

EMDR IN REPRODUCTIVE, PERINATAL & INFANT MENTAL HEALTH

The Integrated Conceptual Lens

Mara Tesler Stein, Psy.D., PMH-C

Where We're Going

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Defining the Landscape

Why are we talking about this at all?

2

The AIP Model

The engine, in a perinatal frame

3

Thematic Conceptualization

Ruptures, themes, three core tasks

4

How Connection Heals

Self as therapist, philosophy of care

5

The Integrated Lens

The matrix, the maps, the plan

6

A Case in the Room

We work it together

By the End of Today

1

Recognise reproductive, perinatal and infant trauma across the journey — including the presentations that are routinely missed.

2

Apply the Adaptive Information Processing model to the developmental realities of the childbearing years.

3

Use the Integrated Conceptual Lens — three core tasks by four trauma themes — to organise what you hear.

4

Translate that formulation into target selection, resourcing and a sequenced treatment plan.

Defining the Landscape

Why are we talking about this at all?



Reproductive and Perinatal Trauma

A traumatizing event or events occurring around efforts to conceive, during pregnancy, birth, or in the three years postpartum.

- Three years, not six weeks. The developmental process of becoming a parent does not conclude when the obstetric care ends.
- Medical, relational, systemic, identity-based, or cumulative — and it can emerge at more than one point in the journey.
- It is not necessary to meet full criteria for PTSD for trauma to be identified and treated.

What Makes the Perinatal Period Unique

Massive hormonal, neurological and identity shifts

The baseline is moving. What is accessible at twenty weeks may be gone at thirty-six.

Developmental, relational, biological and psychological tasks overlap

Four demanding processes running at once, in the same nervous system.

Psychopathology may mimic or obscure trauma symptoms

Sleep loss, intrusive thought, hypervigilance — all have several possible authors.

Insight gaps, ambivalence, and shame carried culturally

The client may not be able to say what happened or may not believe they are allowed to.

Perinatal Trauma Across the Journey

Around Becoming Pregnant	During Pregnancy	Around Birth	After Birth Through First Years	Death of a Baby
• Being a birth parent • Infertility; secondary infertility • Adoption after infertility; disrupted adoption • Third-party reproduction • Being or using a surrogate or gestational carrier	• Pre-eclampsia / HELLP • Preterm labour; PROM • Placenta previa / accreta; abruption • Twin-to-twin transfusion • Molar and ectopic pregnancy	• Preterm delivery • Traumatic labour and delivery • Unwanted, unplanned or emergency caesarean • Resuscitation of baby; separation • Obstetric violence	• NICU; complications of prematurity • Respiratory distress • Genetic or congenital diagnosis • Serious medical condition in the first years • PMADs	• Miscarriage • Stillbirth • Neonatal death — SIDS, NICU, neonatal illness • Perinatal hospice • Pregnancy interruption for any reason

Trauma may be medical, relational, systemic, identity-based or cumulative — and it can emerge at more than one point in the journey.

Hidden Presentations



ABOVE THE WATERLINE — often visible to others

“Healthy baby.” “Good outcome.” “Shouldn’t I be grateful?”

BELOW THE WATERLINE — minimized, hidden, or delayed

High-intervention delivery, good outcome

Intrusive, depersonalized intervention

Unexpected NICU stay

Stressful pregnancy, good outcome

Early loss — “Does it count?”

Non-binary and LGBTQ+ experience

Gender disappointment

Teen pregnancy ending in miscarriage

Non-gestational parent losses

Also: recurrent losses, fear of the baby being taken away, race-based or religious conflict, and the extended family’s experience of loss.

You May Hear from Mothers

"It's better when others take care of my baby."

"I had a horrible nurse — midwife — doctor — delivery."

"I'm anxious when I'm separated from my baby."

"I don't have enough milk."

"I'm determined not to have another C-section."

"I'm pregnant again and terrified."

"I don't feel like a parent."

You May Hear from Partners

“They’re angry all the time.”

“They constantly yell at me and the kids.”

“The house is a disaster.”

“They aren’t sleeping — or do nothing but sleep.”

“They’re crying all the time.”

“They won’t eat.”

“They won’t let anybody help with the baby.”

“They won’t be away from the baby.”

The partner can be essential for treatment and often need treatment, too. They can describe symptoms they have no framework for — and they are often carrying their own untreated trauma while they do it.

Repercussions

Risk to birthing people

PMADs, PTSD, prolonged grief, disrupted bonding, avoidance of future pregnancy, medical avoidance.

Risk to partners

Untreated trauma, withdrawal, blame, relational rupture — and almost no route into care.

Risk to children

Attunement and responsiveness, attachment security, and the intergenerational transmission of trauma.

This is why the work is urgent. We are not only treating a person who is suffering. We are treating a matrix of relationships, including one that is still being built.

What increases the likelihood that these events will be disruptive?

Two people can live through the same birth.

What separates them is usually not the obstetrics.

What Makes an Event Traumatizing

Sense of control — their own, and the providers'

Supportiveness of the environment

Pain control

Ambiguous loss

Prior characteristics and vulnerabilities

Social isolation

Every one of these is clinically useful because any one of them could show up later as a target.

Who Is at Greater Risk — and Why

SOCIOLOGICAL

Age

Socioeconomic status

Disability

Race

Ethnicity

LGBTQ+

SYSTEMIC — CHRONIC TRAUMATIZATION

Fear of children being taken away

Racial and ethnic violence

Criminalization

Precarious immigration status

Environmental and housing insecurity

Transgenerational trauma

Roberta K. Timothy, Global Health, Ethics and Human Rights, York University

Cultural and Structural Considerations

Systemic racism, obstetric violence and healthcare inequity increase PMAD risk for Black and Indigenous birthing people.

