Perinatal Trauma, Dissociation, and Bonding: Cultivating Growth with the Calming Womb Model

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Introduction

Welcome!

Disclaimer around potential triggering content and the importance of self-care - Making time for breathing and space for grounding as needed

The focus of this presentation is on pre/peri-natal complex trauma work, building the bonding capacities between a mother/carrying person and the womb baby and preventing the passage of intergenerational trauma by beginning to build attachment within the mother/carrying person-womb baby dyad as early as conception.

This presentation also seeks to make a case for universal assessment and collaborative-intervention practices.

Presenters

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Presentation Goals

Mission

Presentation of a unique and comprehensive approach to prenatal trauma treatment that re-conceptualizes the client as the mother/carrying person-womb baby dyad.

Vision

To support healthy growth and development, prevent the transmission of intergenerational trauma-related patterns and processes, and increase the capacity for bonding and attachment in the individual, the dyad, and the larger family unit.

Presentation Objectives

Create a bridge between the worlds of prenatal care and infant development and the complex trauma and dissociation field.

Prevention not just intervention by advocating for treatment that begins before birth, in turn giving voice to the invisible experiences of pregnancy and birthing to honour women, carrying persons, babies, and the importance of the beginning of life.

Presentation Outline

01

Theory and Terms

Guiding theory and important definitions

02

CWFTM

Mission/vision/intention of approach

03

Assessment

To support conceptualization and guide treatment

04

Core Pillars and Integration

Five guiding treatment tenets and integration into other modalities

Presentation Outline

05

Case Example

Clinical case to support translating theory into practice

06

Closure

Closing practice and resources

What this presentation will not cover

01

Intersectionality

Considerations for different identities and caregiving structures

02

Theoretical Limitations

Not going into depth

Limits in relevancy and generalizability

The language reflects the time

01 Theory and Terms

Important Definitions and building the theoretical frame

Definitions and Terms

Prenatal refers to care given to pregnant women before their babies are born.
Post-natal/postpartum/post birthing refers to after birth.
Perinatal refers to 5 months before and 1 month after birth.

Womb baby is the term used to recognize the infant from conception and the evolving emotional attunement of the mother, or carrying person (surrogate, differing gender identity), to the baby in the womb (Cortizo, 2019 & 2020)

Definitions and Terms

Perinatal attachment refers to the "extent to which a mother engages in behaviors that are indicative of her bond to the infant and thus are related to her capacity to form a prenatal maternal representation of the child (Malone, 2010, p. 436).

Bonding is defined as the attunement of the mother (mother's behavior) to her womb baby, is protective and may occur in many forms, while **attachment** refers to the relationship the baby forms with the mother, and other caregivers, after birthing and the strategies used to promote it (Klaus et al., 1995).

Definitions and Terms

Traumatic transference is speaking to unconscious relational dynamic, whereby there is implicit assumption that abuse and trauma related-dynamics will occur within present day relationships. Within the context of this presentation, traumatic transference emerges within the mother/carrying person and womb baby dyad.

Prenatal transference refers to the transference pattern whereby the womb baby is given qualities and intentions that do not belong to them, instead belong to other figures in the mother/carrying persons past that reflect elements of unhealed wounds (Cortizo, 2019)

Definitions and Terms

Prenatal projection refers to disowned aspects in the mother/carrying person onto another, which may be the baby, family members, or other supports, and in turn forms a sense of denied or distorted self (Cortizo, 2019). In a Bowenian sense, Family Projection occurs when the primary caregiving structure transmit their lack of differentiation and emotional struggles to the child (Nichols & Schwartz, 1991).

Broken bonds speak to a detachment of the mother or carrying person from the womb baby.

Definitions and Terms

Intergenerational trauma is understood through the lens of Fraiberg's (1980) *Ghosts in the Nursery* metaphor whereby unresolved trauma(s) emerge as "ghosts" in relationship via unconscious schemas, affect the understanding of and interactions with a womb baby/baby, and represent the dissemination and repetition of past trauma in the present. In this way, "the parent, it seems, is condemned to repeat the traumas and tragedies of their own upbringing with her own baby.

Malone, 2010; Fraiberg, 1980

Definitions and Terms

According to Malone (2010), "...as a woman becomes pregnant, and anticipates a new, intimate relationship with her child, it is important to consider the ways in which her history of child maltreatment may affect her internal working models related to the anticipated caregiving" (p. 435).

