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The Calming Womb Family Therapy Model: Bonding Mother and Baby from Pregnancy Forward

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The Calming Womb Family Therapy Model (CWFTM) is an integrative, multi-modal early intervention approach designed to treat mothers and their babies from conception through the first year postnatally. Rooted in Murray Bowen's family systems theory, CWFTM considers families as interactive systems rather than individuals. Building upon Fraiberg's approach, CWFTM extends its focus back to conception, aiming to strengthen the bond between mother and baby in utero and treating the baby in the womb and the infant as active participants in the family therapy process. Additionally, CWFTM integrates Eye Movement Desensitization and Reprocessing (EMDR) from early pregnancy through the first year of life to process maternal trauma and transference reactions to the baby. Understanding that the mother-baby dyad is part of a larger social system, CWFTM involves other caregivers in the therapy process, addresses prenatal and perinatal needs, unforeseen challenges, and traumatic incidents during and after pregnancy, and coordinates care with medical providers. A key requirement for a CWFTM psychotherapist is a thorough understanding of prenatal and infant

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development and a high capacity for relational attunement with both parents and babies.

Keywords: Calming Womb Family Therapy Model, EMDR, conception, pregnancy

The importance and benefits of providing a calm environment for the mother and her baby are numerous. Healthy mother and womb-baby bonding is necessary for the physical and emotional growth of the baby. There continues to be controversy over whether the womb-baby interacts consciously with the mother or whether these interactions are of non-conscious origins (Sivaraman et al., 2018). The model presented below honors and highlights the importance of interacting and caring for the baby beginning from conception. Mothers and fathers, partners, and single mothers can provide their babies with the greatest opportunities for success and empowerment by taking care of them in the womb.

Healing oneself is the most effective way for expectant mothers to care for their babies in utero. Strengthening or developing self-compassion, empathy, dignity, and curiosity serves mothers and their loved ones well. Therefore, the focus of prenatal and perinatal healing begins by assessing the mother's thoughts and feelings about herself, her pregnancy, and whether she feels supported by her partner. As the Dalai Lama stated during the 2017 Graduation Commencement at UCSD in San Diego, California, "The Way to World Peace is Inner Peace."

How a mother feels about herself and her pregnancy invariably impacts the bonding with her baby during pregnancy and affects the baby's attachment after delivery. This paper will use "bonding" to refer to the relationship between mother and womb baby and "attachment" to refer to the reciprocal interaction between mother and infant after birth.

The Calming Womb Family Therapy Model: Mother and Womb Baby

Family therapy is a branch of psychotherapy that works with families, couples in intimate relationships, or with the most motivated family member (Bowen, 1966) to nurture change and development. This systemic framework illuminates the power of the family and views change regarding the systems of interaction between family members. It emphasizes family relationships as an

important factor in psychological health. Salvador Minuchin, MD, wrote that family therapists recognize the pull of the past and that, to some extent, people live in the shadow of family legacies. According to Minuchin, family therapy recognizes the power of the present and addresses itself to the ongoing influence of the family. Therapy based on Minuchin's framework is directed towards changing the organization of the family because when the family organization is transformed, the life of each family member is altered accordingly (Minuchin & Nichols, 1993).

This prenatal and perinatal family therapy model focuses on the mother and womb-baby unit. CWFTM is primarily concerned with the wellness of the baby and the expectant mother from conception or from the womb baby's gestational months in utero up to the infant's first year of life.

If we want society to thrive, we must attend to children in the womb by providing mothers with the needed healing resources at conception, concretely during prenatal and perinatal care, and until the baby is at least one year of age (some [Seigel, 2012] put this at three years of age). Fathers, partners, caregivers, and the prenatal and perinatal medical care personnel all need to be embraced as a team during all the stages of the pregnancy and the babies' development. However, the mother-baby dyad will remain at the core of the prenatal treatment. Prenatal and perinatal psychotherapy is the therapy of the future. Treating a pregnant mother needs to be conceptualized as family therapy because, while the family therapist supports, educates, assesses, and treats the pregnant mother, the future of the womb baby is impacted. Thus, the healing of the pregnant mother functions as a preventive measure and intervention for her baby.

Prenatal Calming Womb Family Therapy and Maternal Challenges

While there may be ongoing moments of bliss and welcome bonding that pave the way for a glorious pregnancy, the prenatal and perinatal treatment team, support staff, and caregivers will benefit from being educated about some of the most common psychological prenatal and perinatal complications, the significant numbers of high-risk pregnancies, prenatal and perinatal myths, and other untold stories. Educating and empowering mothers to self-soothe and remain present and positive throughout the multiple unplanned events is helpful and necessary.

