Prenatal and Perinatal EMDR Therapy: Early Family Intervention

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This article discusses the integration of eye movement desensitization and reprocessing (EMDR) therapy with a family therapy treatment, which was designed for treating mothers and their babies from conception through the first year of life. The Calming Womb Family Therapy Model (CWFTM) is a multidisciplinary, Integrative, early intervention approach. Its foundations originate from Murray Bowen's family model of understanding the individual in the context of their families as emotional interactive systems; Selma Fraiberg's psychodynamic work and psychoeducational interventions with mothers and infants to resolve maternal trauma and transference reactions to their babies followed by educational guidance in infant development through the first year of their lives; and EMDR therapy. EMDR therapy can improve internal resources for expectant mothers; monitor their levels of psychological distress; and enable them to access and process traumatic memories, other adverse life experiences, recent stressors, and pre-perinatal concerns and bring them to adaptive resolution. EMDR therapy can also help pregnant mothers develop imaginal templates of future events that incorporate in utero developmental prenatal education and deepen their bonds with their babies. The pre-perinatal psychotherapist's knowledge of infant development and capacity for interpersonal warmth, affect tolerance, somatic resourcing, reflective stance, and relational attunement can provide a fertile ground for the expectant mother and womb baby relationship and enriching life together. The ultimate goal is to conceive and rear healthy children.

Keywords: calming womb; pregnancy; trauma treatment; EMDR

Pregnancy is a time of profound physiological and psychological transformation for a woman that can dramatically affect perceptions, cognitions, sensations, feelings, and maternal health. Many women experience pregnancy as a joyful time; others experience it as distressing. This article summarizes the Calming Womb Family Therapy Model (CMFTM; Cortizo, 2019) and describes its integration with eye movement desensitization and reprocessing therapy (EMDR) therapy. Focusing on the mother–baby dyad, the article outlines how CMFTM strategies can be used in the preparatory phase of EMDR treatment and recommends a few minor but important additions and adaptations to EMDR's standard procedures for the pre-perinatal mother. The goal of treatment is to eliminate maternal distress during pregnancy, foster the relationship between the mother and her "womb baby," and provide relevant education about pregnancy and parenting. It is hoped that this may help in developing securely attached infants and children and perhaps prevent later relational trauma between mothers and children such as that mentioned by Schore (2016). The psychological, familial, and ecological conditions in which expectant mothers bring children into the world need to remain at the core of psychotherapy and related social programs.

For the purposes of CWFTM, the following definitions are applied (Cortizo, 2019). *Bonding* is defined as the attunement of the mother to her womb baby, and *attachment* as the relationship the baby forms with the mother and the relationship the baby forms with the father after birthing (Klaus, Kennell, & Klaus, 1996).

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The author uses the term *womb baby* to recognize the infant from conception and the evolving emotional attunement of the mother to her baby in the womb.

The Unanticipated Psychosocial Repercussions of Pregnancy: Impact on the Family

Although this article focuses only on the treatment of the mother–baby dyad, the full CWFTM program provides family therapy and addresses the impact of pregnancy on the partner and siblings (Cortizo, 2019).

Men are rarely prepared to become parents and to transition from the role of partner to father. Men often feel displaced, unsure, ambivalent, even jealous as the baby becomes the mother's primary focus. Fathers must also adjust to the mother having diminished interest in sex after birthing due to many hormonal and other medical factors (Rupert, 2016). Having to take a relational back seat may activate traumatic distress in a previously abused or abandoned father. To begin to address these issues early, the father is brought into the CWFTM during the second pre-perinatal visit. During the 6 months postdelivery, parents often experience physical strain, sleep disruption, fatigue, irritability, difficulty concentrating, lower functionality at work, and so on (Chiorino et al., 2016). Commonly, there are also financial and medical access challenges.

Siblings are similarly challenged when a new baby comes home. Their academic performance sometimes suffers for a period. The youngest sibling typically experiences significant fear of being displaced or replaced, especially if still a toddler. It is vital that parents attend to such concerns for a sibling throughout the mother's pregnancy and when the baby comes home. A significant focus of CWFTM is to help the mother maintain a state of calm in addressing the family's needs.

Impact on the Expectant Mother

A comprehensive assessment is needed to identify and evaluate psychosocial preexisting disturbances, current worries, and unresolved losses before the baby's birthing and through the first year of life. The highest levels of prenatal distress are usually experienced during the first and third trimesters (Teixeira, Figueiredo, Conde, Pacheco, & Costa, 2009). Other distressing circumstances include unplanned or unwanted pregnancies, unexpected maternal separations from loved ones, abandonment by partners, family illnesses, financial difficulties, and family deaths. The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) demonstrated that there was a clear relationship between ACEs and disease and health risk behaviors in adulthood. In a conversation with Felitti in 2017, he agreed with this author's conclusions that ACE screening, psychoeducation, prevention, and treatment need to be initiated during prenatal care or before conception. Prenatal care can help prevent complications and inform mothers about important steps they can take to protect their womb baby and ensure a healthy pregnancy. It is essential to provide multidisciplinary and multiphased treatment to support the expectant mother (Weinstein, 2016) and womb baby.

