himself. All of the pencils/pieces had literally been brought together with both of his hands and were being used to create one integrated colorful drawing. I believe that this was a reflection of an integration that Sam had achieved internally regarding the pieces of himself that he had explored in therapy and had successfully brought together.

Finally, when Sam finished his drawing, he laid all the pencils on the floor. He then put each one individually into the cracks between the mats. He did this quietly and deliberately. As I watched him, I could not help but feel that symbolically, and even literally, he no longer needed them. He had finished his work with the pencils. His drawings were done and he no longer needed to tell the stories that he told with them. He was finally putting the pencils down and laying them to rest.

Hide-and-Seek

Description

Sam spent about 25 minutes playing the hide-and-seek games with all of us as players. This was a game that he had only played during the sessions with his father. Katherine had never played it before at the BEBA clinic. Sam placed his mother and me on one team, and he and Paul were on the other. We took turns hiding and seeking. We played at least ten rounds. Hiding places were found by crawling under pillows, mats, futons, and blankets; crawling into tunnels; and hiding behind doors, sofas, futons, and balls. There was much laughter and giggling.

Toward the end of the play, Sam decided that he wanted to hide by himself rather than with his teammate. Paul helped him find a hiding place in the hard tunnel that was standing upright on its end. Sam hid alone in it. Paul hid in the flexible tunnel. Katherine

and I tried to find them. We found Paul first and Katherine asked him if he knew where Sam was. Paul said that he did but that he was not going to tell us.

I reiterated to Paul, "But you do know where he is, right?"

"Yes, he's hiding," Paul said.

I suddenly realized that something was happening in that moment that was similar to something that had happened in the twelfth session when Sam was wrapping up the first doll. In that earlier session, as Sam taped up the doll, he referred to a time when someone was hidden and only he knew where that person was. In this final session, a similar situation was occurring. Basically he was the one who was hidden and only Paul knew where he was. In addition, in both sessions, there was at least one other person who was present but who was not privy to the location of the person in hiding. This felt significant to me and I knew that I needed to make note of it.

Katherine also reiterated "We're gonna find him. It just might take us a while." We continued to look for Sam. Suddenly he moved inside the tunnel which alerted us to his location. Katherine saw his movements, went over to the tunnel, peeked in, and found him.

I sensed that this hiding sequence was particularly significant for several reasons. First of all, this was a hide-and-seek game that was taking place at the same time that two of the dolls were still lost at Sam's house. Either they had not been found because they had been accidentally lost or, perhaps, because they had been unconsciously placed out of sight by someone. Sam was probably the only one who knew, perhaps unconsciously, where they were. Second, this was the only hide-and-seek sequence in all of Sam's hide-and-seek games in which he decided to hide by himself. This felt symbolic and important to me. What was it that had transpired for him that led him to claim his own individual

hiding place? Was his choice an indication that he had stepped into himself in a new way, owning his individuation? Did he desire to be hidden and then found as a single individual that did not involve anyone else? Could his earlier choices to partner up with his dad have come from, among other things, an imprint from an earlier partnership in which he was hidden with someone else, and could that someone else have been an early twin? There are, of course, no definitive answers to these questions but they still must be asked. These questions emerge from a logical progression of thought that could lead one, if they were open, to considering a possible twinship imprint.

We had one more round of playing hide-and-seek. This time, Sam decided, once again, to hide with his dad. This time they hid under the futon. As Katherine and I went looking for them, Sam moved several times under the futon. He did this in a similar manner to the way he had moved inside the tunnel in the round before. In both situations his movements alerted us to his presence there and eventually lead to his being found.

Assessment

Much of the assessment of this segment has been incorporated into the section that describes Sam's signature behaviors and, specifically, his hide-and-seek games. However, there are some additional points to be made here. It is important to note that from a PPN perspective, these hide-and-seek games can be expressive of the events that took place during one's discovery phase in pregnancy. This is the period during which parents discover the presence of their new little one and realize that they have conceived and are pregnant. This awareness usually happens after the implantation process when a mother's chemistry begins to change. However, for some sensitive parents, discovery can take place at any time, including the moment of conception.

I think that Sam moved because he wanted us to find him—he was ready to move

through the final stages of his story and choreograph his new emergence into the present. He used these games to approach and ultimately give full expression to his willingness and desire to be discovered, seen, and perceived. He could now step into his own empowered and individuated self.

Cord Play

Description

After being discovered under the futon and emerging out from under it, Sam shifted his play and gathered up three short, skinny, brown cords and one thick, long, green cord. He gave each of us one of the short brown cords and kept the thick, green one for himself. Then he did something unexpected. He took his thick cord and went over to his mother, stood behind her, and began to tie it around her neck. He made several knots and then tightened it, not too tight, but enough so there was no extra slack and it was secure.

I was moved by how definitively he attached his cord to her and how many knots he made. I commented, "Tying up mom's neck with Sam's cord. It's really attached to her Sam. Your cord is really attached to her." He continued to tie more knots and then began to tuck one of the ends of the cord (approximately two feet) down the back of her shirt.

"I can feel something going in between my shirt and my back," she said. Sam giggled.

"You can feel that?" I asked her. She nodded yes.

"Mmm, now I feel a second part of it going in there," she said as he tucked down the second end (also approximately two feet). I was touched by the way he made sure that the cord was tucked deep into his mother's shirt with no loose ends anywhere. My sense

was that he was making sure it could not come out nor be separated from her.

"You know something, Sam, your mom can feel both ends of the cord going down her back, underneath her shirt," I said. Sam suddenly ran into his dad's arms with a smile on his face

"And Daddy can see it too," I added as I observed Paul watching Sam. "Both cords are safe inside your mommy." Sam settled and looked me straight in the eyes. Then he jumped up, removed the cord from her neck, and went back to his dad. He gave it to Paul to hold and look at as he cuddled deeply into his dad's arms again. A few minutes later he got back up, brought the cord over to me, stood behind me, tied the cord around my neck and tightened it. I really felt that he was letting us each feel how it felt to have the cord firmly attached. There was something special about this cord. It was the only thick, long, half-inch cord that the BEBA clinic had and it was green just like the green one-inch ball that Sam had designated as belonging to him. I had the feeling that this was symbolic of his own umbilical cord, that it was very special, and that he wanted each of us to feel it and to get a sense of what it would be like to be attached to it. As he tightened the cord around my neck, I said, "I know how special this cord is Sam. I can feel how special it is and how hard you're pulling it." Then he ran back into his daddy's arms again.

"Thanks for showing us that and for sharing this special cord with me, Sam." There was a long pause as Sam cuddled more into his dad's hug and at the same time looked me straight in the eyes. I think he felt perceived and there was a pause as he registered something about our exchange. Then he jumped up again, came back, and standing behind me, took the cord from my neck and returned with it to cuddle with his dad. Shortly thereafter he got up, gathered all four cords together, went over to the tunnel,

and dropped them into it. “And all the cords are together and they’re in the tunnel,” I said. He returned to his dad’s lap where he nestled one more time into a long, enfolding hug.

Assessment

This segment was very rich. From a PPN perspective it is filled with umbilical attachment symbology depicted by the particular way that Sam used his cord. This imagery is similar to that of the session in which he wrapped a thin, brown cord around the skeleton’s neck, but in that sequence there were energies of isolation, suffocation, and even strangulation. In this sequence, the cord was strong, thick, and bright green and the energies were of connection, attachment, and closeness. Sam was using his cord to make connections. It was the one that he had designated as belonging to him and it was the thickest and the strongest of all. He firmly attached it to his mother and then tucked the ends securely down her shirt. There was no way it was going to come off or slip away. He ran back into his father’s arms, then removed the cord form his mother, and attached it to me. His play was continually punctuated by these moments of returning to his father’s loving embrace and the connection and closeness that he felt in his father’s lap.

I think that Sam was symbolically showing us his cord of life, one that was strong and firmly attached to both his mother and father. I think he included me and tied it around my neck, too, because I had been his witness and advocate. In order to complete this part of his process, he needed me to also interact with his cord, perceive it, experience it, and acknowledge it.

I think he was also exploring his attachment to me. My sense is that Sam was creating a moment with each of us during which we could experience his symbolic life cord. It felt as if he were showing us two things: the central thread that had sustained him

and anchored his life through the past; and his new current source of connection and strength that was sustaining him in the present, empowering and centering him into his emerging self. In the end, he collected all the cords, each of which had symbolized some form of connection and nourishment, and put them all together in the tunnel.

The Goodbye

Description

A few minutes later, I noticed that the hour was almost up and realized that we were approaching the end of the session. Sam had returned to his dad's arms. I said softly and lovingly to him, "We're coming to the end of our time." He cuddled more deeply into his dad's hug for another few seconds and then sat up and took a long pause. "I wonder if there's one last thing you want to do?" I asked. Sam looked around. "Looking around," I reflected.

Then he got up, went to the tunnel that was standing on its end. He tilted it just enough to be able to reach down under it and gather up the cords. He felt a little mad to me. He somewhat angrily threw two of the cords, one at his mother and one at his dad, saying as each parent received their cords, "Mommy's. Daddy's." Then he took his own green, thick cord and stood behind his father.

"I'm sorry this is the end. I know it doesn't feel good," I said. He did not look at me but he took his cord and pulled it taught between his two hands. I asked him if he would show me what the pulling was like and went over to him. He let me hold one end of the cord and before I knew it, we were engaged in a game of tug-of-war. We were facing each other in full, balanced, cooperative opposition. His body was leaning back, pulling away from me, while I was bending down pulling away from him. He was pulling with his strength. We were having fun and looking into each other's eyes. I monitored my

strength to meet his strength just where his force reached its full expression, supporting him into his power and ability to create what he wanted for himself. “Wow, you’re pulling so hard Sam, and you’re so strong too,” I said. I could feel how much he was enjoying our meeting in this space of face-on resistance and flow. I could feel this declaration of his strength, his presence, and his decision to pull me toward him. I gauged my own resistance just below the peak of his resistance so that I would not overpower him and so that he could succeed at pulling me toward him. I wanted to support him to win and to fully experience his physical and intentional strength. I wanted to support him to experience himself as successfully integrating his intention, his power, and his ability to manifest what he wanted for himself.