Both Bowlby (1979) and Winnicott (Newman, 2013) observed and documented how a parent's own childhood nurturing and mothering experiences became an internalized model of future parenting based on internal working models.

Bowen (1966) noted that family patterns repeat through generations via a multigenerational transmission process.

Definitions and Terms

Relational Attunement is the therapist's sensitivity in attending to interpersonal cues within therapy that transcend beyond mere words, and reflects the clinicians capacities around mirroring and attentiveness to the interpersonal dance. Such attunement is a mindful process within the therapist (Forner, 2019), is empathic (Courtois & Ford, 2016), and may be thought of as a "rhythmic encounter that is entirely dependent of being present in the moment" (Hoppenwasser, 2008, p. 357) and is a "circular, back-and-forth interaction of embodied simulations between patient and therapist" (Gallese et al., 2007, p. 159).

Definitions and Terms

In-utero developmental guidance refers to the early, step-by-step guided prenatal psychoeducation of the parent of caregiver that gets woven into the psychotherapeutic work and promotes a deeper understanding of when development starts and what can be done to promote positive outcomes (Cortizo, 2019)

Birthing vs delivery

Use of womb baby's name/nickname vs she/he/it

Discomfort/waves vs contractions/pain

Foundation
Phased-Approach

Following an approach to trauma treatment that is evidence based and follows the three stages of recovery - safety and stabilization, remembrance and mourning, and reconnection.

Accommodates thoughtful theoretical consideration and a multiple modality frame in treatment.

Process is not linear, but perhaps circular, with each layer of work interwoven and supporting the next. Therapy may start with the mother and womb-baby dyad, and then shift after birthing.

Herman, 2015; Courtois & Ford, 2016

Theoretical Contributors

While pulling from a variety of trauma and dissociation specific theory, the CWFT Model integrates some specific theoretical constructs to inform it's frame:

1. Murry Bowen's **Family Systems** therapy
2. Selma Fraiberg's Mother/Infant **Psychodynamic** therapy
3. Polyvagal Theory (**nervous system impact on dyad**)
4. The phased-approach to trauma treatment (**evidenced based treatment**)

Bowen's Family Systems

Family as an interactive system that uses, in turn continually re-transmitting, multigenerational strategies for reducing tension and finding balance and stability. Strategies are positioned as roles and relational triangles and form a family's emotional system.

Emotional health of children and parents are not separated from the family, which provides a framework that places the individual within the larger system it exists. Patterns of emotional process that consciously and unconsciously shape the development of children repeat, and can either be supportive or detrimental (Haefner, 2014).

Bowen, 1974; MacKay, 2012; Haefner, 2014

Bowen's Family Systems

These patterns and process are then shared through trauma and survival-related ways of engaging within different family relationships, with the child(ren) becoming the object of projection, assuming roles and triangles to navigate relationships, in turn repeating the patten in a multi-generational manner.

These patterns highlight the ways in which a rich interplay of variables and dynamic relational processes exist to ensure survival and reduce symptoms of anxiety within relationship.

MacKay, 2012

Bowen's Family Systems

Within the CWFTM, the mother-womb-baby dyad is the larger family system we are working with.

Example.
The competing needs of womb babies and mothers/carrying people may be at odds, with Womb Babies *always* having a need for togetherness and attachment (within this approach, the mother-womb baby dyad is part of the larger social and family system), which may in turn trigger a pattern to manage the tensions that may arise in response.

MacKay, 2012

Bowen's Family Systems

Some criticisms of Bowen's approach include:

- Focus on the whole family system may effectively remove responsibility for any violence that ultimately lies with the perpetrator, or the individual (MacKay, 2012).

- Does Bowen's approach only reflect white bodied family values? And if so, how can it be re-envisioned across cultures? Adaptations!

Erdem & Safi, 2018

Fraiberg's Mother/Infant Psychodynamic Therapy

Offers a psychodynamic understanding of maternal transferential reactions to their babies as an attempt to resolve maternal trauma.

Seeks to strengthen the caregiving bond while the baby is in utero. As such, the womb baby is seen as a family participant that is already part of the larger system, both as a dyad and separately (Cortizo, 2019 & 2020).