Anxiety

The incidence of prenatal anticipatory anxiety is between 14% and 54% (Garcia Rico, Rodriguez, Diez, & Real, 2010; Madhavanprabhakara, D'Souza, & Nairy, 2015). Furthermore, childbirth anxiety for women with previous stillbirth is understandably common, yet treatable (Zolghadr, Khoshnazar, Moradibaglooei, & Alimoradi, 2019). Pregnancy-related anticipatory anxiety can impact the overall health of the women, increasing the likelihood of bonding difficulty, preterm labor complications, lengthy birthing, caesarian section, low birth weight, attachment, and lactation challenges (Catov, Abatemarco, Markovic, & Roberts, 2010; Chiorino et al., 2016). It is important to note that the perinatal medical staff may focus on the medical aspects of the pregnancy at the expense of the mother's emotional experience, causing unsettling emotions to be dismissed, unexpressed, and denied.

Loss of Efficacy

Numerous healthy pregnant women who were self-directed and capable of making their own decisions before their pregnancy may unexpectedly find themselves responding passively. This passive response oftentimes is enabled by their health providers, partners, and close relatives, who take it upon themselves to make decisions for the pregnant woman.

Hormonal and Physiological Changes

Prenatal health complications and affect dysregulation caused by hormonal changes during the first trimester could trigger existing involuntary traumatic stress processes and have a distressing impact on the life of the parents, and more specifically on the expectant mother (Madhavanprabhakara et al., 2015).

Distress Regarding Unplanned, Unwanted Pregnancies

The practice of expectant mothers "keeping their pregnancy a secret" from others is common, often due to previous traumatic loss, unresolved grief, previous life experiences, shame, fear, powerlessness, confusion, and guilt (Rauchfuss & Maier, 2011). Stigma regarding unplanned and unwanted pregnancies has diminished due to changes in gender norms. This has also led to greater awareness of the emotional impact of pregnancy on the mental state of the mother and the possible effects of her distress on the womb baby (Buss et al., 2012, Kaplan et al., 2008, Lipton, 2005). These unexpressed and painful unresolved feelings may "freeze" into traumatic memories over time (Dana, 2018; Holland, 1989; Porges, 2011).

Stress

Stress, that is, the internal and external demands to accommodate change, plays a very important, potentially negative, role during pregnancy. Stress becomes maladaptive when coping mechanisms fail. It is during periods of overstimulation of the sympathetic system that the parasympathetic system is inhibited. Its inhibition, which usually results in flight-or-fight responses in a person, does not bode well for a pregnant mother's unborn child (DiPietro, 2012; Verny, 2018). Abnormally high and prolonged concentrations of the stress hormone cortisol have harmful effects on the developing baby (McGowan and Matthews, 2017).

Trauma-informed treatments such as EMDR therapy, which increase internal and external resources, self-soothing practices (phase 2), and holistic mind-body-spirit approaches such as mindfulness (Siegel, 2018), prenatal yoga, and meditation early on in therapy (Van der Kolk et al., 2014) are beneficial to both the mother and womb baby during the early parenting periods. Supporting titrated interventions that increase maternal and womb baby's felt sense of safety and regulated internal environments is especially beneficial for women with preexisting histories of trauma, unresolved grief, and traumatic stress symptoms (Weinstein, 2016).

Posttraumatic Stress

Statistics show that many women experience traumatic incidents. One in eight adult American women has been the victim of rape (Kilpatrick, Edmunds, & Seymour, 1992). The highest incidence of exposure to trauma events peaks between the childrearing ages of 16 and 20 and declines noticeably after (Breslau et al., 1998). Childhood abuse and neglect increase the risk of having posttraumatic stress disorder (PTSD) during pregnancy (Seng, Low, Sperlich, Ronis, & Liberzon, 2009). Seng et al. (2013) documented that one in three women report a history of sexual or physical abuse and that 1 in 12 expectant mothers is affected by PTSD.