We pulled against each other for about a minute, and slowly he pulled me over to where he was until I fell forward at his feet. He giggled and then quickly stood up, took his cord, and walked back over to the tunnel. He was not looking at me and I could sense a little fear. I really needed him to look at me, though, so that I could be connected with him while talking about the ending of our session. “Sam, would you be willing to look me in the eyes?” I asked. He was willing to and glanced at me. “Thank you,” I said as our eyes met. But he was having difficulty staying with me and could not sustain our eye contact. He glanced away. I gave up my need for eye contact and just paused with him in the silence that filled the room.

He looked down at the floor where he had dropped his cord. He noticed that it had a small loop in it. He lifted it over his head and stretched it out between his arms. The loop disappeared and in its place was a straight, taught cord. I watched him do this and said, “I can see you straightened it out. That’s your cord and you have it straight, and you can pull on it hard when you want, and you can put it places where you want to put it.”

Sam looked at me with the deep look that he always gave me when he registered acknowledgment. Then there was another pause and he looked down. As he did, he noticed that he was sitting on the cracks of the mats where he had placed the pencils in the beginning of the session. His attention went to the cracks. He reached in and pulled out a pencil that must have become broken sometime during the session. He lifted up the two pieces to show us.

"That's OK," I said, as he tried to manually reconnect the two halves. He put the two broken ends together and pushed them toward each other. After a few attempts to reconnect them, he managed to get them to stay together. He proudly held up the repaired pencil with the two halves that he reconnected. I smiled back at him and reflected, "And you put it back together. That's right. You did [long pause]. You know Sam, you put all the pieces back together in these sessions. You put them all back together." He continued to play with the pencil, and then I added, "I'm going to come over and sit next to you because I want to say a few last things to you." As I began to move toward him, Sam moved away and clearly let me know that he did not want to have any contact. "No. OK," I said.

He jumped back onto the futon and into his dad's arms. I told him that even though we were finishing, if he ever wanted to come back, all he had to do was tell his mom or dad that he wanted a session and we could have one. Then I stood up and walked over to the futon to begin to say goodbye and give everyone a hug.

Sam had a little trouble making eye contact with me and though he did not want to give me a hug, he was willing to let me give him a hug, but only from behind. Katherine and I gave each other a hug, and then I bent down to give Paul, who was sitting on the futon, a hug too. Sam was still cuddled in his dad's arms, but he was watching me

the entire time. I stood up and looked down at him. He looked up at me. He kept his eyes focused on mine and I felt that he was telling me that he was willing to be present for whatever was coming next.

"So, are we doing the Backwards Game?" I asked [pause]. "Are we going to do that?" He nodded yes as he continued to look me in the eyes. I bent forward and gently touched his right big toe. It was not until I reviewed the videos for this research that I realized that I had touched the big toe that he had stubbed in the beginning of his first session. My conscious intention at the time had just been to make loving physical contact with him. I was not aware of which toe it was that I had touched. "So, we're going to say goodbye this time," I said. As I finished my words, he turned to his mom and in a very soft voice asked her if she knew what the Backwards Game was.

She nodded and said, "Yes, I know what the Backwards Game is."

Then, he asked her, "What is the Backwards Game?"

"Do you not know what it is?" she asked with an air of confusion. [pause]

"Did you forget what the backwards Game is?" I asked after hearing their little exchange. He nodded yes. I looked at him for few moments, just sitting with the sensation of his having forgotten what the Backwards Game was after playing it for so many sessions. Then something shifted in me and I understood that, for whatever reason, the Backwards Game was no longer appropriate. "You know what? I don't think the Backwards Game is necessary anymore [pause]. Yea, we don't have to do it," I said. I explained that we could just say goodbye.

Sam kept looking directly into my eyes. There was another pause and then Katherine asked him, "How do you say goodbye?" Sam continued to look directly into my eyes as she asked this, and then almost as if in response to her questions, he silently

let me know with his eyes that he knew what was happening and that we were in the process of saying goodbye. As I looked back at him, I perceived him working hard to stay present and not to give in to an urge to pull away. I saw sadness and fear and his desire to stay with me and be able to say farewell. Then, as if the emotions got too big for him to be with, he suddenly turned away and buried his head into his dad's lap.

I acknowledged that I had seen what he had just shown me and said to Katherine, "Just there. He just did."

Sam turned over onto his belly and pushed closer to his dad. He turned his head so that he faced me and could make soft eye contact with me. Katherine and Paul were at either side of him. Katherine was rubbing his back, and Paul was bending down hugging his head. There was sadness in the room but it was not a melancholy or agonizing sadness. Rather, it felt more like an uncomplicated truth that held both sadness and also strength. Sam turned away from me and took a long pause with his head facing down toward the floor. Then he turned his face back toward me again but would not look me in the eyes. He just looked past me with a soft focus. Katherine acknowledged lovingly that saying goodbye was a really hard thing to do.

I quietly said goodbye one more time, "Bye, Sam [long pause]." I could feel him tracking me and I acknowledged that I could feel it. "Yea, right there." There was another pause and then the moment seemed to get too big to contain, and Sam distracted himself away from what was happening. He looked toward something that was nestled in the crack of the futon and allowed his attention to move there. I silently acknowledged that I understood what had just happened. I told him with my thoughts that I could feel that it was hard to look, that it was OK, and that he didn't need to keep contact with me. I started walking backwards towards the door. "Bye Sam," I said. He still did not respond.

Then, just before I got to the door and walked through it, he looked up at me and we locked eyes. In that glance I saw his strength, his sadness, his courage, and his willingness to say farewell. I felt my heart open and hug him. No words were needed. In that moment, I felt us acknowledge the amazing journey that we had taken together and also make the choice to let each other go and to finally say goodbye.

Assessment

This was a deeply moving sequence to be a part of. Sam had always struggled with his goodbyes, particularly in terms of his presenting behaviors and the need to play the Backwards Game. This time it was different. This time I could feel his courage and willingness to allow the end to take place and to face our final farewell. My sense of Sam, in that moment, was that he had accessed a source within himself that was substantial enough to sustain him and support him through the experience. It felt as if symbolically he had found his own cord of life and finally knew how to hold onto it and allow it to guide him forward. I believe that he connected with his courage and internal strength which enabled him to be present with what was truly happening. I think that our tug-of-war game supported him to fully step into, feel, and claim his power at the moment when it was most needed.

With the broken pencil, Sam symbolically succeeded at using his own strength and internal capacities to bring together the broken pieces of his story and create a healing whole. My sense, while in that last session, and then again while doing this research, was that the pencil was a symbol for the pieces of himself that he had explored in his drawings and that, through his therapy, he had successfully integrated and brought together into one integrated whole.

Finally, it was interesting that Sam appeared to forget the Backwards Game. It

must be remembered that throughout Sam's therapy, the Backwards Game was a tool which I had created from my own agenda in order to provide him with a structure in which to explore some very difficult material. It happened that it was a successful means of supporting him to find his way through the ending of each session and face a separation that would last until the next session. The purpose was to help him to internalize connection despite physical separation. This time, though, he was facing a permanent separation as our therapeutic relationship was coming to an end. My assessment at the time of this last session was that he had achieved a relative comfort with saying goodbye and so the game was no longer needed. That's why it had left his consciousness.

However, since reviewing the tapes, I have come to a different conclusion. I think that during our ultimate and final farewell, the Backwards Game would have extended our goodbye process beyond what was reasonable for Sam to have been able to stay present with and to handle. Though it was very effective during many of the previous sessions, it took about a minute and a half to complete and, as such, extended the goodbye processes. I think this would have been too much for Sam in his final session.

I believe that Sam found his own perfect way of saying goodbye and that he actually said goodbye twice: once in the moment after his mother asked him "How do you say goodbye?" at which point he said his first silent goodbye; then again, at the very end as I walked through the door, he said his second silent goodbye. That time he allowed us to really look at each other and lock our eyes together. In those moments I felt us come together, really see each other, feel each other, and let our hearts say goodbye. Sam allowed himself to be with the truth of our final farewell but he did it in his own special way.

Chapter VI: The Phone Calls

Introduction

The phone calls functioned to enhance Sam's therapeutic process in several ways. They provided me with a means of tracking the evolution of his growth as it was manifested through his behaviors at home, at school, and in his general world outside of therapy. They also gave me access to his world as his family, friends, and teachers experienced it. Whether he was moving through states of anger and aggressiveness, i.e. hitting, kicking, and biting, or emerging into states of self-confidence, self-expressiveness, and willingness to participate in new activities and relationships, each call enabled me to document what was happening to him outside of therapy.

The first call that I had with Katherine and Paul was actually an intake phone call which took place shortly after I received the initial BEBA intake forms from Katherine. Sam had not yet had his first session. The call enabled us to meet on the phone prior to beginning therapy, allowed me to ask some initial questions, and clarified what their intention was for coming to therapy. After that call we spoke on the phone eight more times throughout the therapeutic process. The calls were placed either by me for the purpose of gathering more information, or by Katherine or Paul for the purpose of debriefing sessions, asking questions, and airing concerns. The first six calls contained information that was relevant to this research, therefore, they are described below. The seventh call, which occurred between the fifteenth and sixteenth sessions, had to do with Paul and his own private process, and the eighth, which occurred before the eighteenth session, had to do with logistics of timing and meeting. Neither of those calls is included in this research.

First Phone Call

The first call occurred two days after the second session. Katherine called to tell me that Sam was having episodes of both deep emotional sobbing and anger fits during which he was hitting, kicking, and biting. He did not want to be left at school and would beg her not to leave him. All of these behaviors were out of character for him. I believe that they were indications that his therapy was beginning to loosen his survival strategies and that deeper layers of his material were beginning to surface.

Second Phone Call

The second call has already been discussed on page 151. It occurred the night before Sam's sixth session. During that session he brought in the skateboard and skateboard man. During that call Katherine reported that Sam was exhibiting extreme outbursts of rage. She did not know how to cope with these outbursts—they were uncharacteristic of Sam. I believe that his rage-full behavior was a preemptive response to the material that he was unconsciously preparing to bring in the next day.