Polyvagal Theory

Developed by Dr. Stephen Porges, and speaks to 3 hierarchical but dynamic physiological states that comprise our autonomic nervous system and provide us with neural regulation of our autonomic and emotional states (Porges, 2017). These states work together (and with other brain systems) to detect danger and then provide us with adaptive responses to all types of events and contexts, whether safe (Ventral Vagal/Parasympathetic State), dangerous (Sympathetic State), or life threatening (Dorsal Vagal State)

Polyvagal Theory

“Porges describes a branch of the autonomic nervous system seen in mammals, and in increasingly complex form in humans which is central to easeful “going-on-being.’ A sophisticated myelinated (ventral) branch of our vagus nerve (the ‘smart vagus’) connects our brain stem, heart, stomach and other viscera, as well as our facial muscles. This is active in bonding, social communication, recognizing faces and expressing emotions. It fires alongside feelings such as that warm glow in our chests with someone we love, when feeling deep gratitude or deep ease” (Music, 2019, p. 107)

Polyvagal Theory

Trauma, however, shifts the body's reactions and responses to the traumatic event, often times reorienting our neurophysiology to one of reactive defensiveness.

According to Porges (2011), after trauma, our socially engaged and connected state (ventral vagal/parasympathetic state) may be overridden by our defensive and mistrustful state and the state of immobilization from fear, thus compromising the capacity to bond or be in connection and engagement.

“No society can long sustain itself unless its members have learned the sensitivities, motivations, and skills involved in assisting and caring for other human beings"

Urie Bronfenbrenner, 2009

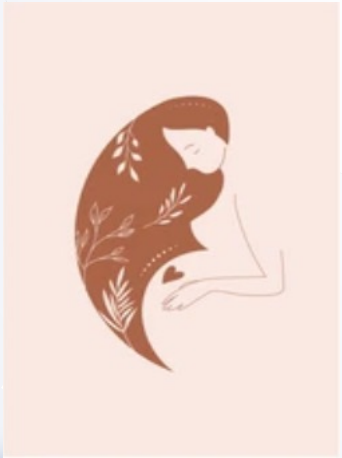
02

The Mission and Vision

The Calming Womb Family Therapy Model

The “why”

Maternal trauma transmission research
&
The role of the CWFTM



"Given the intricate physiological relationship between the pregnant woman and fetus, it would be somewhat surprising if dynamic aspects of the maternal psychological environment did not serve to shape neurodevelopment of the fetus and ultimately, the child" (DiPietro, 2021)

What does the research say?

Estimates state that depression occurs in approx. 7-15% of women during pregnancy, with occurrences in the range of 19-25% in developing countries & 7-15% in developed countries
(Daglur & Nur, 2018)

Reported distress in pregnancy has correlated with the later experience of caregiving as stressful
(DiPietro, 2021)

The nature, duration, and timing of the occurrence of stress during gestation all influence the formation of the prenate, traits, and temperament
(Thompson, 2007)

10-15%

...of mother's experience post-partum depression (Khoury et al., 2020)

25%

...of pregnant women have been found to have a high prevalence of anxiety symptoms (Daglur & Nur, 2018)

8%

...of pregnant women are affected by PTSD (Seng et al. 2013)

Maternal Transmission of trauma research

Higher Rates of PTSD in Perinatal Samples

Seng et al.'s (2010) exploratory analysis of the causal factors of higher rates of PTSD in perinatal samples found that the experience of pregnancy led to an increase in PTSD related symptomology.

Reported symptoms included: "detachment, loss of interest, anger and irritability, trouble concentrating, repeated nightmares, and trouble sleeping."

Maternal Transmission of trauma research

Maternal childhood maltreatment history

Maternal experience of childhood maltreatment correlated with 50-170% increased risk for disease susceptibility and physical health, mental health and neurodevelopmental struggles in children throughout childhood and adolescence (Moog et al., 2023)

Maternal Transmission of trauma research

Smith, Gotman, & Yonkers (2016) sought to examine whether there was a connection between ACE's and pregnancy outcomes, specifically on age and weight.

Findings detailed that ACE's may result in poor pregnancy outcomes and poor adverse birthing outcomes. They found that for each additional ACE, birth weight decreased by 16.33kg.

Maternal Transmission of trauma research

Perinatal mental health and the intergenerational patterning and effects of child maltreatment and trauma

Seng et al. (2013) reported that PTSD affects 8% of pregnant women, and includes historical experiences of childhood abuse and trauma (“12-fold risk of having PTSD in pregnancy”), exposure present day traumatic experiences, and ongoing abuse and revictimization experiences, These traumatic experiences can be pregnancy or birthing related.