Historical untreated trauma can have a deleterious effect on prenatal and parenting experiences: OB/GYN procedures may activate the autonomic system (ANS) dysregulation (Ogden, Minton, & Pain, 2006) of female clients. Women who have experienced childhood sexual abuse may find that trauma symptoms are activated during their pelvic examinations, prenatal care exams, labor, birth, and procedures that require them to remain motionless and in vulnerable positions. Waiting in a gown, on an exam table in a cold medical exam room, even without physical contact, may trigger reexperiencing of past traumatic incidents accompanied by freeze, fight or flight, collapse, or dissociative responses (Sperlich & Seng, 2008; Weitlauf et al., 2008). The mothers' own developmental trauma and PTSD symptoms may be triggered during early postnatal interactions with their newborn (Fraiberg, 1980). For example, a mother who experienced frequent pain growing up may reject her infant girl. Alternatively, the girl child may trigger trauma reminders in the mother who subconsciously withdraws or shuts down based on the prospects of raising a female who the mother anticipates will similarly experience the pain and trauma she did growing up. This projection can lead in this case to infant rejection and poor bonding.

The CWFTM and EMDR Therapy Treatment

The CWFTM

It is important to mention five main elements that inform this model and how each of these concepts serves as a building block.

First, In Utero Developmental Guidance

Early Prenatal Education. The term "in utero developmental guidance" refers to the early prenatal education of the parent that is integrated in the psychotherapeutic work. In utero guidance is a form of psychoeducation guided, step by step, by the preperinatal therapist's clinical awareness. This intervention is adapted to alleviate the expectant mother's

and womb baby's chronic external pressures and emotional distress, as well as the possible impact that the attendant anguish might place on the mother's bonding with her in utero baby. What is addressed in therapy is what the mother brings to therapy, including the psychological conflicts that are already distorting her relationship to the womb baby (i.e., a crisis at the time of conception, or grief during gestation) (Cortizo, 2019). The goal of in utero developmental guidance is to enhance and promote the mother–womb baby bond, educate the parent in understanding fetal development, and assist the parents in doing their own healing before the child's birthing (Cortizo, 2019). It also teaches new, nurturing child-rearing approaches that have been shown to facilitate optimal development in every stage of the baby's existence.

Therapeutic Alliance. The therapeutic relationship is essential in pre-perinatal family therapy. When impediments to the alliance occur, the therapist will do well to view this barrier as a possible manifestation of negative transference. Negative transference is considered a defense against hurtful feelings and memories that are being transferred and reexperienced with the treating therapist. As soon as these transference reenactments and painful feelings are validated and given space, the mother can find new, more adaptive responses to old struggles (Fraiberg, 1980).

Second, Bowen Family Therapy Approach

Theory and Application. Foundational to the Bowen systemic approach is a conceptualization of families as interactive systems rather than individuals. This model identifies and systemically treats the multi-intergenerational dysfunctional family patterns, viewing the family as an *emotional unit* with complex interfaces (Bowen, 1976). It is the nature of a family that its members are intensely connected emotionally (Bowen, 1966). *Multi-generational transmission* process means that family patterns repeat through generations. Specific roles and *triangles* reappear. Examples are the scapegoat/superstar sibling dyad, depression, substance abuse, or secrecy.

The concept of *differentiation of the self* is the cornerstone in the theory (Bowen, 1974). It is the ability to separate feelings and thoughts. Undifferentiated people cannot separate feelings and thoughts; when asked to think, they are flooded with feelings, and have difficulty thinking logically and basing their responses on their thoughts. Further, they have difficulty separating their own from other's feelings; they look to family to define how they think about issues, feel about people, and interpret their experiences. Differentiation defines people according to the degree of fusion between the emotional and intellectual functioning of the individual.

Per Bowen, *family projection* is a process by which the primary parents transmit their immaturity, lack of differentiation, and emotional problems to a child. The projection process can impair the functioning of one or more children and increase their vulnerability to clinical symptoms. Children "inherit" many types of problems, as well as strengths, through the relationships with their parents. The child who is the object of the projection process becomes the one most attached to the parents positively or negatively and the one with the least differentiation of the self (Nichols & Schwartz, 1991).

The mother is usually the primary caretaker and is more prone than the father to excessive emotional involvement with the womb baby or other children, causing the father to occupy the outside position in the parental triangle.

With the addition of a new baby, tensions often increase with extended family members, especially the couple's parents. If, in response, the couple *cut off* their ties with extended family members, they may become too dependent on the baby, their relationship, or another child.

Bowen believed that children develop certain personality characteristics based on the *sibling position* in their families. Sibling position and knowledge of general family characteristics are helpful in predicting what part a child will play in the family emotional process, and in predicting family patterns in the next generation (Bowen, 1974).

Bowen's *family therapy with one person* seeks to work with the most motivated family member, especially when many are unavailable or remain unmotivated. A single highly motivated person, such as a pregnant mother in the case of the CWFTM, can be the pivot for changing an entire family system (Bowen, 1974).