Third Phone Call

The third call occurred between Sam's seventh and eight sessions. Katherine reported that Sam's godparents, his teacher, and friends had commented on how different Sam seemed to them. They specifically mentioned that he seemed to be more outgoing and was less retracted into himself. His godparents noticed that Sam was willing to connect with them immediately upon meeting them. When reunions occurred in the past it took him hours just to say hello, and, even then, he did not relate to them. This is very significant. Clearly something was happening that was freeing Sam to step out of himself and be more available for relationships. Other than his therapy, he was not doing anything in his life that could have accounted for such a dramatic shift.

Fourth Phone Call

The fourth call occurred after session eight. During that session Sam drew all over his arms and legs. After his session he refused to get into the water at his swimming class because of the marks on his body. This call has been discussed in the previous section entitled "*Behavior #4: Drawing*."

Fifth Phone Call

The fifth call occurred between his eight and ninth sessions. Katherine phoned to say that they had returned from a family birthday gathering with thirty family members in Hawaii. All the relatives commented on how outgoing and interactive Sam was with everyone, kids and adults alike. He even participated with other cousins in a birthday play which was performed on a huge stage. Again, this behavior was completely out of character for him. Then, the day before they returned home, one of the two cousins with whom Sam had an inseparable relationship left the island. Two hours later Sam had a major "melt down." He was explosive, attacking, and aggressive. His behavior had continued and it seemed to his mother that he had reverted to his old behaviors. He was sucking on Katherine's arms and hands, having hitting fits, and refusing to make eye contact with his parents or to listen to them.

I supported Katherine, gently suggesting that she to put Sam's behavior into context; to realize the overwhelming feelings that Sam might have been having as he moved from an expansive, loving, and connected place with his family to the sudden separation from his favorite cousin.. I reminded her to use her tracking, reflective, and empathic skills with Sam. Two days later he had his ninth therapy session. He brought in pictures of his trip and his cousin. He was communicative and interactive during the entire session.

Since nothing else had changed in his life, I think that Sam's behavior was, again, an indication that something major was being explored and released in Sam's therapy. The material that he was accessing and expressing appeared to be facilitating internal shifts so that he could experience new sides of himself, make different choices, and be more expressive.

Sixth Phone Call

The sixth call occurred between the eleventh and twelfth sessions. Katherine reported more major changes and shifts in Sam. Even friends and family were noticing. She said that he had been outgoing and willing to participate in new activities and new situations. He was making contact with people easily and even saying goodbye to his friends when he was leaving, although he still was not able to look them in the eyes. Sam's evolution was continuing to expand his horizons and his capacities to engage in relationships.

Chapter VII: Analysis and Interpretation

Introduction

This chapter discusses the research from a larger contextual viewpoint and, in doing so, provides a broader interpretation and more comprehensive analysis of its component parts. The descriptions of Sam's behaviors and his unfolding process are now revisited from a perspective that weaves them into a cohesive whole. His behaviors and themes are considered in relationship to each other as well as to the data that was reported in the literature review. They are linked more precisely to what is known about the psychological and emotional nature of twin loss, the early stages of embryonic development, and the potential causes of the vanishing twin syndrome. In this analysis, I extend my interpretations as an observer in order to draw contextual connections. My intention is to further the understanding of how the behaviors and process of a three-year-old may be expressing specific aspects of the vanishing twin experience.

Summary of the Study

This research sought to explore the vanishing twin syndrome through the therapeutic behaviors of a three-year-old child and the phenomena that were exhibited throughout his therapeutic process. This was done through the lens of PPN psychology and the combined methodologies of phenomenology, qualitative research, case study, and portraiture. The goal was to ascertain if there was a meaningful basis upon which to assess this particular child, Sam, as having experienced a vanishing twin loss. The research question was: "How might the therapeutic behaviors of a three-year-old child be indicative of a potential vanishing twin loss?"

Sam entered therapy struggling with aspects of himself, aspects of his relationships, and certain activities in his life. He left therapy much more empowered,

self- expressive, and eager to engage with his life. What happened during the course of our work together? What, from a PPN perspective, might he have explored and what might he have resolved?

The therapy that I facilitated with Sam was based on traditional models of conducting therapy with children, as well as on basic PPN therapeutic principles, skills, and interventions. All models, both traditional and PPN, have been discussed in the literature review. In addition, my therapeutic postures and interventions were based on other phenomenological approaches to the therapeutic experience including: aspects of the lived-body experience; being in the present moment; the neurological components of psychotherapy; the therapeutic dynamics of somatic empathy; field theory and consciousness studies; biodynamic craniosacral therapy; and trauma resolution therapy. This research sought to explore Sam's experience, to discover new possibilities for assessing his behaviors, and to find potential understandings for what he might have been expressing.

Outline of This Chapter

There are two steps that need to be taken in order to postulate answers to the questions posed in the previous section. First, a review of Sam's relevant history in terms of its possible relationship to a vanishing twin history needs to be assessed. Second, an analysis of Sam's signature behaviors, their possible meanings in terms of twin loss, and their relationship to the changes in Sam's presenting behaviors must be appraised. I suggest that within the convergence of these components is the meaningful and logical assessment that provides the larger answer to the essential research question.

The Triune Foundation for the Research

In order to fully appreciate this analysis and interpretation chapter, the three

fundamental premises that underlie the hypothesis of this dissertation are reintroduced. Each premise emerges from a different field of study and each provides one leg upon which this research stood. The first is the medical data which states that early gestational twin loss, also referred to as the vanishing twin syndrome, is a common occurrence. The second is the data from traditional psychology that states that twin loss, as it occurs after birth and anytime during the life span, is a deeply wounding experience that can leave lifelong psychological and emotional imprints and influences in the surviving twin. The third is the data from PPN psychology that states that embryos, fetuses, and prenates are sentient, aware, and conscious beings capable of being influenced and impacted by their earliest experiences and capable of having memories of those earliest experiences.

These three premises form the triune foundation on which the PPN hypothesis for this research was formulated, namely, that embryos and fetuses are capable of being impacted and influenced by early gestational twin loss in ways similar to older twins who lose their twin sibling after birth and later in the lifespan. This study attempts to identify supporting indications for this hypothesis.

Sam's Original Vanishing Twin Assessment

Sam came to the BEBA clinic after his family chiropractor, Dr. Sobyl Bunis, while treating Sam's severe allergies and sinus infections, assessed a potential vanishing twin wound. She suggested that the loss may have occurred during the first month of pregnancy and may have been the underlying cause of his presenting issues. His mother accepted that assessment and, following Dr. Bunis' recommendation, brought him to the BEBA clinic. This clinic provides an environment in which children can explore and come to terms with a variety of issues including early gestational loss. It is important to note that this research supports Dr. Bunis' assessment although her assessment was made

within a completely different discipline and through a different analytical process.

I was fully informed about Dr. Bunis' assessment when I began therapy with Sam. However, I did not assume that it was necessarily correct. I respected it, considered it, and allowed it to alert me to a possible vanishing twin history. My intention was to keep an open mind—to hold an open space and a receptive container for Sam into which he could express the full spectrum of his prenatal and perinatal experiences. If a vanishing twin were part of that history and needed to surface, then I would be ready to receive it. I simply sat in the wonderment of the entire PPN pallet of possible experiences and waited for him to bring the pieces forward. As his story grew and the pieces became layered upon each other, I began to see correlates between Sam's behaviors, their possible meaning and symbology, and actual embryological stages that could have been implicated and/or could have influenced a vanishing twin experience.

Eventually, I came to my own professional concurrence with Dr. Bunis' assessment and concluded positively that Sam could have been suffering from a vanishing twin loss. This assessment emerged in stages but became progressively pronounced after the sixth (skateboard and skateboard man) and ninth (skeleton sequence) sessions in which an evolving literal logic began to take shape. Sam's coherent behaviors were suggesting the strong possibility of early twin loss. In these particular sessions, Sam dramatized stories that seemed to portray relationship uncertainty, attachment failure, separation, loss, and possible death. Then in the twelfth and sixteenth sessions (taping up the dolls), new themes emerged that seemed to explore the creation of safety, strong containment, and attachment. These later portrayals appeared to provide repatterning for the earlier experiences of separation and loss.

In addition, in the last session, Sam's play depicted apparent states of resolution

for many of his prior themes. These coincided with shifts in his presenting behaviors. At the end of that final session, I felt complete in my own conclusion that Sam very well may have experienced a twin loss and that his work with me had facilitated his process of coming to terms with, integrating, and releasing that past.

A Review of Sam's Relevant History

Sam's relevant history contains dynamics that coincide with data from other research implicating a potential vanishing twin. Only by assessing his complete gestalt can a reasonable hypothesis be formulated.

Sam's Conception

Medicine, embryology, and PPN psychology have all identified circumstances during the early stages of pregnancy that could lead to or cause an early gestational twin loss. As I looked at Sam's conception and early gestational history in relationship to those circumstances, it appeared that two were in his prenatal history. Each could have influenced the first weeks of his gestation and the success or failure of a potential twin conception.

Sam was conceived into a healthy and welcoming environment with parents who loved each other and who really wanted to have children. Though Katherine and Paul were overjoyed to become pregnant, they only wanted to have one child at that time. Twins ran in their family and Katherine thought that they might be pregnant with twins. Neither she nor Paul wanted this to happen and so they kept hoping that it would not. Katherine was also in graduate school and was very stressed and preoccupied through the first seven months of her pregnancy.

PPN psychology cites maternal, and possibly paternal, rejection of a pregnancy, whether it takes the form of mild resistance to being pregnant, strong negativity toward it,

or an actual wish to remove it, as challenging the health and well-being of an embryo/fetus/prenate (Castellino, 2001; Emerson, 2005; Gowell, 2001; Linn et al., 1999; Rose, 1996; Speyrer, 2005; Verny & Weintraub, 2002). The negativity is believed to have such strong impact that it can jeopardize the life of an embryo. Within the body of the mother, thoughts and feelings of rejection can unconsciously interfere with the flow of nutrients and blood supply to that embryo, thus, further challenging its existence and survivability (Emerson, 2005).