Maternal Transmission of trauma research

Impact on neurobiological systems of untreated maternal prenatal stress and trauma symptoms (a developmental perspective)

Focusing on the 2nd generation effects of maternal unresolved states of mind, Thompson (2007) proposed a prenatal model that outlines prenate development and stress responses as experience dependent and contingent on maternal physiological regulation and dysregulation, and unresolved and resolved states of mind (think back to Polyvagal Theory).

Maternal Transmission of trauma research

Contingent on the mother or carrier, neonates are building the physiological foundation of their neuroendocrine, immune/inflammatory and cardio-vascular processes, all of which are needed for stable self-regulation and influence the building sense of self (Thompson, 2007).

Thompson (2007) argues that research indicates that the developing central nervous system is quite vulnerable in-utero, including stress responses regions, to even the most minor of offenses and may persist postnatally.

Maternal Transmission of trauma research

Stress states in a prenate may be recognized by elevated heart rate, greater activity level, lower habituation, and higher reflex activation (Thompson, 2007)

These stress states in the prenate may become behavioral states in a neonate that reflect general neurological and autonomic dysregulation, and if observed to be only in response to primary caregivers, may later manifest in disorganized attachment strategies (Thompson, 2007).

Maternal Transmission of trauma research

In-utero cortisol exposure
***(beyond what is normative in pregnancy)**

In making a case pre-birth parenting, Glover & Capron (2017) reference research by Hompes et al. (2012) and Bergman et al., (2010) that provides further evidence related to associations with in-utero exposure to cortisol and alterations in fetal growth and infant cognitive development via the placenta.

Maternal Transmission of trauma research

Nystrom et al.'s (2019) research examined hair cortisol concentration during the third trimester as a biological mediator between indicators of maternal adversity (childhood abuse, severe mental health struggles, and symptoms/functionality) and later maternal caregiving behaviors. Results found that elevated cortisol levels during pregnancy were associated with overall disrupted maternal behavior, communication, and interaction patterns (disengagement, hostility, and/or intrusiveness).

Maternal Transmission of trauma research

Brain plasticity during gestation

Buss et al. (2012) speak to gestation being a time when differentiation of major brain structures occur, mediated via cascades of specific interactions with the environment support development. Fetal life includes a sensitivity to environmental conditions, and due to the brain's level of plasticity during gestation, there is increased vulnerability to both environmental exposures and opportunities for subsequent interventions.

Maternal Transmission of trauma research

Khoury et al. (2020) reviewed the literature and identified that longer term risks to the neonate include: “insecure attachment strategies, disrupted stress regulation, psychopathology, and enlarged amygdala volume and altered amygdala functional connectivity.”

Nystom et al. (2019) proposed a need to reduce possible outcomes by “focusing on reducing maternal stress during the pre-and early post natal period for mothers.”

The CWFTM

01

Provides an integrative model to reduce prenatal stress and engage collateral systems

02

Builds parenting capacities and dyadically engages the womb baby

03

Is built on 5 core pillars of practice that support the therapeutic process

04

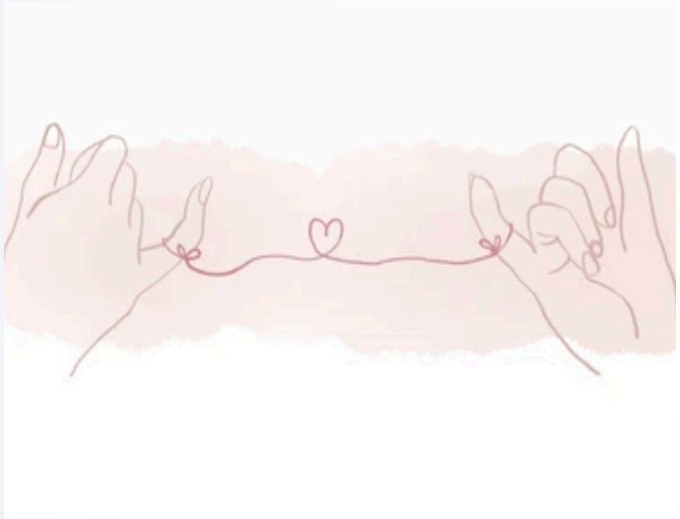
Works with the past and present to promote different future outcomes

What the CWFTM adds

Psychotherapy from conception throughout the first year after birth

A model of comprehensive therapy that focuses on early assessment and treatment as both an **intervention** and **prevention**, which is done by increasing the mother/carrying persons insight, reflectiveness, wellness, and capacity for collaboration and mutuality.