Family Therapy: Mother and Womb Baby Dyad. The CWFTM treats the mother and womb baby as a family dyad (Cortizo, 2019). The father, caregivers, and other relatives may be closely involved in the care of the mother, but the main focus of the EMDR therapy will remain the mother and womb baby dyad who consistently attend the EMDR sessions and the medical pre-perinatal care visits. The father and other relatives are welcomed and invited to assist conjoint sessions throughout her care, if the mother wishes.

It is well documented that the way a mother was cared for and nurtured in her own infancy and

childhood affects how she parents and interacts with others (Bowen, 1966; Fraiberg, 1980). Bowlby (1979) observed and documented how a parent's own childhood nurturing and mothering experiences becomes an internalized model of future parenting. Hence it is imperative to treat both mother and womb baby from the moment she initiates her prenatal care.

The transmission of dysfunctional and negative patterns from one generation to the next is the focus of the CWFTM. It is possible for the pregnant mother and her womb baby to become the endpoint at which negative family cycles that have thrived for generations are exhausted and cannot exert their influence any longer. Breaking the emotional multiintergenerational maladaptive patterns and becoming a differentiated self is a matter of overcoming those values imprinted long ago in order to replace them with conscious awareness and reflectiveness that can positively impact generations to come (Bowen, 1976).

Third, Pre-Perinatal Trauma-Informed Healing Team Approach

The pre-perinatal psychotherapist needs to develop a close working relationship with the mother's OB/GYN team. This includes regular and ongoing conversations and meetings with the OB pre-perinatal medical doctors, midwives, pre-perinatal support staff, medical assistants, coordinators, nutritionists, lactation specialists, health educators, gestational diabetes (GDM) personnel, and front desk receptionists (Cortizo, 2019).

The trauma informed pre-perinatal psychotherapist needs to provide ongoing psychoeducation to the mother's OB/GYN team. These psychoeducational collaterals could be in person or via video conferences, provided to an individual or to the whole pre-perinatal team. EMDR pamphlets, virtual-video links, and online sites with EMDR education are some of the many readily available educational tools (Cortizo, 2019).

Fourth, Mother and Womb Baby Dyad Wellness

Pre-Perinatal Self-Regulation. During her pre-perinatal care therapy sessions, the mother discusses and practices multiple-state change interventions that benefit her sense of wellness, reduce her emotional discomfort, and increase her sense of self mastery and prenatal calmness (Cortizo, 2019). She learns to regulate her affect, remain within her window of tolerance by modulating her arousal (Ogden et al., 2006), practicing mindfulness, practicing relaxation exercises (Van der Kolk et al., 2014), role-playing limits setting (Knell & Dasari, 2011), and rehearsing grounding practices (Ogden et al., 2006; Siegel, 2018). All these activities are expected to positively impact mother–womb baby bonding. Learning the above self-care practices is part of EMDR therapy's phase 2, preparation for trauma treatment (Shapiro, 2018).

Fifth, EMDR Therapy

EMDR is a comprehensive psychotherapy approach that is compatible with most contemporary theoretical orientations. It is applicable to a broad range of clinical issues and its treatment emphasis is placed on processing the neurophysiologically stored memories of events that set the foundation for pathology and health. The adaptive information processing (AIP) model that informs EMDR practice exhorts the therapist to address a comprehensive clinical picture that includes reprocessing the relevant historical events causing present-day anguish, address current incidents that elicit distress, and develop more adaptive neural networks of memory in order to enhance positive, more adaptive responses in the future.

To reprocess traumatic material, bilateral stimulation (BLS) is used. The mother focuses on a traumatic memory and the negative thoughts or feelings associated with that memory and then follows with her eyes while the therapist moves her finger or some other object in front of the mother from left to right. The therapist may choose to use other types of bilateral stimuli, depending on the needs of the prenatal client. The hypothesis is that doing this allows the mother to access and reprocess negative memories, eventually leading to decreased psychological arousal associated with the memory.

Therapy then focuses on fostering a positive belief or emotion in the mother. EMDR therapy entails eight phases and requires that the clinician is appropriately trained and prepared. The EMDR-trained clinician needs to have knowledge of how, when, and with whom to use the protocols and procedures. These precautions are specifically important during prenatal treatment, when expectant mothers are often feeling easily overwhelmed and vulnerable due to natural hormonal shifts related to the babies' growth or other physical developments. Once the treating obstetricians and midwives have been consulted and medical authorization to treat the mother has been provided, and the expectant mother has been

informed about benefits, contraindications, and possible risks and given her informed consent, the mother should be able to initiate pre-perinatal EMDR therapy (Shapiro, 2018).