Blechschmidt (1977), Shea (2006) and van der Bie (2001) discuss this phenomenon from an embryogenesis perspective. They explain that emotional and psychological events can change the physiology of metabolism in a split second; it is the metabolic process that underlies embryonic development. Consequently, the emotional and psychological dynamics that are present during gestation have the potential to affect the life and growth of the embryo/fetus/prenate. When these perspectives and findings are taken into consideration, it is possible that the fear and negative feelings that Katherine and Paul had regarding having twins could have negatively impacted a twinship of which Sam may have been a part.

In addition, medical research and PPN psychology both emphasize that maternal stress can be deleterious to a pregnancy. Stress is as a major contributor to changes in the production and release of maternal hormones in ways that challenge optimum gestational growth and development. It also affects the functioning of the mother's autonomic nervous system and her self-regulatory system. These dynamics can affect over-all health and the long-term success of a conception or gestation (Castellino, 2001; Emerson, 2005; Nathanielsz, 1996, 1999; Segui, 1995; Verny & Weintraub, 2002). Again, when these factors are taken into consideration, it is possible that, if Katherine and Paul had

conceived twins, Katherine's stress could have negatively affected the full viability of that twin conception.

Medical research and PPN psychology have also identified four physical symptoms that can sometimes signal the onset of an early twin loss. These include vaginal bleeding, cramping, pelvic pain, and/or spotting (Anderson-Berry & Zach, 2004; Chasen & Skupski, 2001, 2002; Landy & Keith, 1998; Landy & Nies, 1995). Katherine did not specifically report any of these signs. However, she did make a point of saying that she believes that she would not have noticed any cramping even if it had occurred. Her normal menstrual cycles had traditionally been accompanied by such severe pain that she acknowledges that she would not have paid attention to any minor cramping.

Sam's Presenting Behaviors

When Sam first came to BEBA, his presenting behaviors and emotional posture were very specific. There are similarities between Sam's dynamics and known behaviors and emotional postures related to twin loss that have been identified by several disciplines. Traditional psychology and PPN psychology have both identified twinship as the most intimate of all human relationships. They both say that the twin relationship supersedes the closeness and deep connection that exists between a mother and her child (Cox, 1994; Segal & Bouchard, 1993; Segal et al., 1995; Segal & Blozis, 2002; Tomassini et al., 2002). In addition, PPN psychology postulates that it is the closest human relationship possible, next only to man's relationship with God (Emerson, 2005; Linn et al., 1999; Rose, 1991).

Traditional psychology also identifies twinship as a relationship of couple-hood that affects each twin's identity, behavior, psychology, and his or her capacity to step fully into his/her life (Macdonald, 1994; Sandweiss et al., 1998; Segal, 2000). Twin loss

can be profoundly traumatic and affect the surviving twin's ability to form future relationships, to bond, to trust, and to fully engage in life. It can cause identity confusion, depression, isolation, loneliness, grief, fear, and extreme feelings of vulnerability (Brandt, 2001; Case 1991, 2001; Sandbank, 1999; Segal, 2000; Withrow & Schwiebert, 2005; Woodward, 1988, 1999).

PPN psychology places twin attachment at the core of the formation of a twin's identity of self (Woodward, 1988, 1999). Twin loss, including gestational twin loss, is a significant trauma that can challenge identity and cause attachment problems, generalized fear, feelings that the world is unsafe, insecurity, a defensive withdrawal from the world, fear and avoidance of separation, and missing and yearning for one's lost twin (Castellino, 2001, 2004a; Dawn, 2003; Emerson, 1996, 2005; Rose, 1991,1996; Woodward, 1988, 1999).

Sam's presenting behaviors contain similar themes. These themes include: (1) difficulty engaging in and maintaining relationships; (1) difficulty trusting; (3) a sense of not feeling safe; (4) inward withdrawal; (5) difficulty engaging in activities; and (6) fear of separation and difficulty saying goodbye. Although we can never be sure of the exact etiology of Sam's behaviors, we can look at them against the larger backdrop of behaviors that have been researched regarding twin loss dynamics. There are enough correlates between Sam's presenting behaviors and those behaviors which have been identified as twin loss-related to suggest that Sam was suffering from some form of a lost intimate relationship. Whether or not that relationship might have been an early gestational twinship can only be assessed after further examining Sam's therapeutic imagery and storytelling to see if, collectively, they point to that conclusion.

A Review of Sam's Behaviors and Their Possible Meanings

Portrait One: Our Therapeutic Alliance

The first and third sessions were essential for the establishment of the therapeutic relationship that existed between Sam and me. He used each of these sessions in a specific way to assess, identify, and develop our alliance. It is interesting to note that, from both traditional and PPN psychology perspectives, the therapeutic process needed to come to terms with and release twin loss wounds is very specific and is different from that which is needed to support the resolution of other losses (Castellino, 1999; Dawn, 2003; Emerson 2005, Noble, 1991, 1993; Segal, 2002; Sussman, 2001; Withrow & Schwiebert, 2005; Woodward, 1999).

Twin loss requires a unique kind of therapeutic container. Research indicates that when working with twin loss, the most important healing ingredient is that both the therapist and the mother must be able to acknowledge the depth of the surviving twin's loss, grief, and longing for the other(s). This affirms the presence of the surviving twin, his inherent basic goodness, and his right to life (Dawn, 2003; Noble, 1991,1993; Withrow & Schwiebert, 2005; Woodward, 1999). Castellino (1999) emphasizes that the therapist *must* be able to acknowledge the void that was created by the loss and accurately reflect it in a supportive way. This acknowledgement and reflection assists the surviving twin in establishing a relationship with, and coming to terms with, that void. PPN therapy with infants, babies, and children, requires that the mother, father, or both, be present because of the need for this kind of accurate and empathic reflection from a primary caregiver. In this way, Katherine and Paul's participation was an essential component in the creation of an effective container that was poised to perceive, acknowledge, and hold Sam's prenatal material.

Sam seemed to have an elaborate process that he needed to go through in order to identify and establish his therapeutic container. In his first session, he introduced me to his pain, via his stubbed toe, and to most of the twelve signature behaviors. Eight of them comprised the body of this research because they reflected themes that could be directly related to a vanishing twin history. The other four appeared to reflect birth dynamics and, as such, were not included (See Appendix B).

In his first session, Sam entered our relationship slowly. He seemed to want to participate but cautiously observed and waited to be sure that it was safe for him. He took his time making eye contact with me and eventually let me know that he was willing to proceed with therapy. This first session, as are many first sessions, was an introduction for both of us to each other and to the material that needed to be explored. At the end of this first session, I knew that Sam had a very powerful and painful story to tell but, other than the short sequence with the soft doll and cord, there was no other pronounced indication of a vanishing twin history.

Sam's third session was more elaborate. I kept feeling that he needed to create unusual and very particular parameters of safety. This was evidenced by his need for me to go to his house and walk around his block. He also seemed to need to make sure that I was capable of perceiving him in very specific ways.

The issues of identity and identity confusion regarding the cat, his sister, and the different pieces of beach glass relate to classic themes that confront twins (Castellino, 2001; Emerson, 2005; Segal, 2000; Woodward, 1988, 1999). I believe that Sam brought up these issues because they were facets of the story that he needed to talk about. Also, as children can do so astutely, he provided an experience for me that let me feel the identity confusion that he, on some level, felt himself. It seemed imperative that he make sure

that I could understand and hold these identity issues. Because of the way that he directed his third session and the material that he brought up, I left that session beginning to wonder about a vanishing twin history.

Portrait Two: Signature Behaviors: A Panoramic View

Sam's primary behaviors contain themes, which, from the perspectives of PPN psychology, embryology, and embryogenesis, seem to depict vanishing twin themes and imagery. These disciplines have identified embryological transitions that occur within the first three weeks of gestation which are particularly precarious for an embryo to traverse and which could implicate a twin loss. If these transitions are navigated successfully, healthy development can follow; if not, death can result (Blechschmidt, 1977; Castllino, 2001; Emerson, 2005; Hall, 2004; Shea, 2007; van der Bie, 2001; van der Wal, 1998). Sam's work during therapy seems to speak directly to these themes, images and embryological transitions. If he did have a vanishing twin, his stories could convey the history of that twin's life.

Medical research, on the other hand, which uses different research methodologies, identifies the vanishing twin syndrome as typically occurring between six and twelve weeks gestation (Anderson-Berry & Zach, 2004; Landy & Keith., 1998; Landy & Nies, 1995; Newton et al., 2003). From this perspective, medicine probably would not have perceived Sam's imagery and behaviors as having anything to do with a possible vanishing twin history.

The embryological themes in Sam's behaviors which suggested a multiple conception and a vanishing twin history include the following: multiple scenarios of ovulation, fertilization, fallopian tube journey and implantation; themes of successful and failed umbilical formations; attachment and failed attachment imagery; themes of loss

and death, and related placental dynamics. His doll play, more specifically, focused on failed attachments, separation, and the discarding of figures (animal and doll) into the garbage. If these dynamics are considered in relationship to all of his other work, an interpretation of a lost twin becomes plausible and even logical.

Sam's doll play seemed to go one step further and include the depiction of repatterning, healing, and resolution. In these portrayals, his play suggested that he might have been showing us the steps that could be taken to correct some of the failed embryological attachments that he portrayed in earlier sequences. If he had had a lost twin, these steps might have helped him heal and repattern those old wounds.

Behavior # 1: Playing With Fruit and Balls

In fifteen of Sam's sessions he played with small, round, plastic fruit and one-inch balls. The imagery and energy with which he used them evoked themes of ovulation, implantation, and the discovery period. His play with the one-inch strawberries, which he would stuff into his mouth and spit out with a popping sound, had the quality and imagery of ovulation when an ovum is released from an ovary prior to conception. His attempts to bury the strawberries into the folds of his mother's hair had the quality and imagery of implantation, the process by which a blastocyst burrows into the layers of the uterine wall. "That which has been popped out," becomes embedded into "that which will hold it".

Sam hid the one-inch balls again and again by placing them out of sight, in, under, or behind objects. These behaviors are also interpreted by PPN psychologists as portrayals of implantation. Sam's primary focus was placed, not on the hiding, but on his mother seeking and finding them. This is indicative of the discovery period. It was so essential to Sam that she not only look for each ball, but that she succeed at finding each

one that he would coax her to keep looking. It was as if he were saying to her, "Something is hidden and I need you to find it so that you will know that it is there. Keep looking until you do." Then when she found them, he would giggle with glee. If Sam had had a twin who had been hidden and whose presence was unknown to his mother, these games could have been his way of showing her that part of his story. His need to have her find the hidden balls may have been an important healing and repatterning process for him. This enabled both him and his mother to finally acknowledge together the presence of something important that had been hidden. The glee and delight with which he watched her discover and play with each ball seemed to express not only a heartfelt joy but a deep form of release as well.