Cultural stigma and the absence of culturally responsive care reduce treatment access.

EMDR therapists must develop cultural humility and actively inquire about sociocultural identity and oppression-based trauma.

Use case conceptualization to integrate experiences of racism, marginalization and intergenerational trauma.

Adapt protocols with cultural attunement — language, metaphors and resources aligned with the client's worldview.

MOVEMENT TWO

The Adaptive Information Processing Model

In a perinatal frame

What is Adaptive Information?

Cognitive, somatic, sensory, relational and emotional information that contributes to integration, growth and healing.

In this population the adaptive information is often relational, and often not yet available — because the relationship it would come from is the one that was disrupted.

The Adaptive Information Processing Model

AIP views information processing as the linking of neural networks related to our experience, including thoughts and beliefs, images, emotions and sensations.

~ Uri Bergmann, PhD

Conceptualization drives treatment planning.

Not the diagnosis. Not the event. Not the protocol you know best.

Phase 1 — History

What has happened?

The reproductive story in full — conception, treatment, pregnancy, losses, birth, feeding, separation. Ask; it will not be volunteered.

What is happening?

Present symptoms, present triggers, present risk. Sleep, appetite, medication, intrusive thoughts versus intent, infant safety, support.

Where are the wounds?

Which developmental task is disrupted, and what earlier material is being reactivated.

Listen equally for adaptive information. Competence, values, protective figures, culture, spirituality, persistence, humour, moments of connection with this baby.

Look for the ruptures.



Themes and the Three Core Tasks

Universal Trauma Themes

**Safety /
Vulnerability**

Choices / Guilt

**Responsibility /
Shame**

**Belonging /
Connection**

Perinatal Themes — Three Core Tasks

1

**Developing Parental
Identity**

2

Managing Feelings

3

Managing Relationships

These three tasks are not separate. They are deeply interconnected. Healing in one area supports healing in the others.

Task 1: Developing Parental Identity

In the midst of crisis

**After the initial crisis has
passed**

Enduring bonds

Trauma, shame, reproductive failure, loss or medical crisis all disrupt this task — and the disruption is rarely spoken as an identity claim.

Task 2: Managing Feelings

Grief

The response to what was lost — the baby, the pregnancy, the birth, the body, the future that was assumed.

Trauma

The response to what overwhelmed — terror, helplessness, immobility, the moment the system could not metabolise.

Fear

The response to what may still happen — anticipatory, and often entirely rational in this population.

Making meaning of the experience

Not stages, and not interchangeable. Each one asks something different of you.

Three Words We Use Interchangeably — and Shouldn't

Grief

The automatic internal reaction to loss.

Grieving

The expression of the varied feelings of grief.

Mourning

The process of coming to terms with the loss: grieving, coping, adjusting, transformational growth, making meaning, and healing.

What Might Parents Grieve?

Death of a fetus or baby

Loss of the pregnancy experience

Loss of the birth experience

Loss of reproductive capacity

Injuries to relationships

Losses in identity; interruption to
identity development

Loss of imagined family structure
or function

Loss of the imagined or hoped-for
future

Loss of innocence

Loss of peer group

Loss of function

Loss of the baby they imagined

Only the first one is usually recognized. The others get no ritual, no leave, and no condolences.

GRIEF IS EXPERIENTIAL

“After my first miscarriage, I remember feeling overwhelmed by the grief and thinking that I was ‘not handling it well.’ I talked to my midwife and she offered some good advice: ‘Grief is like labor. You don’t do it, it does you.’ So I couldn’t ‘do it wrong.’ That really helped.”

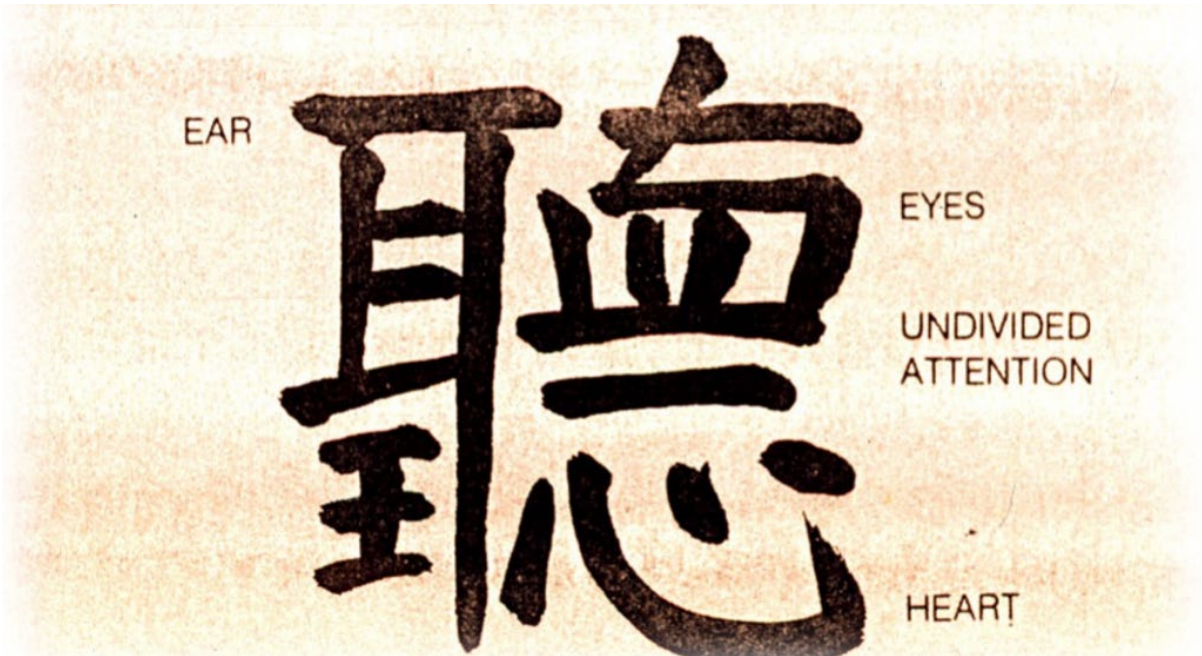
— Tanya



Grief does not happen in stages.