The emphasis of the CWFTM EMDR treatment is based on the cause of the symptoms the pregnant mother has brought to therapy. The signs and symptoms play important roles, as they are the port of entry to core changes. Hence, this article aims to focus on trait changes, accomplishing state changes in the initial phases of EMDR therapy (i.e., phases 1 and 2).

The CWFTM proposes that EMDR therapy is recommended to treat most prenatal mothers, with few medical or psychological exceptions. EMDR therapy is provided and made available from the beginning of the pregnancy, preferably during her first trimester. Treatment is made readily available, as no gains have been observed or experienced from clinically withholding EMDR therapy. Both mother and her womb baby will profit from resourcing and receiving EMDR therapy in a timely manner. In contrast to previous views, the gestational mother is encouraged to benefit from EMDR therapy soon after her medical doctor or midwife provider gives her clearance and as soon as she can attend her first session.

Pre-Perinatal EMDR Research. Recent pre-perinatal EMDR therapy study findings suggest useful effects with expectant mothers who experience acute stress disorder or PTSD (Baas, Stramsrood, Dijksman, De Jongh, & Van Pampus, 2017; Forgash, Leeds, Stramrood, & Robbins, 2013; Sandstrom et al., 2008; Stramrood et al., 2012, 2011), fear of childbirth or tokophobia (Baas et al., 2017), childbirth anxiety secondary to previous stillbirth (Zolghadr et al., 2019), breastfeeding and bonding qualms (Chiorino et al., 2016; Madrid, Skolek, & Shapiro, 2006); and the importance of intervening in the intergenerational transmission of trauma and dysfunction by targeting maternal emotional reactivity, somatic sensations, and dysregulation with EMDR (Okawara & Paulsen, 2018).

Prenatal EMDR-CWFTM Practice

The EMDR application of the standard protocol to the CWFTM proposed will be illustrated step by step through the case of "Naanii." Each EMDR prenatal therapy session was for 45 minutes. However, how the prenatal sessions were divided often depended on Naanii's prenatal needs. Naanii was first seen when she was 7 weeks pregnant and continued to be treated for one and a half years after birthing.

In order to protect clients' privacy and confidentiality, the events, situations, and clinical dilemmas used in the case history provided in this article have been mixed, combined, and changed, and the name given to this case, Naanii, has no relation to a real person's name. The clinical events and situations discussed, though mixed, altered and unidentifiable, are real.

EMDR-CWFTM Phase One. History taking, psychoeducation and treatment planning are the same as standard procedure with special sensitivity to triggering family and relational history, child and adult attachment assessment, and a recounting of disturbing traumatic events. The therapist explains the CWFTM and asks for permission to work with her baby as a dyad. The womb baby is recognized as being in the room from the first visit and appropriate introductions are made (e.g., therapist warmly introduces self to the baby). In this phase, the client is assessed for suitability for EMDR therapy. The mother is invited to communicate to her baby that her EMDR therapy work is about her own healing. The mother is then encouraged, as she sees fit, to visualize surrounding her baby with an imaginary protective, loving, and safe bubble bordered by shielding light (Gwain, 2002). This is done before and after each EMDR therapy session, specifically during trauma reprocessing. This intervention prevents common maternal fears that talking about distress or trauma processing will negatively affect the womb baby. The initial psychosocial history may be titrated and collected in two to three visits, after the initial visit, especially if the expectant mother has preexisting trauma or if she is experiencing affect dysregulation. To assess prenatal baseline, the treating therapist administers the Dissociative Experiences Scale II (DES II) (Bernstein & Putnam, 1986), the Adverse Childhood Events (ACE) questionnaire (Felliti et al., 1998), Patient Health Questionnaire-9 (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), and the Edinburgh Postnatal Depression Scale (EPDS pre-post) (Cox, Holden, & Sagovsky, 1987) questionnaires. This phase also includes an evaluation of client safety factors: her ability to self-regulate and use coping skills that will determine target selection, including the client's ability to withstand the potentially high levels of disturbance that may be experienced during therapy. The clinician, with the expectant mother's consent, will then determine the specific targets that must be reprocessed and their order. This is a particularly important time to establish a strong, collaborative, warm, and trusting therapeutic alliance with the mother.

Case Example. In this initial phase, the pregnant mother and her womb baby were both welcomed to therapy. Naanii's suitability for pre-perinatal EMDR therapy and her medical clearance were confirmed. She was psychoeducated about both the CWFTM trauma treatment approach and EMDR therapy. Naanii completed a detailed child and adult attachment history, as a part of her clinical psychosocial assessment. She discussed her DES II, ACE, PHQ-9, and her EPDS high-scored items respectively. After her presenting problem was identified, her EMDR therapy plan formulation was initiated.