Finally, the three balls could have also been symbolic of the triadic relationship that Sam felt he had with his parents as he assigned each of them a different colored ball. His explorations seemed to be about an individuality that was also connected into a triadic support system. If Sam was a surviving twin, this could have been an expression of his ownership of the unique relationship that he had with his parents as a singleton.

Behavior # 2: Playing Hide-and-Seek

Sam's hide-and-seek games with those of us who were present gave him a lot of joy and seemed to be an extension and more elaborate portrayal of the implantation and discovery dynamics that he expressed with the balls. However, these games enabled him to take us with him into the sensorial spaces of being hidden and then found so that we could really know how it felt. From a PPN perspective, and based on his other collective themes and imagery, this game seemed to indicate a multiple conception and one that he seemed to need us to discover and know about. Each symbolic twin may have needed to be discovered and cherished. In this way Sam may have been able to acknowledge their

presence, accept their passing, and take delight in his own life. His joy could have assuaged guilt, soothed grief, and given him permission to engage fully in his own life.

Behavior # 3: Playing in the Tunnels

Sam's tunnel play introduced new embryological images into his therapy. PPN therapists use tunnels to symbolize fallopian tubes and birth canals. Sam used the tunnel as a chamber through which, in which, and on which he engaged multiple objects. Sometimes he threw balls, dolls, or the skateboard and skateboard man through it, over it, or at it. Sometimes he instructed two of us to climb into it and sometimes he and his father crawled through it or hid in it. It always felt as if his imagery was telling stories about two or more "somethings" being in relationship with the tunnel and most often being inside of it. Images of multiple ova, as they travel through the fallopian tube toward the uterine cavity, kept coming to my mind, again suggesting that Sam was part of a multiple conception.

Behavior #4: Drawing

Clearly, Sam's drawings were powerful creations. The way he dug the pen down into and below the paper layers again could represent a blastocyst as it burrows into the uterine wall. The squiggly movements that he made with the pen as it pierced the top layer of paper suggest images of a sperm penetrating the cell wall of an ovum during fertilization; and the anger with which he sometimes pounded the pen seems to indicate strong feelings about whatever he was portraying. Finally, Sam's drive to dig the pen point down to what felt like a specific point and location under the paper layers suggests that he was trying to reach a particular destination. Perhaps, he was trying to show us the place where something occurred. Aspects of his other images suggest failed umbilical

formation, abnormal growth, and failed attachment. If he had had a twin, he may have been showing us that specific place during implantation where those failures occurred.

Behavior # 5: Hiding Objects in Cracks Between the Mats

Sam's play with the mats further suggests implantation symbology. He would lift up a corner of the mat and slide something under it—a toy, his hand, his toe, the pencils, and sometimes his whole body. Each time it felt as if he was pointing out that underneath place, below the top layer in the implantation site where he wanted me to keep my focus and where, perhaps, something significant had happened in his life.

Behavior # 6: Playing With Cords

From the PPN perspective, Sam's play with cords introduced themes of umbilical formation, attachment, and failed attachment dynamics. Ropes, cords and strings often symbolize the umbilical cord and/or the means with which to maintain attachment and connection. In Sam's therapy, he used cords in relationship to his parents, to me, to dolls, to a skeleton, and to a few toys and stuffed animals. His use of the cords in relationship to his parents seemed to express his deep attachment to both of them and his emotional tones were joyous. In his last session, he also used two cords to establish and maintain connection with me.

In relationship to the soft doll, the white rubber skeleton, and the stuffed animals, his play seemed to depict failed connections and attachments, and, perhaps, the malformation of the umbilical cord. With the soft doll, he tried unsuccessfully to attach the cord to her umbilicus and eventually discarded both the cord and the doll. This play could have been portraying an event in his own history which he held in his implicit memory and which may have depicted the malattachment of a twin's umbilical cord and the subsequent discarding and loss of that twin. With the white rubber skeleton and the

stuffed animals, the cord was used to create strangulating knots that wound around the necks, heads, and torsos of these toys, all of which were discarded. With the giraffe, it became a means of pulling, chaining, and dangling the giraffe. Sam's emotional tones during all of these sequences felt somewhat angry, disconnected, and expressive of an attitude of discard.

Clearly, Sam's use of the cords portrayed almost literal depictions of malformed and failed umbilical connections. His imagery suggests that he knew, from his own experience, something about those dynamics. The formation of the umbilical cord takes place over a period of time and is the result of transitions that other embryonic structures go through. Though it begins to formerly function in the fourth week, each of those earlier stages must be completed correctly for the umbilical cord to function and for the embryo to live. Perhaps Sam was telling us about a twin(s) whose umbilical cord did not develop properly so its connection failed and his twin died.

Behavior # 7: Playing With the Futon

Playing with the futon was Sam's most regularly enacted ritual which he enacted in every session. He used it as a foundation upon which to sit, stand, play, run, tell symbolic stories, do birth sequences, engage lovingly and joyously with his parents, and find his way. In the midst of all of the confusing, painful, and challenging material that he explored in every session, he always returned to his futon to reorient and find himself. The futon reminded me of a placenta which is the organ that supplies the embryo/fetus/prenate with all of its needed nourishment. It provides, in essence, the foundational support upon which and with which all gestational growth and evolution takes place. The futon felt like the new support system that Sam was building for himself as he struggled to integrate difficult parts of his past with his new emergent self.

Behavior # 8: Playing Symbolically With Dolls

Sam's play with dolls was very specific. The six doll sequences that are part of this study depicted literal themes which individually and collectively, suggest a possible vanishing twin history. They are each discussed in the following section.

Portrait Three: Symbolic Play With Dolls—A Signature Behavior Subset

When discussing Sam's play with dolls it is important to remember that he chose the human figure as a primary symbolic object. His play with dolls falls into three categories: play that involves dolls and cords; play that separates and disconnects; and play that involves taping up dolls. Together these categories depicted, in very literal terms, a wide variety of themes including: failed umbilical formation; failed attachment; loss; the development of a discard attitude; potential death; then the establishment of strong containment, connection, and attachment; integration; returning home and putting things to rest.

Play That Involves Dolls and Cords

Sam's play with dolls and cords has been reviewed in the section above on Sam's use of cords. However, there are a few more dynamics that require further discussion. The sequence with the soft doll, which occurred in Sam's first session, portrayed a failed attachment/connection between the umbilical cord and the umbilicus which lead to Sam's discarding the doll. The PPN question to ask is "What might have happened to that umbilical connection to cause it to fail in the first place?"

In the sequence with the white rubber skeleton, a possible answer was offered. Sam wrapped the cord around the skeleton's neck so many times that the neck disappeared and the cord's mass began to expand and take over the head and the torso. The skeleton became a mass of indistinguishable strands and knots, all of which were

eventually discarded. Then the same sequence was repeated with several different stuffed animals.

There are pathological circumstances in the early evolution of an embryo that can cause abnormal growth and development both in the blood vessels of the placenta and the umbilical cord, leading to malformation and dysfunction. These circumstances can lead to the death of an embryo (Castellino, 2004a; Carlson, 1999; Dox et al., 1993). Sam's imagery seems to have depicted this kind of pathology in the excessive winding of the cord around the skeleton. It is possible that he was showing us abnormalities or growth deviations which may have ultimately lead to the very early death of a twin. His use of a skeleton, the remains of a dead person, is another suggestion that he was talking about a person who died.

Play That Involves Disconnecting and Separating

Themes of separation and disconnection appear in several play sequences. Sam's determination to bend, break, and ultimately pull off the soft doll's head was an image of separation and decapitation of the human figure. The sequences with the skateboard man and the skateboard that slipped away, depicted literal portrayals of a connection that was not able to sustain itself. Sam even showed us the deep longing that he felt as he watched them separate when his called out, "Wait for me." He repeated this soft, plaintive cry. When he chose to revisit that separating moment eight more times, he seemed to watch it with curiosity and fascination, as if he really wanted to look at what was going on. His depictions were very literal. I suggest that this was part of a healing process for Sam during which he began to face and integrate some aspects of himself that he needed to come to terms with and which, in conjunction with his other imagery, could very well have been twin loss.

Play That Involves Taping Up Dolls

Initially, Sam taped up the dolls because he wanted to make sure that he could bring them safely home without any possibility of their falling out. He spent the better part of each sequence carefully securing them in between taped sheets of paper. The symbology suggests that he knew about an experience of taking a journey and having someone slip out of a container that failed to keep it safe. I suggest that Sam was talking about a lost twin and that these taping sequences were another step in his healing process. They enabled him to take literal steps to redo the past, to create a safe and secure womb that would enable him to continue on his journey without any possibility that his twin would slip away. He not only secured his twin, represented by taping the single girl doll, but also secured the dyadic relationship that he had with that twin, represented by taping both the doctor and second girl dolls together. The additional pieces of paper that he included felt like more pieces of his story that he needed to bring together in order to take everything back into himself and put it to rest.

Sam kept one of the girl dolls permanently. I suggest that she represented his lost twin and that he needed to keep her with him so that she could remain integrated into his internal world. In his 16th session, as he taped up the doctor doll, he said that his intention was to take him home and keep him. However, Sam chose to keep one of the girl dolls instead. Because of this fact, and also because the original identity issues that he expressed in his third session were with his sister, I suggest that, if he had had a twin, it very well may have been a girl.

Portrait Four: Sam's Last Session

Sam's last session clearly depicted a change in and/or resolution with the major issues and themes around which his therapy had revolved. His demeanor in this session

was dramatically different than it had been in the beginning of his therapy. He had gone from being withdrawn and tentative, of having difficulty communicating and being relational, to being outwardly much more expressive, more communicative, more self assured and willing to step out into his life.

