Hidden Trauma, Dissociation and Prenatal Assessment within the Calming Womb Model

Rosita Cortizo

Abstract: Hidden, unresolved traumatic stress caused by childhood adverse experiences often impacts women before their childrearing years with implications for their prenatal bonding, obstetric experience, and their ability to parent children. The purpose of this article is to inform about trauma conditions and dissociative processes that are often present, yet buried in pregnant women's consciousness due to defensive adaptation, and to provide information about the different types of screening tools designed to identify unsettled trauma in the mother. The Calming Womb Family Therapy Model (CWFTM) integrates questionnaire findings, trauma-informed interventions, and collaborative care to treat and prevent intergenerational trauma, and nurture relational attunement with parents and babies from conception through the first year after birthing.

Keywords: prenatal care, assessment, trauma interventions, CWFTM

> *"A pregnant woman is like a beautiful flowering tree, but take care when it comes time for the harvest that you do not shake or bruise the tree, for in doing so, you may harm both the tree and its fruit."* (Peter Jackson, R.N., September, 2002, Australia, in Mongan, 2015)

Trauma is more often understood by the context of the event and the remembered consequences than by the characteristics of the person experiencing the trauma (Schuder & Lyons-Ruth, 2004). Even though traumatic experiences are often recalled, some may not be readily available due to avoidance of pain (Freyd, 1996) and other protective processes. A dissociative process is a mechanism our minds use naturally,

Rosita Cortizo, PsyD., LMFT, MA currently works as a high risk, multicultural, bilingual pre-and perinatal Clinical Psychologist for behavioral health services working with female adults and children. Dr. Cortizo has worked in Public Health in Southern California with at risk pregnant women with multiple diagnoses, traumatic stress, and relational crisis for more than 29 years. She holds licenses as both a Clinical Psychologist (2001) and Marriage and Family Therapist (1998), and earned a Masters of Arts in Psychology with specialty in Chemical Dependency (1993) in San Diego, California. She is EMDRIA Certified, and an Approved EMDR Consultant. Her websites are www.thecalmingwomb.com and www.rositacortizo.com.

© 2020 Association for Pre- and Perinatal Psychology and Health

and this becomes activated when associations become affectively threatening to the person (Chefetz, 2015). During prenatal psychotherapy, the focus is frequently on the health of the mother-baby dyad, the mother's identified presenting problem, and ongoing obstetric preoccupations. Seldom are pregnant women given screening questionnaires prior to or during their psychotherapy or obstetric intakes, even though the obtained scores provide ample treatment baselines. While such practices frequently provide a wealth of information about existing symptoms, at other times they highlight incongruences, missing biographical narratives, and even psychogenic amnesia (van der Hart & Nijenhuis, 1995; van der Kolk, 2014). Poor childhood recall can be attributed to limited childhood chronicles and narratives by caregivers or long-term memory decay, which can point in the direction of memory interference, fragmentation, and evasion. Memory, forgetfulness, or avoidance can occur due to pain, emotional reactivity, unacceptable wishes, and attachment threat (Freyd, 1996). Acute prenatal hormonal shifts, chronic affect phobia, inability to self-regulate adequately, developmental shame, and scarce familial-social supports can also affect the expectant mothers' narratives (Verny, 2019).

During the past 30 years of prenatal psychotherapy practice, it has been observed with notorious frequency that many nulliparous women who denied traumatic childhood experiences during their first gestation are able to recall new and more painful information years later during a second or third pregnancy. Frequently, childrearing mothers request psychotherapy once their infants are older and they have more time for themselves, or when they are triggered by painful memories of abuse that occurred at a current age of one of their children. Neglect, and sexual, emotional, or physical abuse memories can be painful, and reportedly overwhelm mothers who concurrently need to care for their children. Understanding hidden trauma and establishing universal requirements for assessing the effects of prenatal pre- and post-treatment effects is vital.