Listen

Find cohesion even in the midst of disarray.



Task 3: Managing Relationships

With family members

Partner, other children, family of origin. Grieving-style mismatches collide here first.

With health-care providers

Trust, mistrust — and whether the mistrust is a symptom or an accurate reading of what happened.

With the baby

The imagined baby, the symbolic baby, and the actual baby who is here. Often three different relationships.

With friends and co-workers

Who disappeared. Who said the wrong thing. Who is still pregnant.

And with their own body.

Attachment-Informed Clinical Insights

Bonding is the parent's relationship with the baby. Attachment is the baby's relationship with the caregiver. They are not the same process.

Traumatic disruptions do not equate to failed bonding. Look for attunement and responsiveness.

Repair and re-engagement are possible and expected in healthy relational development.

Identity development and bonding are distinct processes. Don't conflate them.

Neonatal Separation as Toxic Stress

Separation disrupts brain development, stress regulation, and parent-infant attunement.

Visual, auditory and olfactory stimuli help soothe and regulate neonates.

Skin-to-skin contact improves sleep, cortisol levels and neural connection.

Zero separation should be the goal whenever possible.

Precious little should come between parents and their babies. Much of our work is removing what has come between them.

Fathers and Other Non-Gestational Parents

Often overlooked in care

Yet deeply invested and deeply impacted. Present for the same birth, the same NICU, the same loss.

Grief and bonding may look different

Expressed differently, on a different timeline — and just as valid.

Support groups, male facilitators, validation

Non-gestational parents rarely find a room where their experience is the subject.

Hold space for individual difference

In how bonding is expressed, and in when it arrives.

Ask the partner about themselves.



How Connection Heals

Self as therapist, and a philosophy of care

BEFORE ANYTHING ELSE

EMDR is a relational therapy.

The protocol is not what heals. The compassion with which it is delivered is what heals.

Meaning well is necessary, but it is not sufficient.

Self as Therapist



What brought you into this work?

And what is “this work” — therapy, or perinatal work in particular?

What do you love about it?

Name it. It is a resource, and clients feel it.

What do you find challenging?

What you find hard about parents and what gets stirred up in you are intertwined.

What is your own history of loss and trauma?

Perinatal losses. Other losses. Ruptures that injure our capacity to hold space.

Recognition of our own traumatic losses is a precondition for accurate attunement.



What feels challenging to me?

Emotional

Distress I cannot fix. Rage. Silence. Overwhelming anxiety.

Medical

Uncertainty, prognosis, equipment, institutions where I have no standing.

Relational

Couples in conflict. Being idealised. Being blamed. Being the only one who asks.

Where you go numb is where your clients will not be able to take you.

Your Philosophy of Care

Your philosophy of care is a beacon that guides you and informs your practice.

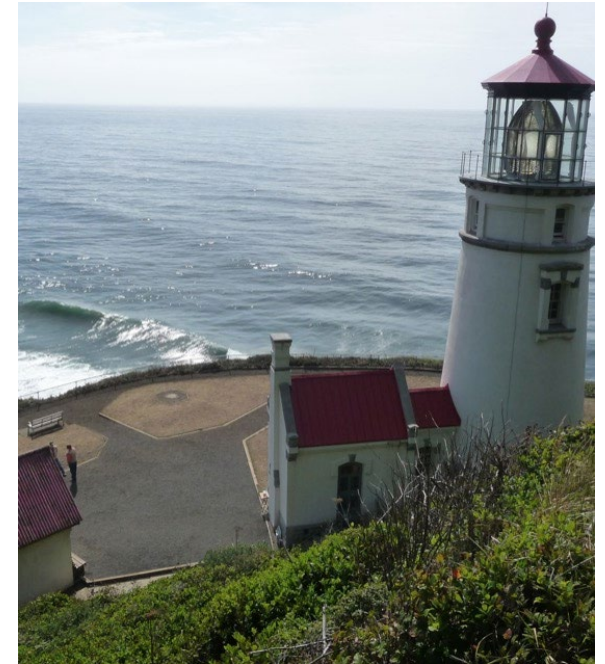
- What you do
- How you do it
- And why

Awareness

Reflection

Evaluation

Fine-tuning



Fine-tuning promotes quality care — and professional fulfilment. It is an ongoing process, not a conclusion you reach.

PROTECT & DIRECT



Almost always well-intentioned. And almost always experienced by parents as being managed rather than accompanied.