His drawings in his last session, instead of expressing the need to dig down and pound through the papers, became an expression of fluidity and calm as he drew his shapes and lines across the surface of the paper. When he finished the second drawing, which was his last, he put all of his pencils away into the cracks of the mats. It felt as if he was saying that he no longer needed them nor did he need to tell any more stories through his drawings.

His hide-and-seek games provided him with wonderful moments of being found and seen. His sense of himself felt strong and clear as he stepped into the experience of hiding alone without his father. This felt like a significant statement of his new found empowerment, sense of self, and his knowing that he could survive by himself.

His use of the cord no longer depicted disconnection and loss. Rather, it became the means with which to establish and sustain firm connections and attachments with each parent and with me. He seemed to feel confident in its strength and reliability, and confident in his own capacity to connect and disconnect it whenever and wherever he needed.

Our farewell marked the end of Sam's therapy with me. Symbolically and literally it brought him to the threshold moment of saying goodbye. This moment is what he had historically avoided and had so much difficulty facing with friends and relatives. This time, however, he met me fully in our farewell, and participated with me in our acknowledgement of what our relationship had been. He was able to accept closure.

As we came to the very end of our final session and looked each other in the eye to say goodbye, Sam met me fully. He looked at me from a place within himself that felt strong, clear, and capable of holding connection in the face of separation. He faced me with his ability to be with what was happening, and with his willingness to acknowledge our connection, then to say farewell. It felt as if something very powerful had shifted for him. He had found something important for himself and it was with him in that moment when the ending of our time together was upon us.

Conclusion

Sam's behaviors during therapy expressed themes and images that were rich with symbolism and meaning. I believe that the PPN therapy that I facilitated with him supported him to bring forth material and stories that were reflections of his own inner world and his previous experiences. Though we will never know for sure the exact nature of those experiences and whether they include a vanishing twin or not, his therapy was the means through which he was able to face, integrate, come to terms with, and heal certain aspects of those early experiences. Segal (2002), Sussman (2001), and Woodward (1988, 1999) remind us that the healing of twin loss requires mourning, adjustment, and the reordering of one's sense of self.

Sam came to therapy struggling with dynamics and behaviors which, from a traditional and PPN psychology perspective, were similar to classic struggles that surviving twins experience. At the end of his therapy these dynamics and behaviors had significantly changed. In the beginning of therapy he was (1) inwardly withdrawn, (2) reluctant to express himself, (3) had difficulty being in relationships, (4) had difficulty trusting and feeling safe, (5) was reluctant to engage in many activities and (6) was unable to maintain eye contact when saying goodbye. When he finished therapy he was

more (1) self-empowered, (2) outwardly self-expressive, (3) able to enjoy new relationships with friends and relatives, (4) much less timid and more secure, (5) able to participate in and enjoy new activities, and (6) able to maintain eye contact when saying goodbye.

He also came to therapy with a pre-existing vanishing twin assessment from his family chiropractor. Through symbolic play, his therapy depicted and articulated the potential evolution of an early gestational twin loss. His stories portrayed scenarios that suggested specific embryonic stages in early human development. They portrayed themes of multiple conception, fallopian tube journeys, and implantation which are life supporting. They also portrayed themes of malformed umbilical cords, failed attachments, separation and loss, all of which are conditions which do not support embryonic development and which can lead to death. In addition, Sam showed us the deep pain that can be felt by the one who is left behind when these connections fail. Finally, he appeared to explore alternative ways to repattern those experiences of separation by finding new symbolic and literal means to form attachments and maintain connections.

Sam's therapeutic process seemed to support him to gather and integrate the aspects of himself that were depicted and symbolized by the different stories he told. He appeared to own and step into himself in a different way than he had been able to before his work with me at BEBA. As I look back on this therapeutic process several things are clear: Sam went through a definite behavioral evolution; his parents and I held a conceptual, perceptual, and therapeutic container for him that was receptive to his prenatal and perinatal experiences including a possible twin loss; something happened in that therapeutic space that enabled him to release and heal aspects of his experiences

which were restricting his expression and ability to live; he ultimately stepped out of therapy willing, ready, and able to engage with himself and his life in new ways that were more expressive, relationally oriented, empowered, and secure; and finally, Sam appeared to have arrived at a place within himself where he was able to hold everything together with a sense of peace and joy.

In addition, at the very end of his last session, Sam exhibited what seemed to be a newfound capacity and willingness to face, participate in, and integrate our final moment of goodbye. This was extremely significant because of his historic avoidance of those kinds of moments. I suggest that this avoidance originated in an early wound that occurred as a result of a separation experience, perhaps from a twin; and that the pain of that experience, and the fear of reliving it, had been at the core of his unwillingness to look people in the eyes when they left. His inability to face separation may have been due to the agony that separation held for him. In light of this, his capacity to meet me so fully in our last session was an indication of the significant resolution and integration that he had achieved for himself during therapy.

This dissertation concludes that the collective evolution of Sam's behaviors, along with the themes that he explored in his therapy and their interrelatedness with each other, suggests that he very well may have experienced a vanishing twin loss. His therapy indicates a likelihood of the following: that he was conceived in a multiple conception; that the presence of his twin went unnoticed; that his twin died sometime during the first three-four weeks after conception; that the loss was probably due to a malformed umbilical cord and connection that occurred sometime during implantation; and that his sense of self and his capacity to engage in relationships and with the activities of his life had been hindered by the pain that he felt from that early separation. The fact that nothing

in his life had shifted during the course of his therapy, other than his father's job which actually created more stress for the family, is further indication that whatever changes occurred for Sam were most likely the result of the work that he did for himself in therapy.

At the end of his experience in therapy, Katherine described Sam as having taken a big step for himself through the work that he did at the BEBA clinic. She said that he was more sure of himself; that he was coming into his own; and that he was more comfortable with who he was, with exploring, and with being in new situations. She said that when things bothered him, he was finally able to use words to communicate with both of his parents and let them know what the problem was.

A year later she wrote me the following note,

> Sam is so different now. He is so much his own person. He is very sure of himself and loves to experience new things and craves to be challenged. He is a happy person and I know that he feels safe here in this world and that he is confidant in who Sam is as a boy! It is such a gift for me to watch him grow and to enjoy his life with him. I am so grateful for the work you did with Sam.
>
> Many Thanks,
>
> Katherine

It is expected that after reading this dissertation, other therapists, both PPN and non-PPN oriented, will come to their own conclusions and interpretations regarding this research data. They may or may not concur with mine. I believe that the inherent richness of Sam's process will, and should, stimulate many different responses, assessments, and conclusions.

I offer Sam's story as clinical research data to be added to the clinical research base regarding the subject of vanishing twin wounding. I believe that it will inform and broaden our awareness and knowledge of the subject. As we open ourselves to Sam and enter his world, I feel that we will be touched by his story, his strength, his commitment, and his courage to face his pain. His journey is a doorway through which we can enter into a deeper understanding of the possible nature of the vanishing twin experience. It can expand our sensitivity to the potential emotional and psychological imprints that can be left for the surviving twin from this kind of early loss, especially when that surviving twin might be a three-year-old.

Additional Wonderments About Sam's Therapy

After completing this research, I am still left with several wonderments about the significance of some of Sam's behaviors. His work was rich with so many different dynamics that as I review and think about them, new awareness continues to surface. Two themes stand out.

Playing Hide-And-Seek

Sam's choice and need to play hide-and-seek with those of us who were present has been discussed as both an expression of his own need to experience being hidden and then found, and his desire to have us know what that feels like. After reviewing his therapy, I have discovered another possible component to that choice. In shifting the game from being played with small symbolic balls into a game that was being played with real people, Sam may have been taking a step toward greater ownership and acknowledgement of the reality of the experience.

A fertilized egg or blastocyst (as represented by the balls) implants and then begins to develop. Sometime between the third and fourth weeks, the umbilical cord

begins to function. By that time, the blastocyst no longer exists and in its place is an embryo with the distinguishing shapes of an early human figure (represented by those of us who were playing the game). Given that Sam may have had a twin that died from a failed umbilical formation, it is likely that when it died it had already begun to develop its distinguishing human features. By using real people, Sam may have been exploring a more real and undeniable dimension of that event. In this way, playing hide and seek first with the balls and then with actual people could have reflected an evolutionary willingness and courage on his part to more fully own, acknowledge, and integrate the reality of what he was exploring.

Sam's Placenta

After doing this research, I was moved by an association of themes that kept drawing my attention and which made me think about Sam's placenta in a completely new way. I was struck by the recurrence of three primary themes that ran throughout Sam's work and that were also mirrored in the events that occurred around the birth of his placenta. First, was the theme of separation and the pulling apart or falling away of connections. This was depicted in the way that Sam pulled his drawings apart into many pieces; in the way that dolls were separated from cords; in the way that the skateboard man and the skateboard became separated; and finally, in the way that Sam's placenta fell apart into separate pieces after his birth.

Second, was the theme that something can exist without its presence being detected or seen. This theme was expressed in the way that the hide-and-seek games hid objects so that they were not seen or visible to those of us who were present; in the way that Sam's story suggests that he may have had a twin that his parents never knew about; and in the way that Katherine continued to carry in her uterus a piece of Sam's placenta

of which neither she nor the doctor were aware. Third, was the theme of three to four weeks as being the time frame when something that exists falls away and is no longer. This theme was expressed through Dr. Bunis' assessment that Sam may have had a twin who left four weeks after conception; through the concurring conclusion of this research that, if he did have a twin, it probably left in the third or fourth weeks of gestation; through the embryological propensity for umbilical failure to occur between the third and fourth weeks; and finally, through the fact that the last piece of Sam's placenta was released from Katherine's uterus approximately four weeks after his birth.

I know that from a physiological perspective, the placenta is capable of revealing aspects of the history of the gestation and is, therefore, routinely examined after birth. From a broader and more symbolic perspective, the placenta is sometimes referred to as the tree of life, capable of revealing the holistic and energetic aspects of the individual's story. The post-birth events around Sam's placenta had an uncanny similarity to some of the key themes that he expressed in his therapy. I am left wondering whether his placenta was, in essence, his tree of life; whether it did reveal the holistic, energetic aspects of his story; and whether its last piece, which remained in Katherine's womb unnoticed for four weeks before falling away, was a final expression of the story of Sam's lost twin.