For the purposes of The Calming Womb Family Therapy Model (CWFTM) and this article:

- "Womb baby" is the recognition of the infant from conception and the evolving emotional attunement of the mother to her baby in the womb (Cortizo, 2019; Cortizo, 2020).
- "Bonding" is defined as the attunement of the mother to her womb baby, while "attachment" refers to the relationship the baby forms with the mother as well as with the father after birthing (Klaus et al., 1996).
- "EMDR therapy" is a comprehensive form of psychotherapy for trauma-related psychological conditions. Clinicians guide their clients to focus on a disturbing past or feared incident while performing rapid eye movements (EM). These EM are directed by

visually following the therapist's moving fingers. This is known as bilateral stimulation (BLS). EMDR therapy uses a three-pronged protocol: past, present, and future. This protocol involves eight phases: client history, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation (Shapiro, 2018).

Child Abuse Prevalence and Pregnancy

The significance and consequences of childhood mistreatment, neglect prevalence, and its impact on prenatal wellness has been extensively addressed. Putnam & Trickett, initiated in 1987 the first female sexual abuse longitudinal research study at the National Institute of Mental Health (NIMH). The follow-up study they conducted uncovered the profound psychological devastation of child abuse in the life span. They reported that sexually abused girls have significant difficulty in trusting, making friends, and liking themselves, resulting in emotional reactivity, numbness, and a complicated psychobiosocial developmental trajectory. Sexual abuse increases sexual hormonal secretion, and evidence revealed that these girls had three to five times the testosterone and androstenedione, as their control group counterparts. This study continues to inform us with their follow up publications (Putnam & Trickett, 1997).

In 2009, a meta-analysis was conducted that analyzed 65 studies in 22 countries; the international findings estimated that 7.9% of males and 19.7% of females universally were sexually abused before the age of 18 years. Studies from 21 high- and middle-income countries revealed that 7% to 36% of females testified being victims of sexual rape during their childhood. Female reports from seven countries indicated prevalence rates as being more than 1/5 including 25.3% in the US (Wihbey, 2011).

In another meta-analysis on the prevalence of child sexual, physical, and emotional abuse and physical and emotional neglect, including 244 periodicals and 551 prevalence rates for the various types of cruelty, it was established that child maltreatment is a pervasive, international occurrence affecting masses of children around the globe. The results show a lower limit estimate of self-reported child sexual abuse (CSA) prevalence in girls of 164/1000 and an upper limit estimate of 197/1000. Even the lower estimates are alarming in their demonstration that CSA is a global phenomenon affecting the lives of millions of children. (Singh et al., 2014; Stoltenborgh et al., 2014).

According to Seng et al., (2009) child abuse history seems to be the largest risk factor for posttraumatic stress disorder (PTSD) criteria in pregnancy. In another analysis, Seng et al. (2010) confirmed that PTSD symptom rates are higher in prenatal samples than in the general female population (6–8% versus 4–5%), perhaps due to exacerbations of pre-existing PTSD, which is often chronic or recurring. This finding has been

linked with physical illness across a lifetime. The researchers estimated that the overall rate of lifetime PTSD was 20.2%; 17% in the predominantly private-payer settings, and 23% in the predominantly public-payer settings (Seng et al., 2009). Links between gestational PTSD and both lower birth weight and shorter pregnancy were stronger for women whose PTSD was subsequent to abuse (Seng et al., 2011). PTSD in pregnancy, or coexisting with depression, is associated with postpartum dysphoria, while postpartum depression alone, or simultaneous with posttraumatic stress, was linked with impaired bonding (Seng et al., 2011). Experienced dissociation during labor predicted worsened outcomes. Pregnancy is a crossing opportunity between generations, and because PTSD has been associated with intergenerational transmission of traumatic stress, it seems essential to address symptoms prior to birthing or during the childbearing years (Seng et al., 2013; Weinstein, 2016).