Accept, Attune, & Connect

Protect parents from pain



Support parents who are already in pain

Parents should not see



Parents look through eyes of love and see their beloved baby

Parents are sad when they are with their baby



Parents are even sadder when their baby is taken away

Parents won't know when they are ready



Parents will know — or will be as ready as they can be, with my support

Do what I consider best



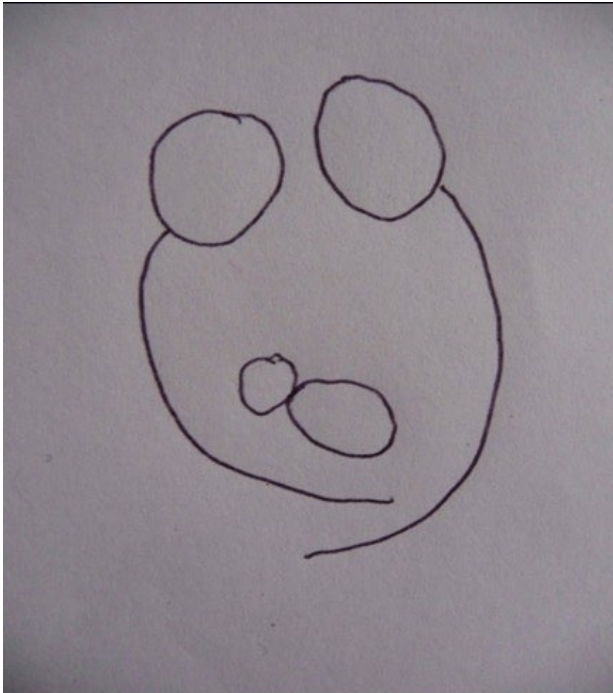
Support parents in determining and doing what they consider best

Host and guest. I am the host when it comes to guiding. I am the guest when it comes to observing, listening, and holding space.



Precious little should come between parents and their babies.

Be a nonjudgmental witness and companion on their journey.



Relationship-centered care nurtures all the relationships.

Any behavior, attitude, philosophy, intervention or setting that supports, respects, and responds sensitively to a parent's physical, spiritual, emotional, social and developmental well-being.

The baby is part of a family, and the family is part of the health care team.

AND SO

“There is no such thing as a baby.”

The unit of treatment is never the individual alone — even when only one person is in the room.



The Three Tasks Are Also Your Resourcing Map

Supporting relationships

Developing parental identity

Emotional regulation

= Resourcing

We foster everything that supports and affirms the bond between parent and baby.

Phase 2 is not a generic skills module here. In this population, resourcing is developmental support, and developmental support is resourcing.

PHILOSOPHY SHIFTS

The baby is part of a family, and the family is part of the health care team.

RESPECT

If you can see parents as whole, they benefit from your seeing them that way.

The Comprehensive Integrated Lens

The matrix, the maps, and the plan

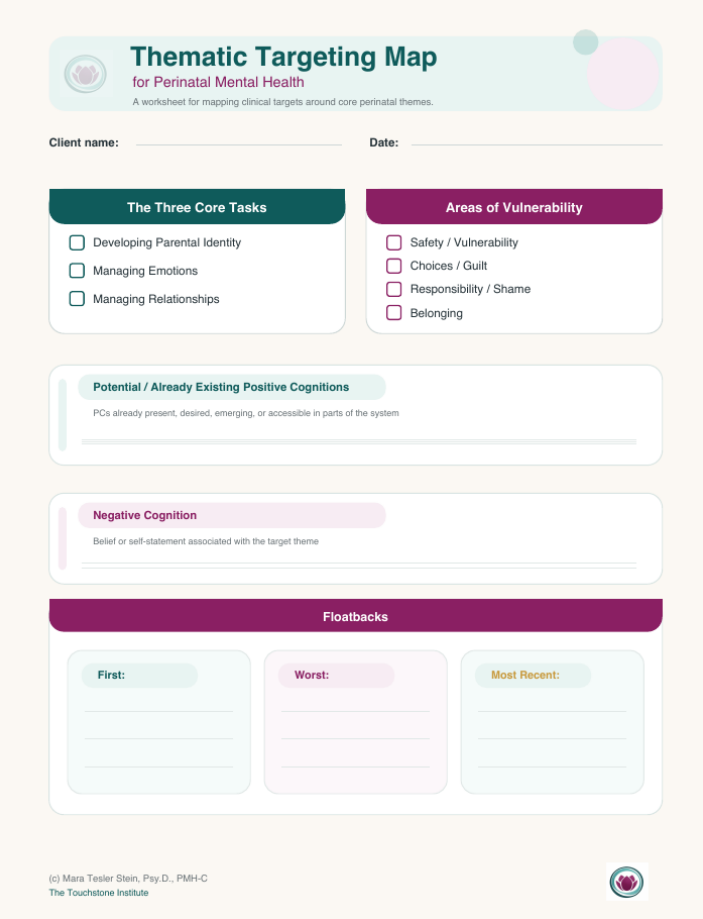
The Integrated Conceptual Lens

	Safety / Vulnerability	Choice / Guilt	Responsibility / Shame	Belonging
Parental Identity	(In)ability to make the risk to the baby not happen. Pregnancy or birth risk to health.	Am I making the right decision? What sort of parent...?	Parent myth: I should have known. I am permanently damaged.	Am I a parent? What does this mean about me as a parent?
Managing Emotions	Overwhelming fear. Immobilizing grief.	Internal conflict in the face of medical decision-making.	Do my feelings interfere with my ability to make good decisions? To take in information?	I don't deserve support. I don't deserve to join.
Managing Relationships	Can I talk about this with others? Can I trust my medical team? My family? My friends?	Can I be trusted to choose care providers — and others — who will support my family?	Parent myth. Beliefs about collaboration and mutuality: who is on the medical team?	I'm different. Loss of peer group.

Thematic Targeting Map

WHAT IT DOES

- Names the disrupted task and the activated theme — the cell.
- Captures positive cognitions that are already present, desired, or emerging somewhere in the system.
- Names the negative cognition attached to that theme, in the client's words.
- Floatbacks: first, worst, most recent.