My Experience as Researcher

In my methods section, I described a PPN therapy session as a multidimensional, living experience that unfolds to reveal itself. My research process was also a multidimensional experience that unfolded to reveal itself. As I kept reviewing the data from many different angles, I found myself drawn into the sessions in a very organic and non-linear way. Insights, understandings, and connections came into view from many different perspectives. I related all of these back to the whole gestalt of Sam's therapeutic

process for fuller and more complete integration and understanding.

My research, and the many hours of reviewing the session videos, also gave me the opportunity to observe myself as a practitioner and the choices that I had made, the container that I had created, and the ways in which I had held space for Sam and met him in his world. Though I had remembered myself with Sam as a beginning facilitator who kept trying to find her way, my research gave me a new appreciation for the actual skill level that I already possessed when I worked with him. I was surprised to find how developed my capacities as a prenatal and perinatal clinician were and how consistently I was able to hold a receptive, loving, and non- judgmental container for Sam.

Finally, at the onset of this process, I was already well acquainted with my own vanishing twin history. Yet, in order to be fully present with my research and the exploration of Sam's story, I had to be willing to face deeper truths about my own past. In that process, I gained a greater understanding of the consequences of my own vanishing twin loss and the wounding that had impacted areas of my life. As I moved through my research, I found that I moved more deeply through certain aspects of myself. Therein, I found new liberation, empowerment, and an even deeper ownership of my own existence. For that I am extremely grateful.

Recommendations for Further Research

The vanishing twin syndrome is a well-documented physiological phenomenon in medicine and science. As aptly stated by Blockage (1995),

> There is little room to doubt that the question of vanishing twins and sole survivors of twin gestation represents issues of broad and fundamental importance. The numbers estimated here for the frequency of twinning at conception and the prevalence of sole survivors of twin gestations are little short

> of astonishing at first consideration, and they are conservative, perhaps even minimum, estimates (p. 49).

Though there are different opinions regarding the exact frequency and timing of the vanishing twin occurrence as a physiological event, it is, nevertheless, a subject that is fully recognized in mainstream medicine and science. However, the vanishing twin occurrence as an experience which can leave an emotional and psychological impact on the surviving twin is still a concept that, for many, is just a burgeoning idea, at best.

This research has focused on the therapeutic behaviors of a three-year-old as a means of looking at the vanishing twin dynamic and its possible influences on the surviving twin. To date, PPN vanishing twin research has been conducted with both adults and children. I suggest that further research could be conducted with any age group and that comparative studies could all focus on the client's signature behaviors and their evolution. The same research steps that I designed and followed very successfully in this study (listed on pages 94-95) could also be used by other researchers and even adapted to research data that was logged in charts only and not on videos.

Because of the implications for health and well-being that a vanishing twin wound can present for the surviving twin, and because of the prevalence of the vanishing twin syndrome, it is important that professionals conduct research on the subject, document their findings, and cross pollinate data. The knowledge base that is being developed can expand and be made available to others. It can be used to educate and broaden our understanding of this very unique and challenging form of human loss.

Appendix A: The BEBA Clinic

Mission

BEBA supports families to resolve prenatal, birth and other early trauma, both physical and emotional, while facilitating the development of compassionate relationships, the healthy growth of children, and effective parenting. This research clinic was co-founded by Dr. Raymond Castellino and Dr. Wendy McCarty. Raymond Castellino, D.C. (retired), R.C.S.T., R.P.P. (Doctor of Chiropractic, Registered Craniosacral Therapist, Registered Polarity Practitioner) is the Clinic Director of the BEBA Clinic. He is a pioneer in the field of prenatal and perinatal trauma resolution. Wendy McCarty, Ph.D., is the founding Chair of the Prenatal and Perinatal Psychology Program at Santa Barbara Graduate Institute. She has worked with families for 25 years as an obstetrical nurse, childbirth educator, psychotherapist, prenatal and birth therapist, educator, and consultant. She co-founded the BEBA Clinic and worked with clients at this clinic for several years.

Family Clinic

The clinic offers weekly sessions to Santa Barbara area families. Families come until the original trauma has been resolved and then are welcome to return on an as needed basis. Services are available on a sliding scale. Parents learn to understand what their babies/children are communicating with body language, symbolic play, behaviors and words about their earliest experiences; families learn ways of interacting and activities that will lead to resolution of early trauma and closer, more loving family bonds.

BEBA families work with trained facilitators who utilize approaches that respect the innate wisdom of the child and seek to understand the child's perspective and

experience. This model brings together the best of body oriented therapies and prenatal and perinatal psychology, including craniosacral therapy, playing, modeling, movement facilitation, role-playing and focusing on pacing, tempo and establishing harmonic resonance.

In addition, the BEBA clinic provides supervision to its facilitators with Dr. Raymond Castellino, the clinic director. Supervision supports facilitators, assistants, and videographers to explore various aspects of the therapeutic process, including session dynamics, their client's material and their own counter transferences. Supervision is also used for the purpose of sharing research data, discussing relevant issues, and keeping abreast of current trends in PPN psychology and related fields.

Who Comes to the BEBA Family Clinic?

- prenatal couples concerned that their own early experiences might interfere with their ability to bond with their children
- families who have experienced prematurity, low birth weight, early medical problems and/or hospitalization of mother or baby, difficult pregnancy or births or other early important losses such as a death in the family, anxiety/depression or a high stress pregnancy
- parents concerned about their infants who cried without apparent cause, have difficulty sleeping, have breastfeeding challenges, are unable to make eye contact, or who seem listless or slow to develop physical strength
- families concerned about their toddlers who throw frequent tantrums, exhibit poor coordination and balance, are overly aggressive towards other children, isolate themselves, have difficulties focusing their attention or are hyperactive
- couples and single parents who want to enhance their parenting skills

- parents who want help bonding with their adopted children
- parents who feel unduly frustrated or depressed about their family situation, are concerned about sibling rivalry or are unable to communicate satisfactorily with their children
- parents seeking support to face acute conditions with their babies and children including hospitalization, surgery, parental death, and sexual abuse.

Although BEBA works with families anytime from pregnancy until the children turn twelve, we have found that trauma imprinting can be resolved most effectively when it is addressed as soon as possible. For this reason, we prefer to see families as early as possible. (Reprinted with permission from BEBA Clinic, 2005.)

Appendix B: The Four Behaviors Not Described In the Research

As stated earlier, Sam exhibited four additional primary behaviors which I believe spoke more directly to issues of birth and post-birth dynamics. These were all observed and assessed in my research but not included in the body of this study because they did not directly contribute to the exploration of my research question. However, it is important to briefly mention them. They were (1) birth simulation sequences which Sam did in every session, (2) play which involved the toy ambulance and which, when assessed in relationship to context and other play, seemed to speak to Sam's experience of being transported in an ambulance during his labor from his home to the hospital, (3) sucking behaviors during which he sucked on his mother's and father's noses which seemed to speak to issues of post birth nursing, and (4) the angry pounding of a shark which, when assessed in context, seemed to speak to expressions of general anger.

Appendix C: List of Session Participants

Session #1: Sam, Katherine, Paul, Nancy, videographer.

Session #2: Sam, Katherine, Paul, Nancy, videographer.

Session #3: Sam, Katherine, Nancy, Emily, Marlene at Sam's house video camera on tripod.

Session #4: Sam, Katherine, Nancy, videographer.

Session #5: Sam, Katherine, Nancy, videographer.

Session #6: Sam, Katherine, Nancy, videographer.

Session #7: Sam, Katherine, Nancy, videographer.

Session #8: Sam, Katherine, Paul, Nancy, videographer.

Session #9: Sam, Katherine, Paul, Nancy, videographer.

Session #10: Sam, Katherine, Nancy, video camera on tripod.

Session #11: Sam, Katherine, Paul, Nancy, video camera on tripod.

Session #12: Sam, Katherine, Nancy, video camera on tripod.

Session #13: Sam, Katherine, Paul, Nancy, video camera on tripod.

Session #14: Sam, Katherine, Nancy, video camera on tripod.

Session #15: Sam, Paul, Nancy, video camera on tripod.

Session #16: Sam, Paul, Nancy, videographer.

Session #17: Sam, Paul, Nancy, video camera on tripod.

Session #18: Sam, Katherine, Paul, Emily, Nancy, videographer.

Session #19: Sam, Katherine, Paul, Nancy, videographer.

Appendix D: Informed Consent Forms

An Exploration Into The Vanishing Twin Syndrome And Its Possible Psychological Influence On The Surviving Twin:

A Phenomenological Analysis of the Behaviors of Three-Year-Old During Therapy

INFORMED CONSENT

As you know, I am a doctoral student at the Santa Barbara Graduate Institute (SBGI) and I am writing my Ph. D. dissertation on the possible emotional and psychological imprints that can result for the surviving twin from a vanishing twin experience. My research will be conducted from the prenatal and perinatal psychology perspective (PPN).

My hope is to write a case study of your son and the therapeutic work that he did with me about five years ago at the BEBA clinic in Santa Barbara. Although you have provided consent to BEBA for their use of the videotapes and the clinical notes of your son's sessions for educational and research purposes, my dissertation will be conducted under the auspices of SBGI, rather than BEBA. In accordance with ethical research practices, SBGI has required that I obtain your voluntary approval for me to proceed with my dissertation. I am giving you this form and the information it contains so that you have a full understanding of the study's procedures in order to make an informed consent for my undertaking this research.

If you choose to sign this form, that will mean that you have (a) received this document describing what is involved in my conducting this study; (b) been apprised of the potential benefits and risks of your consent to this research; (c) been given enough time to consider the information in the document; and (d) voluntarily agreed to allow me to proceed with my research.

Description of Study and Participation

The purpose of my research is to learn as much as I can about the possible long-range emotional and psychological imprints that might occur when one loses a twin early during gestation. About six years ago, your son, who was three at the time, was diagnosed by his chiropractor as suffering from this loss, and you brought him to BEBA to resolve those early issues. For my dissertation I hope to look at your son's presenting behaviors during his therapy at BEBA, the therapeutic process that he went through, the evolution that he created for himself, and his final emergence at the end of our work together. To do this, I plan to review BEBA's videotapes of my therapy sessions with him, examine chart notes or any other records BEBA has, and rely on my memory. Included in my study will also be an examination of my own participation in his process as his therapist, a reflection on your participation in his growth as his parents, and an interview with the chiropractor who initially diagnosed your son's prenatal twin loss.