To make good use of the above prenatal research information, the provider needs to have a clinical grasp of the subjective experience involved in developmental trauma, and treat all presentations within the trauma-dissociation continuum with empathic curiosity (Chefetz, 2015). The existence and authenticity of developmental trauma memories as well as their avoidance has been at the core of complex professional deliberations and disputes. The definition and context of memory lapses, amnesia, or suppression has been so historically controversial that it is easy to conceptualize the delay in our understanding of hidden memories and dissociative processes (Freyd, 1996; Dumont et al., 2014; Collin-Vézina et al., 2015). Van der Kolk (2014) refers to working with the psychological complexities of developmental traumatic memories as uncovering someone's mind's secrets, and remembering them, although under unbearable sensorimotor immensity and weight.

Hidden Trauma and Dissociative Phenomena

Trauma experienced before verbal expression is developed could lead to a distinctive experience in which there can be both experienced or suppressed emotional and/or body-based recollection, but no pictorial memory. This is an important and often overlooked hidden trauma that can be exacerbated during prenatal and post-birthing experiences. Research from Van der Kolk & Fisler (1995) demonstrated that regardless of the subjects' age at which the trauma was experienced, trauma was recalled in the body in the form of sensorimotor and affective flashbacks.

A survivor who forgets childhood abuse may have memory that manifests in some other ways, such as phobias, learned behaviors, and shameful self-perceptions of "not good enough" or "being insignificant." Being betrayed or violated by a person who is important or in a position of authority disrupts basic trust. The closer the child is to the abuser, the more profound the betrayal, and often the less likely the chances of escape

(Freyd, 1996). Memory avoidance, traumatic amnesia, and dissociation are ways of forgetting that which one cannot bear. Disbelief, self-doubt, denial, memory confusion, and recall disorganization are some of the frequent dissociation culprits, but betrayal is the main source. The amnesia rate for sexual abuse incest survivors is higher than for other sexual abuses. Throughout the past 30 years, forgetting childhood sexual abuse and dissociating painful material prevalence has been well documented (Herman & Schatzow, 1987; William, 1995; Freyd, 1996; Easton, 2013; Alaggia et al., 2017). Dissociated phenomena and related experiences are subtle and often overlooked by most outsiders, unless specifically interested and inquisitive (Chefetz, 2015). Trauma is emotionally devastating, implausible, and intolerable, with dissociative phenomena likely occurring as a protective mind-body savior. Pregnant women who present with developmental, relational trauma may require that we hold the incongruence of an unbearable past in the present, along with a reasonably stable and consistent present (Van der Kolk, 2014)

It is at this pivotal stage, after identifying trauma or other pre-existing psychological conditions, that pregnant mothers are referred by their treating medical teams to trauma-informed psychotherapists for further assessment, screening, and prenatal trauma treatment. During this psychotherapeutic juncture, it is essential that the prenatal psychotherapist initiates the trauma assessment at the first visit; these initial verbal and written screening evaluations usually precede the psychosocial history intake and the presenting problem identification. Comprehensive and ongoing evaluation is needed to identify and assess mothers' preexisting psychosocial conflicts, unresolved losses and trauma, current stressors, and reactions specific to pregnancy and birth, both before the baby's birthing and through the first year of life. In the following section the underrepresented benefits of assessing a prenatal mother are discussed.

Significance of Prenatal Assessment

Once a referral has occurred or the mother has initiated therapy motivated by her own curiosity, the prenatal psychotherapist must conduct an extensive assessment of current relational and past developmental trauma, in order to increase the wellness and bonding of the pregnant mother and womb baby.

Evaluation screening scores may be unanticipated, inconsistent, or confirming. Evaluations with high screening scores may be indicative of needed areas of treatment, and significantly low scores, accompanied by psychological or physical morbidity, could signal denial, minimization, normalization of crisis, avoidance, forgetfulness, dissociated symptoms, dissociative disorder unspecified, or in extreme cases, dissociative identity disorder.