An **integrative** early intervention model of **comprehensive** treatment that is rooted in **collaboration** and **teamwork** by encompassing the individual, the family, dyads within the family, and collateral systems



Prevention through bonding

Building attachment by supporting in utero bonding and preventing bonding disorders.

Daglur & Nur, 2018; Klabbers et al., 2016; Salmela-Aro et al., 2011

Prevention through prenatal bonding

- Support neural growth & development
- Build new internal working models of self, others, and relationships
- Build the foundation for affect regulation through co-regulation
- Build capacity for post-natal bonding and attachment strengthening (Rossen et al., 2106)
- Support adjustment between pre and postnatal periods (Mazzeschi et al., 2015)
- Protective against risky coping strategies, such as substance use (Sanjuan et al., 2019)

Okawara & Paulsen, 2018; Glover & Capron, 2017

Applying the CWFTM starts with an assessment of maternal trauma, symptoms, and dissociative processes to inform theoretical understanding and identify appropriate adjunctive mother/carrying person-womb baby dyadic bonding approaches, repair broken bonds, and increase internal resources to disrupt the transmission of intergenerational trauma patterns processes.

03

Assessment

The importance of assessment as guide

Assessment

Why

To guide case conceptualization, choice of theory and modality, pacing, and treatment planning

When

Ideally within phase 1 of treatment and titrated to a tolerable pace

How

Clinical interviewing, Screening, Assessment according to treatment guidelines and evidence based practices

Areas of Assessment

Trauma

Screening and Assessment

Attachment

History and Experiences

Dissociation

Screening and Assessment

Areas of Assessment

Pre and Peri Natal Complications

Clinical Interviewing

Symptoms, triggers, and barriers

Clinical Interviewing

Dyadic Needs, practices, and resources

Clinical Interviewing

Warren, 2022

Assessment within CWFTM

Assessment is embedded within a larger comprehensive bio-psycho-social intake and clinical interview that seeks to understand someone's current symptoms and distress levels, as well as history of trauma, attachment, dissociation, past experiences with therapy, attachment, and pre and perinatal complications.

Formal and informal tools may be used to support building the entire clinical picture (are we working within prevention, intervention or both), which in turn informs the theory and treatment modality that the CWFTM is then integrated into.

Screening & Assessment

...beyond clinical interviewing

Trauma

ACES (Felliti et al., 1998),
PTSD checklist for DSM-5 (PCL-5),
EPDS (Cox et al., 1987)
PASS
(Somerville et al., 2014)

Attachment

AAI (George, Kaplan, & Main, 1984),
DMM-AAI (Crittenden & Landini, 2011),
PBI (Parker, Tupling, Brown, 1979)

Dissociation

Screening: DES-II (Putnam & Bernstein, 1986, DES-B (Dalenberg & Carlson), MID-60 (Kate, 2020)
Assessment: MID (Dell, 2006), SCID-D-R (Steinberg 1994, 2022), DDIS (Ross, 1982)

Clinical Interviewing

Pre and Peri Natal Complications

Clinical Interviewing

Symptoms, triggers, and barriers

Clinical Interviewing

Dyadic Needs, practices, and resources

Clinical Interviewing

04

5 Pillars of the CWFTM

5 Pillars

1. Creating the team

Creating the pre and perinatal trauma informed medical team and space, which includes Psychiatry and all helping professionals.

2. In-utero developmental guidance

Relevant Psychoeducation

3. Dyadic work

Bowenian Family Therapy concepts applied to mother/carrying and womb baby dyad; multigenerational family therapy

4. Symptom control and care

Preparation, needs meeting, regulation, mother/carrying and womb baby bonding and wellness

5. Trauma reprocessing

Integration of phase 2 and 3 work via prenatal EMDR therapy, or other modalities

Pillar 1 –
Creating the Team

In creating a trauma-informed prenatal systems approach to healing, all other treating and medical professionals that the pregnant person may encounter are included as team members:

- OB's and/or any specialists part of the medical team
- Midwives, Doulas, medical assistants and coordinators
- Pre and perinatal Psychotherapists
- Psychiatrist and support staff
- Wellness professionals and supports
- Nutritionists and Lactation Specialists
- Health Educators
- Office Administrative Professionals