The worksheet is titled "Thematic Targeting Map for Perinatal Mental Health" with a subtitle "A worksheet for mapping clinical targets around core perinatal themes." It includes fields for "Client name:" and "Date:". The main content is organized into several sections: "The Three Core Tasks" (Developing Parental Identity, Managing Emotions, Managing Relationships), "Areas of Vulnerability" (Safety / Vulnerability, Choices / Guilt, Responsibility / Shame, Belonging), "Potential / Already Existing Positive Cognitions" (PCs already present, desired, emerging, or accessible in parts of the system), "Negative Cognition" (Belief or self-statement associated with the target theme), and "Floatbacks" (First, Worst, Most Recent). The footer includes copyright information for Mara Tesler Stein, Psy.D., PMH-C, The Touchstone Institute, and a logo.

Thematic Targeting Map
for Perinatal Mental Health
A worksheet for mapping clinical targets around core perinatal themes.

Client name: _____ Date: _____

The Three Core Tasks

- ☐ Developing Parental Identity
- ☐ Managing Emotions
- ☐ Managing Relationships

Areas of Vulnerability

- ☐ Safety / Vulnerability
- ☐ Choices / Guilt
- ☐ Responsibility / Shame
- ☐ Belonging

Potential / Already Existing Positive Cognitions
PCs already present, desired, emerging, or accessible in parts of the system

Negative Cognition
Belief or self-statement associated with the target theme

Floatbacks

First: _____

Worst: _____

Most Recent: _____

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The Touchstone Institute

Fill it in with the client, not about them. It is a shared instrument — and completing it together is itself an intervention.

Thematic Resourcing Map

WHAT IT DOES

- Starts from the same cell — the same task, the same area of vulnerability.
- Three resources, each with a name, cue, image or phrase.
- For each: does it develop qualities of self? Self-regulatory capacity, addressing or counteracting emotion? Relational resources?
- And the question that keeps it honest: what does this resource support?



The worksheet is titled "Thematic Resourcing Map for Perinatal Mental Health" and is described as "A worksheet for organizing resources around core perinatal themes." It includes fields for "Client name:" and "Date:". Below these are two columns: "The Three Core Tasks" and "Areas of Vulnerability".

The Three Core Tasks:

- ☐ Developing Parental Identity
- ☐ Managing Emotions
- ☐ Managing Relationships

Areas of Vulnerability:

- ☐ Safety / Vulnerability
- ☐ Choices / Guilt
- ☐ Responsibility / Shame

The worksheet features three identical resource sections, each with a heading (Resource #1, #2, #3), a field for "Resource / cue / image / phrase:", and a list of checkboxes for "Developing qualities of self", "Developing self-regulatory capacities / addressing overwhelming emotion", and "Installing relational resources". Each section also includes a field for "Notes / installation targets / observations:" and a question "What does this resource support?".

At the bottom, it is credited to "(c) Mara Tesler Stein, Psy.D., PMH-C The Touchstone Institute" and features a logo.

Resourcing must answer the physiological and relational realities of the childbearing journey. A calm place is not enough when the client is going back to the NICU this afternoon.

WHICH MEANS

**Target selection will be drawn from your
Phase 1 work.**

EMDR Treatment Planning Flow

1

Identify the perinatal context + developmental task

- Locate the client in the reproductive story.
- Name the active developmental tasks.

2

Map distress across perinatal dimensions

- Symptoms, risk, dissociation, sleep, medical status, supports.
- Distress in body, identity, caregiving, culture, partner, baby cues.

3

Decide what is needed now

- Resource and stabilize when safety, dual attention, affect tolerance, sleep or advocacy must come first.
- Reprocess when there is stabilization, consent, window, and support.

4

Organize targets through the 3-prong protocol

- Past: earlier attachment, loss, medical trauma, identity wounds.
- Present: medical visits, baby cues, feeding, sleep, anniversaries, body.
- Future: birth, procedures, parenting moments, advocacy, loss ritual.

5

Sequence by urgency, access + developmental logic

- Begin with safety, risk, support systems, and the client's priorities.
- Choose targets that protect functioning and the parent-baby relationship.
- Titrate when the system is overloaded.

6

Reassess and adapt across phases

- Monitor readiness, symptoms, risk, sleep, supports, relational repair.
- Return to resourcing or reformulation whenever the perinatal context changes.

Feedback loop: perinatal status changes quickly. Update the treatment plan as the story unfolds.

A Case in the Room

We fill the maps together

READ FOR 90 SECONDS

The Case

“A couple experienced a traumatic birth — emergency caesarean, baby in the NICU for two weeks. The mother is now three months postpartum. She has intrusive memories of the operating room, hypervigilance about the baby’s breathing, and rage toward her partner for ‘not protecting’ her. She feels she failed as a mother. Her partner feels blamed and has withdrawn. The baby is home and healthy, but she cannot relax. She is not sleeping, has lost interest in the baby, and feels disconnected from her body.”

BEFORE WE FORMULATE ANYTHING

- Loss of interest in the baby at three months postpartum requires a full PMAD and risk assessment.
- Rage plus sleeplessness means asking directly about intrusive thoughts — and distinguishing them from intent.

Fill the Targeting Map Together

The three core tasks

Which one is most disrupted right now?

Areas of vulnerability

Which theme carries the most heat?

Positive cognitions

What is already present, desired, or emerging?

Negative cognition

In her words — not in ours.

Floatbacks

First. Worst. Most recent.

Fill the Resourcing Map Together

SAME CELL — NOW WHAT DOES SHE NEED?