Since prenatal pre-existing trauma could be activated during gestation, this period offers enormous opportunity for intervention and hope for parents, particularly if either or both are survivors of CSA. Trauma-enduring pregnant women may lack prenatal medical and emotional social supports as they start to fulfill their mothering role in the potentially stressful prenatal phase. The goal of targeted trauma-informed support services and programs is to decrease the pregnant woman's traumatic stress morbidity, improve her experience of prenatal care, and positively impact the outcomes for her and her infant.

The Calming Womb Family Therapy Model

The primary goal of the Calming Womb Family Therapy Model (CWFTM) is to swiftly assess, treat, and prevent traumatic transference, enactments, and intergenerational traumatic bonding (Bowen, 1966, 1976), and to enhance the pregnant mother's internal resources (Fraiberg, 1980). The concurrently titrated and contained practice of the CWFTM and EMDR therapy promotes mothers' and womb babies' wellness and connectedness. Much attention needs to be paid to dissociated trauma responses, specifically since confusion and avoidance of hurt and humiliation can be a prenatal bonding barrier. The model provides the pregnant mother with intrapersonal and interpersonal psychoeducation, experiential insights, behavioral and emotional programing modification, and practical tools for symptom reduction and self-regulation throughout their prenatal care and a year postnatally (Nathanielsz, 1999; Lipton, 2005; Kaplan et al., 2008).

EMDR therapy reduces symptoms and processes past traumatic and dissociated memories. These memories are the result of disturbing recent or earlier life experiences that cause ongoing distress, and interfere with both maternal bonding and the possibility of post-birth secure attachment. While the selected trauma treatment for the CWMTM is Eye Movement Desensitization and Reprocessing (EMDR) therapy, other practices such as hypnosis, art work, and body-oriented therapies can be easily integrated.

EMDR phase 1, includes psychoeducation, psychosocial evaluation, screening tools, questionnaires, and prenatal treatment planning. Phase 2 involves internal and external resourcing, symptom reduction and stabilization, and processing preparation. Phases 3 through 8 are the same as the EMDR standard protocol with a focus on gestational bodily attunement, and prenatal self-regulation (Cortizo, 2020).

Prenatal Assessment within the CWFTM: Phase 1

A description of five recommended prenatal screening questionnaires follow below. These evaluation measures were developed to be

administered at the initial clinical consultation visit, to establish a baseline prior to EMDR phases 3 through 6 (trauma processing), and to monitor treatment progress. To measure treatment effects, post-testing can be administered six months after psychotherapy was initiated or upon completion. The questionnaires are evaluative in nature, and not diagnostic, but may contribute to prenatal clinical decision making.

Screening Questionnaires for Prenatal Care

Adverse Childhood Events. The Adverse Childhood Events (ACEs) questionnaire (Felliti et al., 1998) offers useful baseline information about the mother. As in the case of CSA disclosures, the initially reported ACE answers may change and expand in the context of therapeutic interpersonal safety, increased education, awareness, treatment length, and the evolving quality of the relationship. Dr. Felitti demonstrated that ACEs are highly predictive of adult physical and mental health problems.

The 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 Dr. Felitti in 2017 (personal communication), he agreed with this article's author and her conclusions that ACE screening need to be initiated before conception and certainly during prenatal care. This questionnaire can be easily downloaded; it has been translated into multiple languages and use is free to the public.

Dissociative Experiences Scale II. The Dissociative Experiences Scale II (DESII) has been used to measure the frequency of dissociative experiences, from simple absorption to more extreme dissociative phenomena, such as loss of time, and psychogenic amnesia. This 28-item individual difference scale has been shown to be both valid and reliable in research designed to test its psychometric properties, and is useful to administer. The DES II was developed by Bernstein and Putnam (1986). This revised scale uses a sequence of numbers ranging from zero to 100. Arranged as a continuum in increments of 10, the revised scale allows for a quicker and more efficient scoring procedure. Initial research has shown that the scores of the DES II are similar to those obtained on the original scale.