Pillar 2 –
In-utero developmental guidance

Early prenatal education that is relevant to the parent is woven into the model as a means of: enhancing and promoting an understanding of fetal development, the importance of the mother/carrying person-womb baby bond, and possible challenges as a result of past unprocessed trauma. It is informed by assessment related information and may include, but is not limited to:

- Most up-to-date information related to bonding, working through relational challenges, doubts and concerns, and identifying the ways in which the past shows up in the present
- Womb baby needs
- Mother/Carrying person needs
- Bonding needs

Pillar 3 –
Family Therapy/Dyadic Work

Informed by assessment related information and also initially explored within developmental guidance, multigenerational attachment patterns are identified and addressed through a Bowenian frame. The mother and womb baby are conceptualized as the family unit/dyad, who are the focus across treatment. This may include:

- Bonding practices
- Addressing unmet developmental needs
- Preparatory interventions that include role playing limit and boundary setting, attunement, and building self-mastery and competence.

According to Weinstein (2016), “supporting titrated interventions that increase maternal and womb baby’s felt sense of safety and regulated internal environments is especially beneficial for women with pre-existing histories of trauma, unresolved grief, and traumatic stress symptoms” (p. 106).

Pillar 4 –
Mother + Womb baby Wellness

Symptom control & preparation

Building wellness within the dyad during the pre and perinatal periods, with a focus on affect regulation, containment, state change capacities, emotional modulation, and mastery,

- The pace and focus is determined through assessment related information and conceptualization
- Focused on the mother/carrier-womb baby dyad
- Seeks to repattern defensive autonomic processes

Pillar 5 –
Trauma reprocessing

According to Ogden, Minton, & Pain (2006), “historical untreated trauma can have a deleterious effect on prenatal and parenting experiences,” and may be triggered during the prenatal period, in turn reactivating a pattern of autonomic dysregulation to manage symptoms of re-experiencing, or in the post natal periods via an inherent relational experience that awakens trauma-related attachment patterns and strategies.

Concerns & Myths – Therapy during pregnancy

- The womb baby will be harmed by an influx of cortisol during reprocessing.
- Medical professionals are the ultimate deciders
- "Its mostly safe" - Poor methodological quality of studies to provide certainty around adverse effects of memory work on the womb baby.
- Birthing trauma is uncommon.
- Mother's/carrying persons do not need follow up a year after delivery.

Research on use of EMDR therapy with expectant mothers

- EMDR therapy with expectant mothers with Acute Stress Disorder or PTSD Baas, Stramsrood, Dijks- man, 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);
- Intergenerational transmission of trauma (Okawara & Paulsen, 2018).

Phased-Approach

Herman 2015; Courtois & Ford, 2016

Phase 1

Safety & Stabilization

- Assessment & Conceptualization; Building the team; In-utero developmental guidance; Symptom control and care; Dyadic work

Phase 2

Remembrance and Mourning

- Trauma reprocessing; Dyadic repair

Phase 3

Reconnection

- Revised IWM's; Returning to phase 1 and 2 within post natal work as the baby takes on a new role.

EMDR therapy

- AIP Model
- 8-phases

CWFTM + EMDR therapy

- Adaptations and modifications are necessary (like with any population) that are attuned and tailored to the unique person and clinical presentation.
- Treatment plan is created around the mother/carrying person's present day symptoms and may focus on past adverse experiences, present experiences or occurrences, or a future or anticipatory anxiety.
- Emphasis on gestational somatic attunement
- Some common plateaus, considerations in the use of BL-DAS (bi-lateral dual attention stimulus), increased use of containment and somatic regulation

Future Directions

Research

High quality methodological studies

Follow-up trainings

Practical trainings, panel focused on across the life span.

Explore integration into other modalities

Practical integration of other concurrent somatic, hypnotic, and narrative based interventions

05

Transforming Theory into Practice

Case example

Clinical Case Example

06

Closure

Practice and Resources

Closing Practice

Resources

Resource Card

- Five pillars and references

Pre-natal Bonding Cards

- Focus on bonding through self-care, womb-baby care, and dyadic care

Storybooks:

- Developing and cultivating prenatal bonding, relational adjustment, reflective capacities, preconception awareness, sense of self, and facing and embracing grief and confusion through mindful and educational storytelling, playful activities, compassionate repetitions, and mindful dyadic conversations.

Thank You!

Q & A

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