Qualities of self

Competence she had before this. Who she is when she is not frightened.

Self-regulatory capacity

Sleep. Orientation. Containment she can use at 3am and in medical settings.

Relational resources

The partner — repaired or not. Anyone who believed her. Other parents with a comparable experience.

- And the question that keeps it honest: what does each of these resources actually support?

Notice what just happened. Restoring her parental authority is both the resource and the developmental goal. In this population they are the same act.

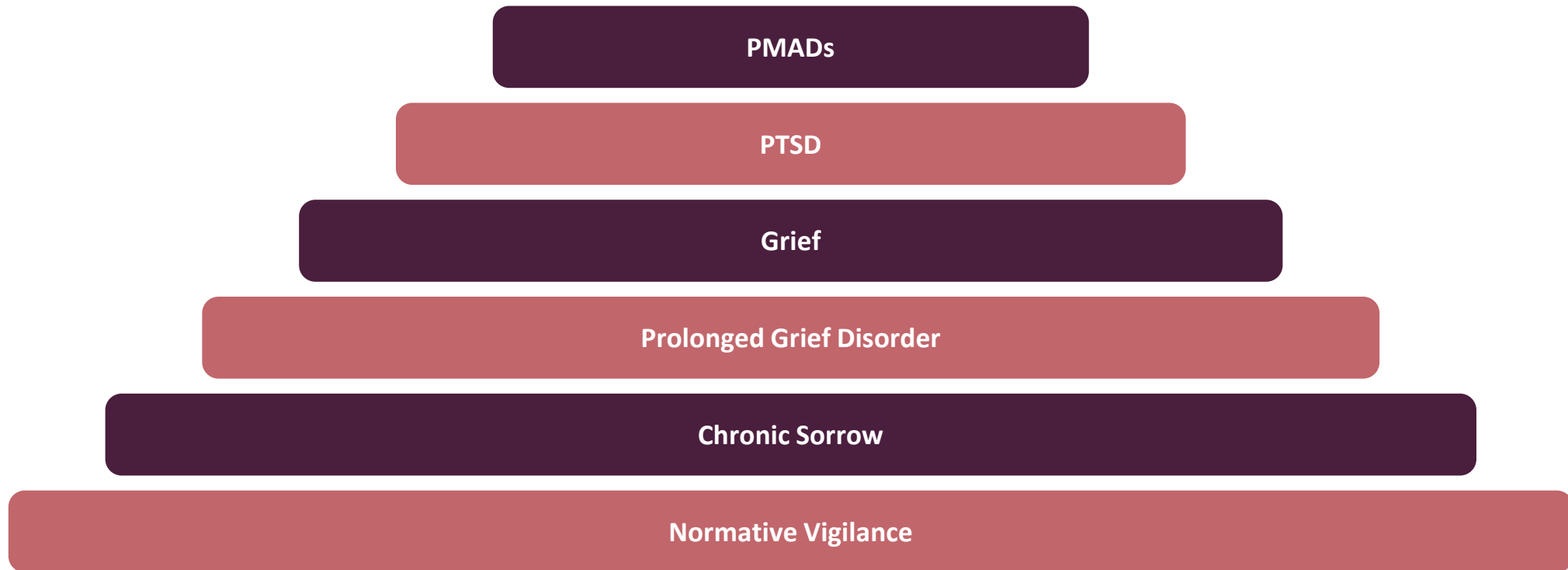
MOVEMENT SEVEN

When It's Not (Only) Trauma

Differential, safety, and pregnancy

The Differential

PMADs are the most common complication of pregnancy — affecting as many as 1 in 5.



They overlap heavily. They are treated differently.

Telling Them Apart

	What you see	What points to it
PTSD	Involuntary reliving — flashbacks, nightmares, reactivity, hypervigilance, startle.	
Depression	Ruminative, self-critical thought. Watch for shame, worthlessness, suicidal ideation.	
Grief / complicated grief	Yearning, searching, emptiness, loneliness. Overlaps PTSD but lacks re-experiencing and hyperarousal.	
Normative vigilance	Functional concern proportionate to a genuinely fragile child. Understand the context before labelling it.	

Shared symptoms mislead: anhedonia, sleep disturbance and concentration problems belong to all of them. The distinguishing features are in the right-hand column.

When to Stop and Refer

BIPOLAR IN THE PERINATAL PERIOD

- Bipolar II is frequently underdiagnosed here — symptom overlap with depression.
- Watch for mixed features, rapid cycling, and histories of hypomania, especially in treatment-resistant depression.
- Treatment only when mood is stable and under psychiatric care.
- Avoid trauma processing during manic or hypomanic states — Phase 1 and 2 only.

PERINATAL PSYCHOSIS — CLINICAL EMERGENCY

- 1–2 per 1,000, typically emerging in the first two weeks postpartum.
- Delusions, hallucinations, disorganized thinking; high suicide and infanticide risk.
- Differentiate intrusive, ego-dystonic thoughts (OCD) from fixed delusions.
- EMDR is contraindicated during active psychosis. Immediate psychiatric intervention, often inpatient.

Know these two well enough to recognise them at speed. In both, our first job is not treatment. It is getting the client to the right care.

EMDR and Pregnancy

The question, the evidence, and the recommendation



The Question

“Can I use EMDR therapy with a client who is pregnant?”

So. Many. Answers.

“Never during the first trimester.”

“Never during the last trimester.”

“Only if it’s about this pregnancy.”

“Only if it’s NOT about this pregnancy.”

“Only do Phase 2.”

“I’ve done it and it was fine.”

“Be careful not to trigger labour.”

“New EMDR therapists should avoid it.”