Since this study focuses on sessions that took place six years ago, your son will not be asked to participate. However, regarding your involvement, and with your consent, I may ask you to participate in one of two ways: (a) to provide clarification for information that was collected in the past if it becomes apparent that I need clarification, or (b) to provide additional information if it becomes apparent that important information for this study is missing because it was not collected at the time of the sessions. I estimate that the amount of time your participation would take would be no more than one hour.

Voluntary Nature of Participation

A central principle of ethical research conduct is that those who serve as research participants be accorded the right to consent or decline to participate and that the researcher honor this right. I will, of course, respect the decision you make with regard to my proceeding with the project described in this form as my dissertation.

Should you consent to my project by signing this form, I will ask, however, that you waive your right to change your mind at a later date because your doing so would require that I conduct an entirely new study in order to obtain my doctorate. As a result of this, I ask that you take the time to consider your decision before signing this consent form and that you feel free to ask any questions or discuss any concerns you have so that you can feel comfortable making whatever decision you choose to.

Confidentiality

In conducting this study, I intend to maintain your and your son's anonymity to the greatest degree that I can. To this end, I will use pseudonyms in the dissertation instead of your real names and plan to change any identifying information (dissertations are considered public documents).

Your anonymity, however, can not be guaranteed because the videos, chart notes, records, etc. regarding your son's therapy belong to the BEBA clinic and may be used for the purpose of research, publication, or teaching by those affiliated with the clinic. Furthermore, in the future, as I indicate in the addendum to this form, I hope to lecture on PPN psychology in classrooms, workshops and conferences following my graduation. In those teaching settings, I may want to show videos of your son's therapy in order to illustrate possible vanishing twin dynamics (I would do this under the auspices of BEBA, not SBGI, and in accordance with BEBA's guidelines.) You should be aware that, should I show the tapes, audience members who have or will read my dissertation may be able to deduce that the family in the videos is the same as that described in my thesis. If this were to happen, then the anonymity of your family's story as my dissertation case study would be compromised. As the addendum indicates, you have the right to withdraw your consent of the showing of the videos at any time.

Risks

Because this case study focuses on a historic series of events (therapeutic sessions which took place five years ago), there is no risk that can result from the actual participation in the sessions themselves. However, it is possible that a variety of feelings may arise

through the revisiting of memories, the reading of the dissertation (should you chose to) and the sharing of Sam's story in such a public way. If this study were to elicit concerns or feelings, I would be happy to speak with you about them and support you to find the appropriate means of resolution.

Benefits

Your willingness to allow your son's story to be the focus of my Ph. D. dissertation research may help to further knowledge about early prenatal and perinatal experiences. In particular, it may shed light on the possible impact of the vanishing twin experience on the surviving twin, how this type of loss might be expressed in a three-year-old, and what kinds of therapy might be helpful in addressing and supporting the resolution of these possible early losses.

Contact Information

If you have any questions about the study at any point, please feel free to call Nancy Greenfield, principle researcher, at 805-640-8979.

If you have any concerns or complaints about this study, you are encouraged to discuss them with Dr. Jill Kern, Director of Research, Santa Barbara Graduate Institute. Dr. Kern can be reached by mail at Santa Barbara Graduate Institute, 525 East Micheltorena, Suite 205, Santa Barbara, CA. 93103; by phone at 805-963-6896 ext. 106; or by email at jkern@sbgi.edu.

Thank you for your willingness to consider consenting to this study.

AGREEMENT TO PARTICIPATE

I have been asked by Nancy Greenfield, a Ph. D. candidate at the Santa Barbara Graduate Institute, to allow Sam's story to be the focus of her doctoral dissertation research project regarding the vanishing twin syndrome. I (print name)_____ have read the procedures specified in this document.

I understand the nature of this research, its possible risks to me and my family, and its possible benefits to the field of prenatal and perinatal psychology.

I understand that our names will not be disclosed in this dissertation in order to protect our privacy. We are also aware of the fact that all of the data and videos belong to the BEBA clinic, which has permission to use them in a variety of ways in order to further the knowledge base of prenatal and perinatal psychology; and that, as a result of this, it is possible that our identity could be recognized by someone.

I understand that we may request a copy of this dissertation when it is complete.

I understand that we may contact Nancy Greenfield, principle researcher, with questions about the project. Further, we may register any complaint that we may have about the project with Dr. Jill Kern, Director of Research, Santa Barbara Graduate Institute.

I agree to participate in this project, which means that I am allowing my son's story and his therapeutic process at the BEBA clinic in Santa Barbara, CA to be the case study for Nancy Greenfield's Ph. D. dissertation.

___ I do consent to provide clarification or additional information if needed.

___ I do not consent to provide clarification or additional information if needed.

_____	_____	_____
Mother's signature	Mother's printed name	Date
_____	_____	_____
Father's signature	Father's printed name	Date
_____	_____	_____
Researcher's signature	Researcher's printed name	Date

ADDENDUM TO SANTA BARBARA GRADUATE INSTITUTE CONSENT FORM

After earning my doctorate, I hope to teach psychology students and other related professionals about PPN psychology and the vanishing twin dynamic, and would do so in education settings, workshops, and conferences. In that capacity, I may want to show videos of some of Sam's sessions at BEBA in order to clarify potential aspects of the vanishing twin dynamic. I would do this in my capacity as a BEBA researcher and in accordance with the BEBA guidelines that you signed in the fall of 2005.

As stated in the consent form, it is possible that when I teach in the future, an audience member who has read my dissertation might reasonably infer that the child in the video is the one featured in my thesis. Were this to happen, the anonymity of your family's story, as my dissertation case study would be compromised. You have the right, at any time, to withdraw, in full or part, your consent from the BEBA disclosure to have your videos shown. This also means that Sam, as he grows up, also has the right, at any time, to withdraw consent to have the videos shown. In addition, at such time that I decide to use the videos for teaching, I will provide you with a copy of the chosen video clips first for your approval. If any of you decide to withdraw consent, you simply need to notify me in writing at the following address: Nancy Greenfield, 311 Palomar Rd., Ojai, CA 93023 and let me know. I will immediately abide by your wishes. You should recognize, however, that your future withdrawal of consent cannot undo any impact that may be caused by my having showed the videos prior to your request that I stop.

By signing this form, you are acknowledging that you understand that I may teach in the future with the use of the videos as per the BEBA guidelines, that this teaching could effect your anonymity as my dissertation case study, and that you have the right to withdraw consent of the showing of the BEBA videos at any time.

_____	_____	_____
Mother's signature	Mother's printed name	Date
_____	_____	_____
Father's signature	Father's printed name	Date
_____	_____	_____
Researcher's signature	Researcher's printed name	Date

INFORMED CONSENT

I am a doctoral student at the Santa Barbara Graduate Institute and am undertaking research on the vanishing twin syndrome for my dissertation. This study will look at the vanishing twin syndrome from the perspective of prenatal and perinatal psychology (PPN) and will explore the possible emotional and psychological wounds that might result from this kind of loss.

I plan to conduct a case study of the PPN therapy I conducted with Sam Evans at the BEBA clinic in Santa Barbara. Because you were the person who initially diagnosed Sam as suffering from a vanishing twin wound and referred him to BEBA, I would like to interview you (in person or by phone) at a mutually convenient time. Specifically, I hope to ask you four questions about how you diagnosed Sam's vanishing twin experience (I have listed the four questions on page three of this document for your review.) The interview should take about 1/2 –3/4 hour. I hope to audiotape it so that I can transcribe our conversation. You will have the opportunity to review and amend the transcript, should you want to.

I do not intend to analyze your answers to my questions. Rather, I hope to use them to gain a better understanding of Sam's history. I plan to incorporate what I learn from you into my dissertation and into any presentations or publications that may stem from my doctoral research. With your permission, I would also like to add the information you share with me to Sam's file at the BEBA clinic where your diagnosis is already referenced. If you prefer to remain anonymous in my dissertation, publications, or presentations, I will disguise your identity by using a pseudonym.

Voluntary Nature of Participation

You have already received a copy of Kathleen Evan's permission to discuss Sam's history with me regarding his possible vanishing twin experience.

Your participation in this project is strictly voluntary. You can withdraw in part or in full at any time with no consequences.

Contact Information
If you have any questions about the study at any point, please feel free to call Nancy Greenfield, principle researcher, at 805-640-8979.

If you have any concerns or complaints about this study, you are encouraged to discuss them with Dr. Jill Kern, Director of Research, Santa Barbara Graduate Institute. Dr. Kern can be reached by mail at Santa Barbara Graduate Institute, 525 East Micheltorena, Suite 205, Santa Barbara, CA. 93103; by phone at 805-963-6896 ext. 106; or by email at jkern@sbgi.edu.

Thank you for your willingness to consider consenting to this study.

AGREEMENT TO PARTICIPATE

By signing below, you agree to participate in the interview for my dissertation research.

Please indicate whether or not you would like your real name to be used and whether you agree to allow me to include information you share with me in Sam's BEBA file.

Last, please initial the bottom of all three pages to indicate that you have received a copy of the interview questions.

____ I would like my real name to be used. ___ I would like a pseudonym to be used.

___ I agree to let Nancy Greenfield add the information I provide in my interview with her to Sam's file at the BEBA clinic.

Signature_____Date_____

Name (print) _____

Signature of
researcher_____Date_____

Questions for Sam's Chiropractor

Santa Barbara Graduate Institute
Nancy Greenfield, MA

An Exploration Into The Vanishing Twin Syndrome And Its Possible Psychological Influence On The Surviving Twin:

A Phenomenological Analysis Of A Three-Year-Old During Therapy

Interview Questions for Dr. Sobyl Bunis:

1. What is your specialty? How long have you been practicing? What are the disciplines that you incorporate into your practice?
2. How do you diagnose a possible vanishing twin dynamic?
3. What led you to diagnose Sam Hyatt as the survivor of a vanishing twin?
4. Is there any other relevant information that might shed light on Sam and his possible vanishing twin experience?

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