EMDR-CWFTM Phase Two. Preparation and symptom stabilization is the same as standard practice *with special attention to extended resourcing and grounding preparation*. It is essential to practice a variety of grounding and self-soothing techniques during the visits in order to deal with the disturbing information that may arise during and between sessions. EMDR therapy is an interactive model that strives to inspire the client with a sense of hope, empowerment, and control. It is mandatory to prepare the client to maintain a dual awareness of present safety along with the dysfunctional material from the past, which is arising internally (Shapiro, 2018; Schubert, Lee, & Drummond, 2011). Symptom stabilization and resource development skills such as breathing exercises and breathing retraining (Beck, 1979; Burns, 1980), basic hypnosis (Hammond, 1990), mindful relaxation practices (Ogden et al., 2006), creative visualization (Gawain, 2016), and womb-bonding in session (Verny, 2018), to name a few, are all important aspects of prenatal wellness.

If a mother is unwilling or not ready to proceed with the assessment–phase three, she can still fully benefit from mood stabilization and bodily resourcing in preparation for birthing. Pregnant mothers who are in their first trimester have abrupt hormonal shifts and bodily discomfort and often would like to be educated about prenatal incidences and self-soothing practices until the discomfort subsides. Equally, mothers in their third trimester oftentimes prefer focusing on birthing preparation and relaxation techniques with a trauma-informed prenatal therapist. Depending on their personal preference, mothers at any gestational stage may benefit from being referred to trauma-informed prenatal yoga, massage therapy, acupuncture, certified hypnobirthing (Mongan, 2015), and doula practitioners.

Case Example. The therapist continued by focusing on establishing a warm, therapeutic alliance with Naanii. This was achieved by offering comfort and prenatal psychoeducation throughout the following weeks of therapy. As recommended in session, Naanii found a nickname for her baby and talked to him or her before knowing the gender. Spontaneously, she asked her husband to talk to the baby to enhance their bonding, positively impacting her new family system. Inquiring about her pregnancy and clinical symptoms and her home life, as well as discussing current events were crucial in promoting interpersonal closeness and a sense of clinical togetherness between the therapist and client. In her sessions and during the course of treatment, Naanii role-played assertive communication, limit setting with family members, self-soothing, grounding practices (Ogden et al., 2006), and guided imagery (Gwain, 2002). It was beneficial for the pregnant mother to gain mastery over her affect, thoughts, behaviors, and somatic experiencing with the coaching support of her EMDR therapist.

EMDR-CWFTM Phase Three. Assessment and target selection are the same as standard procedures with careful attention to the mother's capacity for dual awareness, present orientation, and self-regulation. The mother and womb baby will benefit from careful pacing and initially restricting phases 3 and 4 to a shorter period of reprocessing time (e.g., a third of the session time with plenty time to close at the end). Every case is unique and will need specific treatment formulation and assessment. While an expectant mother may be ready to reprocess a past abuse, another mother may be able only to target a future fear, a present occurrence, or a recent past incident. Special attention needs to be consistently paid to prenatal and perinatal events and the expectant mother's ability to cope and problem-solve. Before the end of the session, the mother is encouraged to recall a positive experience or learned lesson during the session.

Case Example. Naanii continued to build rapport with the therapist. It was during this phase that she was educated in detail about the EMDR standard protocol, selected the negative cognition linked to her present problem "I am afraid of what could happen to my child," and identified the touchstone event related to her childhood sexual abuse. Once this memory was identified, she selected the image that best represented the memory. She chose "I am unsafe" as the negative cognition that embodied the maladaptive self-assessment related to the chosen event. Naanii choose "I am safe" as the positive cognition (PC) to replace the negative cognition during the installation phase. She identified the pretreatment Validity of Cognition

(VOC) and Subjective Unity of Disturbance (SUD), as well as the emotion and bodily location of the felt disturbance.

Common negative cognitions for pregnant mothers, including first-time mothers who are afraid of birthing, include "I am unsafe," "I am powerless," "I am out of control," and "I am helpless."

During this phase and due to unexpected prenatal occurrences, mothers may prefer targeting recent events or work on resourcing, over-desensitizing past traumatic incidents, and such requests need to be tailored to the needs of the mother. Each prenatal dyad presents different necessities. Before termination, Naanii was encouraged to recall a positive resource or learned lesson during the session.

EMDR-CWFTM Phase Four. Desensitization and reprocessing are the same as standard procedure. The expectant mother will continue to benefit from careful pacing and initially restricting phase 4 to a shorter period of reprocessing time (e.g., a third of the session time with plenty of time to close at the end). To increase reprocessing understanding and clarity, it is important to continue to brief the mother on the theory of EMDR therapy and the procedures it involves and facilitating a "calm place." It should be emphasized that the reduction of distress is only a by-product of the reprocessing. During this phase, the mother may also gain insight and awareness of associative patterns, an increase of efficacy, and a new sense of self.