In the spirit of assisting mother-baby and their supportive prenatal and perinatal team, I have compiled a list of the many unexpected emotional difficulties and physical symptoms a pregnant mother may experience, be exposed to, and suffer.

Some of the psychological prenatal and perinatal complications include:

- Preexisting anxiety
- Prenatal anxiety
- Preexisting depression
- Prenatal dysphoria
- Hormone-induced affect or mood shifts accompanied by increased sensitivity
- Multiple co-existing psychological disorders (i.e., depression and acute stress)
- Substance abuse
- Exacerbated chronic pain
- Bodily-triggered traumatic memories
- Maladaptive body image
- Unexpected weight gain
- Acute stress
- Developmental, adult post-traumatic stress disorder (PTSD), flashbacks, or nightmares
- Recent romantic relationship rupture
- Sexual assault resulting in pregnancy
- Past or ongoing domestic violence with current flashbacks
- Incest resulting in pregnancy
- Unplanned teen or adult pregnancy
- Abortion indecision leading to shame
- Adoption ambivalence and guilt
- Lack of social and familial support
- Partner’s lack of involvement and dismissiveness
- Loved one’s over-involvement resulting in stress
- Financial limitations
- Unemployment
- Homelessness, or at risk of, due to pregnancy

- Laboratory abnormalities resulting in fear and affect dysregulation
- Prenatal medical complication(s)
- Planned or unplanned cesarean section
- Preeclampsia
- Gestational Diabetes

Many mothers experiencing the above medical and psychological difficulties are initially hesitant to be referred to a pre-perinatal psychotherapist. The reasons some mothers may refuse therapy include prenatal mood swings, feeling easily overwhelmed, fatigue, dysphoric mood, familial stigma, cultural biases, religious beliefs, not wanting to be perceived as "damaged goods," or past limited benefits from such services. Introducing pre-perinatal psychotherapy early on as a part of the integrated and comprehensive routine of preventive care reduces such discomfort and stigma.

Despite some mothers' reluctance, most pregnant women are receptive to receiving services if these enhance or provide womb-parenting skills, developmental education, and tools to become attentive mothers. Most expectant mothers embrace the opportunity to attend couples therapy, hypnobirthing groups (Mongan, 2015), and health educational classes with their significant others. Maternal developmental attachment wounds and deficits are important reasons to heal in the psychotherapy situation. Selma Fraiberg (1980) referred to these attachment wounds and deficits as "the ghost in the nursery." It is not unusual for mothers who coped with difficult life situations prior to becoming pregnant to have a hard time once pregnant due to various added pressures. Thus, current prenatal stresses and preexisting difficulties often become the port of entry to psychotherapy.

High-risk pregnant mothers (i.e., homelessness, a domestic violence history, Bipolar I-II, actively dissociated, with PTSD, suicidal thoughts, substance dependent, chronically medically ill, recently separated) with current or chronic symptoms of emotional dysregulation, exacerbated by the current pregnancy and or other factors, need to be educated, encouraged, and referred in a timely manner for pre-perinatal therapy. Pervasive multigenerational maladaptive patterns (Nicholas & Schwartz, 1991), adverse childhood events (Anda & Felitti, 2003), environmental stresses, intrapersonal incongruences or conflict caused by unresolved trauma, relational conflicts, developmental or adult post-traumatic stress disorders, acute stress disorders, prenatal medical

concerns, or unplanned pregnancies are common roadblocks to wellness and need to be assessed and treated promptly.

Since pregnancy, previous fetal or infant loss, and parenting itself can all trigger PTSD symptoms (Pullen, 2014), this article provides a clinical treatment model I have found effective when treating pregnant women with simple to moderate levels of traumatic stress. While many women feel blessed and content throughout their pregnancies, others are surprised by their pregnancy circumstances. Often, these mothers feel ashamed about their lack of prenatal happiness, as if they should or could control its emotional and, often, hormonal rollercoaster.

Calming Womb Family Therapy After Delivery

Many mothers have wonderful post-delivery support and experiences. Unfortunately, others will encounter unforeseen medical or emotional challenges. Mothers expect to hold their babies soon after delivery, to be discharged home with their newborns, and to hold their babies in the comfort of their homes. However, many mothers will not be able to do so. As much as mothers may have been educated and prepared by their health educators and lactation specialists, unplanned cesarean sections occur, and lactation challenges are common. Also, postpartum affect dysregulation often interferes with the mother's bonding and her child's attachment.