When the DES II is given to a pregnant mother 20-30 minutes prior to her second or third psychotherapy visit, the highly-scored items can provide a wealth of information for future interventions. The same could be said for noticeably-low scores in the presence of acute or chronic symptoms (i.e., anxiety, flashbacks, dysphoria, time absorption, psychogenic amnesia, derealization, and depersonalization). Due to its multiple treatment benefits, it is recommended that this questionnaire is offered at the beginning of psychotherapy, and certainly prior to EMDR therapy. The DES II may enhance clinical information, but it is not a

diagnostic instrument. The authors have given permission for the DES II to be used, distributed, or reproduced for research or clinical purposes.

Patient Health Questionnaire-9. The Patient Health Questionnaire-9 (PHQ-9: Kroenke et al., 2001) is a nine-item primary care standard instrument for detecting depressive disorders with good sensitivity and specificity. The PHQ-9 is a brief, well-validated measure for diagnosing and monitoring depression, and sensitivity to change is well established. Both the questionnaire's efficacy to measure treatment effects and its brevity make the PHQ-9 an attractive tool for evaluating response to prenatal therapy in both private and public care, as well as in prenatal clinical research settings (Lowe et al., 2004).

Edinburgh Postnatal Depression Scale. The Edinburgh Postnatal Depression Scale (EPDS: Cox et al., 1987) is a 10-item scale. The PHQ-9 and EPDS are both proven to be reliable and valid scales for prenatal depression assessment; the PHQ-9 detects somatic symptoms, while the EPDS captures depressive symptoms concurrent with anxiety during early gestation. Hence, using both scales simultaneously may increase the timely identification of prenatal depressive disorders in public and private clinical settings. Conversely, if rapid screening for dysphoria is required in busy prenatal clinical settings or due to upcoming birthing, the PHQ-9, can be completed and scored in only a few minutes (Kroenke et al., 2001). If there is a need to identify and treat depressed women with coexisting anxiety, which is a feature of prenatal depression, it is recommended to use the EPDS with added calculation of the scores of the depression subscale and anxiety subscale (Zhong et al., 2014).

DES II Brief Option: Brief Dissociative Experiences Scale Modified. The Brief Dissociative Experiences Scale (DES-B) Modified (Dalenberg & Carlson, 2010), is a modified DES II version. The DES-B is an 8-item measure that assesses the severity of dissociative experiences in individuals 18 and older. This shorter screening questionnaire can be readily used with a pregnant mother, especially if time is of the essence, or if she is entering treatment when approaching birthing. This shorter questionnaire must also be offered at the beginning of psychotherapy to measure treatment progress, and prior to EMDR therapy. This tool is in the public domain and freely available for use without permission, but credit should be given (Dalenberg & Carlson, 2010).

For the purposes of this article, only one of the five pillars of the CWFTM is being discussed. For additional information on the model, refer to previous publications (Cortizo, 2019; Cortizo, 2020).

Recommendations

The article discussion and findings significantly underscore the importance of:

1. Early child abuse interventions and dissociative processes screenings starting in infancy;
2. Prenatal interventions and treatment before conception.
3. Prenatal screening, psychosocial assessment, and treatment of pre-existing PTSD, anxiety, depression, and other disorders;
4. Establishing universal requirements for assessing antepartum pre-treatment baselines and post-treatment outcomes;
5. Evaluating both resiliency and maladaptive intergenerational patterns at the beginning of psychotherapy;
6. Further research studying the impact of dissociation on prenatal care.
7. Prenatal secondary and tertiary treatment for the parents, and primary prevention for the womb baby;
8. Concurrent practice of the CWFTM, EMDR therapy, and other somatic, hypnotic, narrative interventions to support pregnant women and their womb babies' attunement and bonding;
9. EMDR therapy is indicated, without changes to the standard protocol, but with a few important pre- and perinatal additions and adaptations, such as extended symptom stabilization, internal resourcing, and grounding preparation before trauma processing;
10. Titrating trauma reprocessing to prevent potentially destabilizing pregnant mothers is recommended;
11. Once the obstetric provider has given treatment authorization, and the expectant mother has been evaluated and informed about benefits, contraindications, and possible risks and has given her informed consent, the mother should be able to initiate paced pre- and perinatal EMDR therapy;
12. A revision of the ISSTD trauma and dissociation treatment guidelines (2011) is recommended prior to trauma treatment; and
13. Prenatal interventions and research should be developed, tested, and measured for effects.