Identifying the therapist as a safe resource and a pre-perinatal supportive coach allows the client to face intense emotions that come along with the process. Although eye movement bilateral sets (BLS) are preferably used, tappers are also available. Prenatal clients may prefer the use of tappers due to visual problems or prenatal dizziness. It may be prudent to keep the first desensitization and reprocessing sessions shorter to ensure that the prenatal mother remains within her window of tolerance and with dual awareness.

Case Example. Naanii was nauseous during her first trimester but preferred eye movements. Prenatal clients may prefer the use of tappers due to visual problems or prenatal dizziness. It may be prudent to keep the first desensitization and reprocessing sessions shorter to ensure that the prenatal mother remains within her window of tolerance and with dual awareness. Naanii responded well to regular 45-minute sessions of 20-minute BLS sets. When Naanii requested to stop, the rest of the session time was spent in psychoeducation, discussing her disturbance, and practicing grounding exercises. Naanii was often surprised at her spontaneous memory connections, the felt sense of release, the bodily memories being released, and the information being accessed. However, she wanted to focus on her delivery fears and birthing resourcing once close to childbirth. Naanii reprocessed multiple targets throughout her EMDR therapy treatment and even while she was lactating. When her baby was born she oftentimes refused to stop the BLS when she needed to feed her newborn. During these occasional and brief occurrences, her baby was observed closely and seemingly her newborn remained calm as the mother continued to desensitize existing emotional and bodily reactivity. Near completion of such sessions, Naanii was coached to attend to and talk to her baby and to compensate for the redirection of attention from the baby to therapist. The newborn and Naanii seemed to respond well to this supportive and developmentally guided intervention (Fraiberg, 1980). As recommended in phase 3, before termination Naanii was encouraged to recall a positive resource or learned lesson during the session.

EMDR-CWFTM Phase Five. Installation of PC is the same as standard practice. The focus is on increasing the strength of the PC that the client has identified to replace the original negative cognition.

Case Example. Naanii remained grounded and hopeful during this phase. She easily strengthened her chosen PC "I am safe," which replaced "I am unsafe," her previously identified NC. To measure progress, she used the VOC score. Most mothers go through this phase uneventfully. As recommended in phases 3 and 4, before the session termination Naanii was encouraged to recall a positive resource or learned lesson during the session.

EMDR-CWFTM Phase Six. Body scan is the same as standard procedure with special attention to differentiating those somatic sensations pertaining to the pregnancy versus the traumata.

Case Example. For a pregnant mother this is a confusing phase of treatment, specifically because most pregnant mothers experience bodily changes on a regular and frequent basis. Naanii had a hard time differentiating between her bodily prenatal tensions and the ones linked to the body scan. It helped when I asked her, "Could you leave all the prenatal bodily aches and tensions in your container and just keep and feel the tensions pertaining to the original memory? Now

close your eyes. Bring up the incident and the PC, and mentally scan your entire body. Tell me if you notice anything." She responded well to such inquiry, especially during the third trimester, when her baby was growing, her body was tenser, and the bodily memories were harder to differentiate. Before therapy termination, as recommended in phases 3, 4, and 5, Naanii was encouraged to recall a positive resource or learned lesson during the session.

EMDR-CWFTM Phase Seven. Closure of a session is the same as standard practice, with careful attention to grounding and present orientation before the session ends. This consistent practice will increase the mother's sense of therapeutic safety and self-control. The pregnant mother must be returned to a state of equilibrium at the end of each session, regardless of whether reprocessing is complete or not. A variety of self-regulation and self-care techniques may be used to close the session. The mother is briefed on what to expect between sessions, and in the use of an imaginary container or a journal to report on the experience.

Case Example. During the last 10 minutes of closure, Naanii was guided to return to a state of grounded presence; as per self-reports, before the session was completed she did. If more time was needed it was provided. She was encouraged and reminded to write thoughts or concerns that may arise between sessions in her journal for future discussion.

EMDR-CWFTM Phase Eight. Reevaluation is the same as standard process. A reevaluation of effects must be made at the beginning of the following session. *At the beginning of each session time needs to be used to discuss emerging prenatal concerns and treatment doubts, as well as to review journaled material to ensure optimal treatment effects.* After a reprocessing session, a reevaluation of effects should be made at the beginning of the following session. Successful treatment can be determined only after sufficient reevaluation of reprocessing and behavioral effects over time (Shapiro, 2018).