Frequent post-delivery challenges include moderate to severe postpartum depression (PPD), moderate to severe postpartum anxiety (PPA), acute stress, trauma, and moderate to severe post-traumatic stress disorder (PTSD), all of which could increase two to four weeks after delivery or over a more extended time.

Mothers who lose a child prenatally or postnatally have high rates of depression and anxiety and receive limited treatment for these conditions, if any. "Moms who were bereaved had much higher odds of depression and PTSD" (Gold et al., 2014). According to Dr. Gold, there are more perinatal deaths every year in the United States than suicides and homicides put together. Annual perinatal deaths also exceed annual motor vehicle deaths of children and adults combined.

Trauma-Informed and High-Risk Prenatal and Perinatal Family Treatment

The first year of parenthood can be a stressful time, especially for already stressed and high-risk couples. Perinatal developmental guidance and family therapy may alleviate ongoing childrearing difficulties. Having treated mild, moderate, and high-risk multicultural, bilingual, pregnant mothers and their families in different clinical settings for more than 28 years, I have come to favor a combination of Eye movement desensitization and reprocessing (EMDR) trauma-informed therapy and family-systems multigenerational work.

This treatment combination evolved over many years of prenatal and perinatal clinical observation and close collaboration with pregnant women, their babies, caregivers, and my trauma-informed training evolution and advancement.

Prenatal and perinatal psychology is a growing science that studies the psychophysiological effects and implications of the earliest experiences of the individual before birth (prenatal) as well as during and immediately after childbirth (perinatal). Prenatal and perinatal experiences are fundamental in shaping psychological development's future. Working with pregnant families and practicing prenatal and perinatal psychology before knowing such a term existed, I came to understand the vital therapeutic importance of three factors:

1. Acknowledging and involving the womb baby in the healing therapeutic process
2. Supporting the expectant mother and her womb baby as a family unit
3. Practicing the most effective, specifically tailored, "spot on" interventions and trauma-informed therapy models with the mother before her baby is born.

Based on extensive clinical observations, the following lists several mother and womb-baby bonding exercises and symptom stabilization and wellness practices for pregnant women.

The womb baby needs:

- To be talked to, said hello to, frequently

- Their mother to engage the baby and let them know about the activity they are doing together
- To be interacted with, read to, sung to, danced with;
- To experience mindfulness via mom
- To receive words of love from those around them
- To feel wanted and released from any responsibility, even if initially unplanned or unwanted
- To participate in Yoga, Tai-Chi Chuan, or other forms of movement
- To experience fun such as swimming, nature walks, or walks on the beach
- Peace sharing in a meditative state with mom
- To be acknowledged and welcomed at birth

Expectant mother practices:

- Become a vehicle of peace, love, and service for the child and others
- Become focused, grounded, and live blissfully in the present
- Monitor self-talk and practice gratitude for everyday lessons
- Practice self-compassion and dignity, facilitating empathy, tolerance, and consideration towards others, especially the baby
- Work with a registered prenatal nutritionist who will recommend life-enhancing foods
- Work with a lactation specialist to learn relevant practices
- In-utero-development guidance
- Developmental parenting education throughout the baby's first year of life
- Parallel parenting education (i.e., mom's past and baby's development will unfold side by side)
- Awareness of the ghosts (i.e., the legacies of trauma) in the baby's nursery
- Attentiveness to her own attachment wounds
- Multigenerational identification of strengths, dysfunctions, and reenactment prevention
- Bonding (mom to womb baby) and attachment genograms
- Attachment repair, if needed
- Play assessment, education, modeling, and practice

- Humor as a healing tool
- EMDR Therapy

With a few yet important prenatal and perinatal additions and adaptations, the EMDR model offers a very effective, trauma-informed treatment for the mother and her in-utero baby. EMDR therapy strives to achieve trait (permanent) versus state (temporary) change. It accomplishes this by reprocessing the originating trauma linked to the presenting symptoms and thus goes beyond symptom reduction.