“Not if the pregnancy is high risk.”

“Not if the pregnancy is after
infertility.”

“It’s a liability issue.”

“Always do it — it helps later with
bonding.”

“Don’t! Because — cortisol!”

“I did it once and the client
decompensated.”

“I’m uncomfortable and prefer to wait
until after birth.”

“I think it’s unethical to reprocess
during pregnancy.”

PTSD in the Perinatal Period

3.1%

of community samples

15.7%

of at-risk samples

Grekin & O'Hara, 2013

Community-related samples

0 – 21%

High-risk samples

0 – 43%

Lower-income samples, childhood adversity, pregnancy complications

18 – 29%

Khoramroudi, 2021 · Narayan et al., 2017, 2019 · Yildiz, Ayers & Phillips, 2017

What That Means in Numbers

4 MILLION LIVE BIRTHS

120,000

will have PTSD — conservatively

1 MILLION WHO ENDURED LOSS

210,000

will suffer PTSD

United States, 2010 birth cohort

After a Loss

4×

higher odds of a positive screen for depression

7×

higher odds of a positive screen for post-traumatic stress disorder

Nine months after a loss, bereaved women showed high levels of distress — with limited rates of treatment.

Gold et al., 2016 — controlling for demographic and personal risk variables

WHERE THE CAUTION COMES FROM

“The potential effects of aroused emotion on women who are pregnant should also be taken into account. While, to date, there have been no reports of serious physical side effects, it is always better to use caution.”

— Shapiro, 2018

The Omission Bias

Omission bias: automatically weighing the risks of something a clinician does as worse than the risks of not intervening.

- Cognitive biases are systematic errors in judgment stemming from reliance on unconscious decisional shortcuts. In clinical decision-making, omission bias is an especially common one.
- Norm theory: when an action leads to an adverse outcome it is easy to imagine the alternative — “if only I had not...” — and the regret is strong. When no action is taken, the alternative is harder to imagine, and the feeling is weaker.
- Physicians withhold evidence-based preventive treatment because they fear the risk of adverse effects more than the higher risk of morbidity and mortality from the untreated disease.

Blumenthal-Barby & Krieger, 2015 · Kahneman & Miller — norm theory

Pregnancy is not a disease state.

Not all stress is the same.
Not all stress is damaging.

Toxic Stress

Strong, frequent and/or prolonged activation of the body's stress-response systems in the absence of the buffering protection of adult support.

MAJOR RISK FACTORS

- Extreme poverty
- Recurrent physical or emotional abuse
- Chronic neglect
- Severe maternal depression
- Parental substance abuse
- Family violence

Shonkoff et al., 2009

THE DEFINING CHARACTERISTIC

It disrupts brain architecture, affects other organ systems, and establishes stress-management systems with lower thresholds for responsiveness that persist throughout life.

Risks of Untreated PTSD in Pregnancy

Obstetric complications

Infant cognitive, behavioral, social and emotional development

Addictive substance use

Reduced nursing

Parent-infant bonding and interactions

Adverse effects on parenting couples

Obstetric Complications

Preterm birth and low birth weight

Increased risk

With comorbid PTSD and major depressive disorder

4× the risk of preterm birth

Gestational diabetes and pre-eclampsia

Increased rates

Gelaye et al., 2020 · Rashid et al., 2020 · Seng et al., 2011 · Nillni et al., 2020 · Shaw et al., 2014, 2017 · Yonkers et al., 2014

By contrast: a history of PTSD with no active symptoms — for example, after effective treatment — is not associated with increased obstetric complications.

Infant Development

FETAL PROGRAMMING

- Stress-related alterations in maternal hormonal and immunologic physiology affect placental and fetal gene expression.
- Neonates of mothers with PTSD had different gene expression profiles in umbilical cord blood, with more genetic loci associated with impaired developmental outcomes.
- FKBP5: infants with the CC genotype appear relatively protected from antenatal maternal PTSD; those with CT or TT genotypes do not.

DEVELOPMENTAL OUTCOMES

- Reduced cognitive performance at 24 months in children exposed to maternal PTSD symptoms in utero.
- With comorbid depression: reduced adaptive behaviors and less favorable social-emotional development at 24 months.
- At 6 months, infants of mothers with PTSD had significantly more difficulty regulating emotions; at 13 months, more social-emotional difficulties.

Grasso et al., 2020 · Enlow et al., 2011 · Brand et al., 2006

And Then the Rest of the Ledger

ADDICTIVE SUBSTANCE USE

- PTSD symptom severity substantially influences cravings and use.
- The association is partially mediated by reduced feelings of fetal attachment.
- Severe PTSD symptoms increase the odds of smoking in pregnancy — with its own risks of previa, abruption, growth restriction and perinatal mortality.

REDUCED NURSING

- Reduced initiation, less exclusive breastfeeding, and not breastfeeding for as long as wanted.
- Adjusted odds ratio of 5.98 for not initiating breastfeeding, compared with control women.
- The association is especially strong with the avoidance symptoms of PTSD.

BONDING AND INTERACTIONS

- Findings are genuinely mixed. Birth-related PTSD does not appear to impair self-reported bonding, but may increase avoidant attachment.
- General PTSD is associated with reduced bonding, especially with comorbid depression.
- PTSD does not uniformly impair bonding or parenting — but it has the potential to.

PARENTING COUPLES

- Postpartum PTSD predicted low couple satisfaction at two years — via concomitant postpartum depression.
- Consistent qualitative themes: relationship strain, loss of intimacy, anger, guilt, numbness, detachment.
- Some couples report strengthened relationships; more report difficulty with mutual support.