References

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2017). Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). *Sage Journals, 20*(2), 260—283. https://doi.org/10.1177/1524838017697312

Bernstein, E.M., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. *The Journal of Nervous and Mental Disease, 174*(12), 727–735. https://doi.org/10.1097/00005053-198612000-00004

Bowen, M. (1966). *Family therapy in clinical practice.* Jason Aronson.

Bowen, M. (1976). *Family therapy: Theory and practice therapy.* Gardner Press.

Chefetz, R. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real.* W.W. Norton & Company, Inc.

Collin-Vézina, D., Sablonni, D.L., Palmer, A.M., & Milne, L. (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse & Neglect, 43*, 123–134. https://doi:10.1016/j.chiabu.2015.03.010

Cortizo, R. (2019). The calming womb family therapy model: Bonding mother and baby from pregnancy forward. *Journal of Prenatal and Perinatal Psychology and Health, 33*(3), 207—220.

Cortizo, R. (2020). Prenatal and perinatal EMDR therapy: Early family intervention. *Journal of EMDR Practice and Research, 14*(2), 104—115. https://doi.org/10.1891/EMDR-D-19-00046

Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150,* 782–786. https://doi.org/10.1192/bjp.150.6.782

Dalenberg, C., & Carlson, E. (2010). *Brief Dissociative Experiences Scale (DES-B).* Modified for the DSM-V by C. Dalenberg and E. Carlson.

Dumont, M., Messerschmitt, P., Vila, G., Bohu, D., & Rey-Salmon, C. (2014). Le processus de révélation dans les agressions sexuelles intrafamiliales et extrafamiliales sur mineurs [The disclosure process in intra-family and extra-family sexual assault in minors]. *Annales Médico-Psychologiques* [*Medico-Psychological Annals*], *172,* 426–431. https://doi.org/10.1016/j.amp.2012.06.024

Easton, S.D. (2013). Disclosure of child sexual abuse among adult male survivors. *Clinical Social Work Journal, 41*, 344–355. https://doi.org/10.1007/s10615-012-0420-3

Felliti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245—258.

Fraiberg, S. (1980). *Clinical studies in infant mental health: The first year of life.* Basic Books, Inc.

Freyd, J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Harvard University Press.

Herman, J., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. *Psychoanalytical Psychology, 4*(1), 1—14.

International Society for the Study of Trauma and Dissociation (ISSTD). (2011). Guidelines for treating dissociative identity disorder in adults. *Journal of Trauma & Dissociation, 12*, 115–187. https://doi.org/10.1080/15299732.2011.537247

Kaplan, L.A., Evans, L., & Monk, C. (2008). Effects of mothers' prenatal psychiatric status and postnatal caregiving on infant biobehavioral regulation: Can prenatal programming be modified? *Early Human Development, 84*(8), 249—256. https://doi.org/10.1016/j.earlhumdev.2007.06.004

Klaus, H., Kennell, J., & Klaus, P. (1996). *Bonding: Building the foundations of secure attachment and independence.* Addison-Wesley.

Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606—613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lipton, B. (2005). *The biology of belief: Unleashing the power of consciousness.* Mountain of Love Elite Books.

Lowe, B., Unutzer, J., Callahan, C., Perkins, A., Kroenke, K. (2004). Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. *Medical Care, 42*(12), 1194—1201. https://doi.org/10.2307/4640875

Mongan, M.F. (2015). *Hypnobirthing: The Mongan Method: The natural approach to safer, easier, more comfortable birthing, 4th edition.* Health Communications, Inc.

Nathanielsz, P.W. (1999). *Life in the womb: The origin of health and disease.* Promethean Press.