The recommended therapist for this task needs to be a licensed psychotherapist who is EMDR trained by the EMDR Institute, the Humanitarian Assisted Program (HAP), or by an EMDR International Association (EMDRIA) approved entity. Optimally, the prenatal and perinatal therapists will be certified in EMDR by EMDRIA. Such trainings are rigorous, and educational updates are enforced. In addition to pre- and perinatal therapy experience, preparation and education are crucial as the EMDR clinician is expected to practice within her/his scope of clinical training and practice.

The Calming Womb Family Therapy Model: In Utero Developmental Guidance and EMDR Pre- and Perinatal Therapy

It is important to mention four main elements that inform this model and how each concept serves as the building blocks of the CWFTM. This discussion will be followed by the model's integrated conceptualization.

First: In Utero Developmental Guidance

The term *in utero developmental guidance* refers to the early prenatal education of the parent that is integrated into the psychotherapeutic work. In utero, guidance is a form of psychoeducation guided, step by step, by the pre- and perinatal 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 impact that the attendant anguish places on the mother's bonding and relationship with her in-utero baby. What is addressed in therapy is what the mother brings to therapy, including her psychological conflicts that are already distorting her relationship with her womb baby (i.e., a crisis at the time of conception or grief during gestation). In

utero, developmental guidance endeavors 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. Finding new, nurturing, childrearing approaches will facilitate optimal development in every stage of the baby's existence.

These are some of the possible clinical scenarios and relational challenges the EMDR pre- and perinatal family therapist needs to consider and promptly address during the expectant mother therapy visits.

Multi-intergenerational Dysfunctional Patterns. It is well documented that how a mother was cared for and nurtured in her infancy and childhood affects how she parents and interacts with others. Sansone (2018) noted that both John Bowlby and Daniel Winnicott observed and documented how a parent's own childhood nurturing and mothering experiences become an internalized model of future parenting (p. 331). The baby's needs for care, love, and attention in utero may lead the mother to discover her unsatisfied yearnings. When the mother recognizes these yearnings, they can shift her into new ways of bonding. Once the mother initiates her own reflective healing and embraces her grief over previously unmet needs, desires, and wishes to be cared for, she will be able to respond to her womb baby and infant with feeling and self-compassion. The multi-intergenerational ghosts represent the repetition of trauma from the past in the present. Thus, pre- and perinatal psychotherapy with the mother and the womb-baby benefits the whole family.

Prenatal and Perinatal Transference. The therapeutic alliance is crucial to all therapeutic work and is essential in prenatal and perinatal family therapy. When impediments to the alliance occur, the therapist would do well to view this barrier as a possible manifestation of negative transference. Negative transference is considered a defense against hurtful feelings and memories being transferred and re-experienced with the treating therapist. When these transference reenactments and painful feelings are validated and given space, the mother can find new, more adaptive responses to old struggles. When the womb baby is at the center of negative transference, the therapist has a golden opportunity to intervene caringly and assist the mother in gaining control and insight. During these negative transferences, the womb baby or small child may be given qualities and intentions that do not belong to the baby or child and often belong to other figures in the mother's past.

When the mother is helped to re-experience and reprocess loss, grief, shame, guilt, rejection, and feelings of abandonment in her own childhood, she will be less likely to project these no-longer-disowned feelings onto her child. This also increases the chances that a mother will be better able to differentiate the boundaries between her feelings and experiences and those of her child as she cares for and parents that child. Once a mother can speak about her own painful childhood experiences in a safe, nurturing place, she can move protectively toward bonding with her child (Fraiberg, 1980).

Projections. The prenatal and perinatal therapist assists the mother in identifying ways in which she defends against unconscious desires or wishes, both positive and negative, by denying their existence in herself and attributing these to others. Discussing the costs of externalizing emotions and projecting these onto others is important. An important conversation between the mother and her pre- and perinatal therapist centers on the problems associated with creating a false self-image. Disowned aspects of the mother form a denied or distorted self, and that is why it is important to identify and become aware of the types of projection that most impact the expectant mother (i.e., a person who is habitually jealous may constantly accuse other people of being jealous).

A mother who experienced a lot of pain growing up may reject her infant girl based on the prospects of raising a female who the mother anticipates will similarly experience the pain and trauma she did growing up. This is another projection that can lead, in this case, to infant rejection and poor bonding. This trauma could be cultural, religious, social, sexual, or educational, not just familial. Parenting a female may trigger many of the mother's unhealed wounds, hence the wisdom in EMDR trauma-informed treatment for expectant mothers.