Case Example. At the beginning of every session, Naanii was consistently asked about the target that had been processed in the previous session, and treatment effects were discussed at the beginning of every visit. Journaled incidents, dreams, or any other concerns were addressed and talked about during the first 15 minutes of every session. Prenatal updates were discussed, as well as current events and any other important thoughts she presented.

Pre-Perinatal EMDR Discussion

Relevant to pre-perinatal treatment are common myths that can impact outcomes.

Anecdotal Common Myths

"The mother should initiate her EMDR therapy during her second trimester." In reality most expectant mothers enter therapy by their eighth gestational week. By the time phases 1 and 2 are completed, including a thorough assessment, questionnaires, attachment genogram (Bowen, 1974), and an EMDR treatment plan, most likely the mother is in her second gestational trimester. Hence, there is no need to delay healing.

"The womb baby may be affected by the influx of cortisol during reprocessing traumata." Although the womb baby may be exposed to cortisol levels during reprocessing, the important goal is of reducing the maternal chronic stress over the following EMDR therapy sessions. Resourcing, containment, and self-care practices are all needed abilities. Precautions include titrating EMDR processing material and OB/GYN integration of services during the mother's gestational months. Titrating traumatic material allows the mother to participate with her therapist in determining how much discomfort will be reprocessed in every session. This active collaboration allows the expectant mother to replace traumatic stress and helplessness for empowerment. The EMDR prenatal clinician needs to keep the mother from re-experiencing marked disturbance, but there is no need to postpone health restoration.

"Ask the OB/GYNs, midwives, and other medical treating professionals for permission to proceed with EMDR prenatal therapy." This is an important practice, but unfortunately most gynecologists, obstetricians, midwives, and medical providers lack information about how EMDR therapy can assist their prenatal clients. It is the function and role of the EMDR therapist to educate such providers. In-services, psychoeducation, EMDRIA pamphlets, bibliography, and the distribution of virtual materials are crucial.

Complicated Presentations

"Unperceived pregnancy" has not attracted sufficient attention in the psychological and psychiatric literature, despite the existing solid epidemiological research concerning this phenomenon (Sar et al., 2017). "Unperceived pregnancy," previously called

"denial of pregnancy," is defined as the inability to recognize gestation until the 20th week of conception. In the case of total denial, the pregnancy goes unrecognized until birthing by the woman. This condition can result in a traumatic birthing, medical and psychiatric complications, the loss of the newborn, traumatic stress, and forensic consequences (Sar et al., 2017). Partial denial occurs in approximately 1 of 500 pregnancies, while total pregnancy denial occurs in 1 of 2,500 (Wessel & Buscher, 2002). The EMDR standard protocol can reduce the shame, guilt, and traumatic stress caused by an "unperceived pregnancy."

"Tokophobia," first described in literature by Knauer in 1897, is the severe fear of pregnancy, which can lead to avoidance of childbirth and "C-section" requests or demands. It can be classified as primary or secondary. Primary is the morbid fear of childbirth in a woman who has no previous experience of pregnancy. Secondary is the morbid fear of childbirth, developing after a traumatic obstetric event in a previous pregnancy. Most women are able to cope with such fears and anxieties by self-help efforts, social support, and medical help. However, when it becomes pathological dread, it is treated as tokophobia. The EMDR standard protocol with focus on processing the present fear of childbirth can reduce the mothers' distress.

Cautions

When a mother is experiencing drastic hormonal shifts, feels constant physical pain, is at high risk of premature labor or childbirth, or declines EMDR therapy phases 3–6, the best course of treatment is to focus on phases 1, 2, 7, and 8, specifically phase 2, including relaxation practices, in utero developmental guidance, pre-perinatal bibliotherapy, and EMDR resourcing.

Recommendations

Further research by medically trained EMDR pre-perinatal clinicians is needed, specifically to provide EMDR therapy while the pregnant mother is attached to a fetal monitor, during EMDR therapy's reprocessing phases. Such procedure is currently uncommon due to the providers' time constrains and clients' privacy protocols.

To demonstrate the efficacy of the model, replication of the EMDR protocol along with the CWFTM to a wider prenatal population is recommended.

Conclusions

Prenatal EMDR and CWFTM applicability is aimed at restoring the affective and interpersonal equilibrium, facilitating adjustment and resilience, and allowing preexisting or recent traumatic experiences related to conception to be processed. Pregnancy does not suggest disability, and pre-perinatal EMDR therapy needs to be readily available and offered.

This article proposes that EMDR therapy and the CWFTM can be used together efficiently to provide support to pre-perinatal women, their families, and medical providers. It also demonstrates the varied applicability and benefits of expanding both resourcing and treatment to those expectant mothers with preexisting distress, chronic anticipatory anxiety, specific grief, and potential traumatic events. The ultimate goal is to conceive and rear healthy children.

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