Putnam, F., & Trickett, P. (1997). The psychobiological effects of sexual abuse. A longitudinal study. In R. Yehuda & A.C. McFarlane (Eds.), *Annals of the New York Academy of Sciences: Vol. 821. Psychobiology of posttraumatic stress disorder* (pp. 150–159). New York Academy of Sciences.

Putnam F., & Trickett, P. (1987). *The psychobiological effects of child sexual abuse.* W.T. Grant Foundation.

Seng, J., Low, L., Sperlich, M., Ronis, D., & Liberzon, I. (2009). Prevalence, trauma history and risk of posttraumatic stress disorder among nulliparous women in maternity care. *Obstetrics and Gynecology, 114*(4), 839—847. https://doi.org/10.1097/AOG.0b013e3181b8f8a2

Seng, J., Low, L., Sperlich, M., Ronis, D., & Liberzon, I. (2011). Posttraumatic stress disorder, child abuse history, birth weight, and gestational age: A prospective cohort study. *An International Journal of Obstetrics and Gynaecology,* 1329—1339. https://doi.org/10.1111j.1471-0528.2011.03071.x

Seng, J., Rauch, S.A.M., Resnick, H., Reed, C.D., King, A., Low, L.K., McPherson, M., Muzik, M., Abelson, J., & Liberzon, I. (2010). Exploring posttraumatic stress disorder symptom profile among

pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology, 31*(3), 176—187. https://doi.org/10.3109/0167482X.2010.486453

Seng, J., Sperlich, M., Low, L., Ronis, D., Muzik, M., & Liberzon, I. (2013). Childhood abuse history, posttraumatic stress disorder, postpartum mental health and bonding: A prospective cohort study. *Journal of Midwifery and Women's Health, 58*(1), 57—68. https://doi.org/101111/j.1542-2011.2012.00237.x

Singh, M.M., Parsekar, S.S., & Nair, S.N. (2014). An epidemiological overview of child sexual abuse. *Journal of Family Medicine and Primary Care*, *3*(4), 430—435. https://doi.org/10.4103/2249-4863.148139

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures.* Guilford Press.

Schuder, M.R., & Lyons-Ruth, K. (2004). "Hidden trauma" in infancy: Attachment, fearful arousal, and early dysfunction of the stress response system. In J.D. Osofsky (Ed.), *Young children and trauma: Intervention and treatment* (pp. 69—104). Guilford Press.

Stoltenborgh, M., Bakermans-Kranenburg, M., Alink, L., & van IJzendoorn, M. (2014). The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Review, 24*(1), 37—50. https://doi.org/10.1002car.2353

Van der Hart, O., & Nijenhuis, E. (1995). Amnesia for traumatic experiences. *Hypnosis*, *4,* 417– 455.

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin Random House Company.

Van der Kolk, B., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Review and experimental confirmation. *Journal of Traumatic Stress, 8*(4), 505—525.

Verny, T. (2018). *Prenatal psychology 100 years: A journey in decoding how our prenatal experience shapes who we become.* Cosmoanelixis.

Weinstein, A.D. (2016). *Prenatal development and parents' lived experiences: How early events shape our psychophysiology and relationships.* W.W. Norton & Company, Inc.

Wihbey J. (November 15, 2011). Global prevalence of child sexual abuse. *Journalist Resource*. www.Journalistsresource.org/studies/ ./ global-prevalence-child-sexual-abuse.

William, L. (1995). Recovered memories of abuse in women with documented child sexual victimization histories. *Journal of Traumatic Stress, 8,* 649—674.

Zhong, Q., Gelaye, B., Rondon, M., Sanchez, S., Garcia, P., Sanchez, E., Barrios, Y., Simon, G., Henderson, D., Cripe, S., & William, M. (2014). Comparative performance of patient health questionnaire-9 and Edinburg Postnatal Depression Scale for screening antepartum depression. *Journal of Affective Disorders, 162*, 1—7. https://doi.org/10.1016/j.jad.2014.03.028