Gender Preference and Expectations. In many cultures, male offspring are desired in order to inherit property, carry on the family name, and provide support for parents in old age. In countries such as India, China, Indonesia, and Nepal, sons are commonly favored over daughters. According to a 2011 survey (Guilmoto, 2015), American parents favor boys by a 28% to 40% margin. In 1941, survey results were similar (Guilmoto, 2015), when Americans preferred a boy to a girl by a 24% to 38% margin. The overall preference was driven by men, of whom 49% preferred a son compared to 22% who preferred a daughter. Men's preference for sons was most pronounced among men aged 18 to 29.

Women, on the other hand, showed no preference for either sex, with 33% stating that they preferred a girl and 31% responding that they favored a boy.

Likewise, in many countries, parents prefer sons over daughters, as evidenced by the sex ratios of children in various countries. Although biologically, the sex ratio of children is around 95 girls to every 100 boys, this number generally evens out due to the higher infant mortality rate of boy infants (Seager, 2009). Scholars argue that the expected birth sex ratio in a normal population ranges from 103 to 107 males to females at birth. However, in several countries, such as South Asia, East Asia, and the Caucasus, the sex ratio of children is severely distorted (Guilmoto, 2015; Hesketh & Xing, 2006). The problem is particularly severe in China and India. The preference for sons over daughters can be due to numerous reasons. In these countries, it is argued that son preference is linked to factors including economics, religion, and culture. Having a son ensures that families are more economically secure by not having to provide but rather receive dowry payments. In China, the one-child policy has contributed to the sex imbalance, while the dowry system in India is responsible for a strong son preference.

Furthermore, in countries where there are discriminatory practices regarding women inheriting, owning, or controlling land by law, having a son ensures that the family will not have to worry about the legal aftermath if something were to happen to them (Seager, 2009). It can also be argued that parents in these countries are aware of the potential hardship their daughter would endure in her lifetime; therefore, they prefer to have a son rather than see their daughter suffer. This son preference often results in female feticide and prenatal sex selection (Das Gupta et al., 2003).

Given the previously presented reports, it is important to assess the cultural and familial gender expectations and assist the mother in identifying her anticipated wishes. Embracing the gender of the baby openly and unconditionally is the ultimate pre-perinatal treatment objective.

Second: The Prenatal and Perinatal Psychotherapist

The prenatal and and perinatal psychotherapist must develop a close working relationship with the mother's obstetric and gynecological (OB/GYN) team. This includes regular and ongoing conversations and meetings with the OB prenatal and perinatal medical doctors, midwives, prenatal and perinatal support staff, medical assistants, coordinators, nutritionists, lactation

specialists, health educators, gestational diabetes (GDM) personnel, and front desk receptionists.

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

Third: Family Therapy Dyad: Mother and Womb Baby

The mother will discuss and practice multiple state change interventions that will benefit her sense of wellness during her pre-perinatal care therapy sessions, reduce her emotional discomfort, and increase her sense of self-mastery and prenatal calmness. During this time, the pregnant mother will learn to regulate her affect, remain within her window of tolerance by modulating her arousal (Ogden et al., 2006), enhance her dual awareness (Schubert et al., 2011), practice relaxation exercises (van der Kolk et al., 2014), role-play limits setting (Knell & Dasari, 2011), and learn grounding practices (Siegel, 2010; Ogden et al., 2006). All these practices will positively impact mother and womb-baby bonding. Learning the above self-care practices is also a part of EMDR phase 2 (Shapiro, 2012).

Fourth: EMDR Therapy at a Glance

EMDR treatment allows people to heal from symptoms that are the result of traumatic or disturbing life experiences. EMDR therapy reprocesses the relevant historical events causing current anguish, incidents that elicit distress, and future events requiring different, more adaptive responses. 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 has given her informed consent, the mother should be able to initiate pre-perinatal EMDR therapy. Case studies available describe EMDR treatment with expectant mothers but also pertain to women with acute or post-traumatic stress disorders (Forgash et al., 2013). For detailed information, go to www.EMDR.com

Conclusion

CWFTM In-Utero Developmental EMDR Pre- and Perinatal Therapy is a family wellness approach that includes the expectant mother and her baby in utero and the baby's first year. The goal of this model is to provide EMDR trauma-informed family therapy, which is supportive to the pregnant mother while protecting the womb baby against future maternal projections and inter-multigenerational maladaptive revivals. The hope is that pre- and perinatal psychological services and trauma-informed therapy, such as the EMDR therapy model, will be systematically embedded in the mother's OBGYN care.

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