Sanjuan et al., 2019, 2020 · Kornfield et al., 2017 · Garthus-Niegel et al., 2018 · Radoš et al., 2020 · Seng et al., 2013 · Delicate et al., 2018

Tolerable Stress

A physiological state that could potentially disrupt brain architecture — but is buffered by supportive relationships that facilitate adaptive coping.

DEFINING CHARACTERISTIC

It occurs within a time-limited period, during which protective relationships bring the stress-response systems back to baseline — giving the brain time to recover.

WHAT DOES THE BUFFERING

- The therapeutic relationship
- Phase 2 preparation skills and practice — including recruiting environmental and social support

Shonkoff et al., 2009

Positive Stress

Moderate, short-lived increases in heart rate, blood pressure and stress hormone levels.

An important aspect of healthy development, experienced in the context of stable and supportive relationships that facilitate adaptive responses — which in turn restore the stress response system to baseline.

Precipitants: the challenges of dealing with frustration, receiving an injected immunization, and other normative experiences.

Shonkoff et al., 2009

The Healthy Stress Response in Pregnancy

Adaptive

Dynamic

**Attenuated stress
reactivity**

Protective

- Compared with non-pregnant women, healthy pregnant women exhibit attenuated stress reactivity in cortisol, catecholamine and blood pressure responses.
- Neurophysiologic responsiveness to stress reduces as pregnancy progresses — heart rate and blood pressure increase less in the third trimester than the second.
- The blunting is nonspecific: physiologic responses to relaxation exercises are attenuated in pregnancy too.
- These adaptations appear to serve a protective function — preventing mother and fetus from excessive exposure to stress hormones and changes in uterine blood flow.

DiPietro et al., 2003, 2005, 2012 · Christian, 2012 · Entringer et al., 2010

Mild, Intermittent Stress Is Adaptive

THE FETAL RESPONSE MATURES

- Unlike the mother's, the healthy fetal response increases as pregnancy progresses.
- Reduced motor activity and change in heart rate variability — more pronounced in the third trimester than the second.
- Fetal cardiac and motor responses become more coordinated with one another. This may represent maturation of the fetal stress response system.

AND IN THE TODDLERS

- Toddlers exposed to more maternal distress in utero have more advanced motor skills and neural maturation than those exposed to less.
- This holds in offspring of otherwise healthy women who did not experience perinatal trauma and had no clinically significant mental health symptoms.

Chronic — but not acute — maternal stress affects fetoplacental CRH secretion.

DiPietro et al., 2003, 2006 · DiPietro, 2012 · La Marca-Ghaemmaghami et al., 2017

EMDR Therapy and the Stress Response

Decrease in HR and BP reactivity to trauma cues

Significant psycho-physiological de-arousal

Sharp increase in parasympathetic tone

- Rapid habituation of heart rate, heart rate variability, respiratory rate and skin conductance within EMDR sessions.
- After successful trauma-focused therapy, heart rate and blood pressure reactivity to trauma cues decline.
- No direct studies of maternal or fetal neurophysiologic effects of EMDR during pregnancy yet — and no adverse effects of PTSD psychotherapies on pregnant women or their offspring reported to date.

Sack et al., 2005, 2008 · Elofsson et al., 2008 · Schubert et al., 2011 · Zantvoord et al., 2013 · Farina et al., 2015 · Baas et al., 2020

Weighing the Two Risks

UNTREATED PTSD

Behaves like chronic and/or severe stress, with documented adverse effects on the pregnant woman and her offspring.

VS

TRAUMA-FOCUSED TREATMENT

Fits the description of health-promoting adaptive stress: mild to moderate, intermittent, buffered, and time-limited.

The risks of the former substantially exceed the risks of the latter.

Arch et al., 2012, and subsequent corroborating studies

Use EMDR Therapy Appropriately During Pregnancy

1

The population is vast

Withholding any phase of a gold-standard treatment without clear clinical indication is unsupported by extant data — and runs the risk of doing harm.

2

Exposure is already happening

The consequence well-intentioned clinicians fear is occurring already. Avoidance of treatment prolongs exposure to known risks.

3

Pregnancy is not a disease state

Its physiology buffers mild to moderate stress. Women cry, get angry and feel stress in every kind of therapy — and outside it. Transient stress is adaptive, entraining the fetal nervous system for future buffering.

4

Assume competent practice

Thorough assessment, attention to the window of tolerance, stabilization and containment are cornerstones of every EMDR treatment plan. The claim that EMDR induces intolerable distress assumes we are not doing them.

Pregnancy itself is not a contraindication for the use of any phase of EMDR therapy.

Decide from formulation, from current stability, and from the client's own goals.

Not from the trimester — and not from the omission bias.

What to Take Home

- Recognition is the bottleneck. Most of these clients are already in your caseload under another heading.
- Conceptualization drives treatment planning — not the diagnosis, not the event, not the protocol you know best.
- The lens is three developmental tasks by four universal trauma themes. The cell holds the client's own words, and the negative cognition.
- Resourcing in this population is developmental support. They are the same act.
- Standard EMDR therapy is preserved. The adaptation is in the conceptualization, the pacing, the sequencing, and the relational and medical context.

The question to hold when a case feels shapeless: “What developmental process was interrupted here, and what would support its repair?”

CLOSING REFLECTION

What is one insight from today that you will carry into your practice?

“The childbearing journey is one of the most consequential developmental passages in human life. EMDR therapy offers us a way to meet people in that complexity — to listen to what the nervous system has carried, what the body has not been able to forget, and what is needed for healing and development to resume.

Thank you for the work you do at this intersection.”