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Creating Attunement in Utero: Dance/Movement Therapy for Women Who Are Incarcerated While Pregnant

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Abstract

This thesis reviews the experience of pregnancy in prisons; pregnancy in bonding, attachment, and attunement; and pregnancy in dance movement therapy. Every woman deserves the help and guidance to connect with their baby as much as possible: during pregnancy and after. For women whom are incarcerated, the time to connect is shortened. For most women, they do not have access to their babies after delivery. I have researched the living conditions for women who are pregnant while incarcerated; this includes accommodations, possible health risks, and programs set up for pregnant women. Also researched is the importance to have connections made to baby while pregnant; specifically attunement and bonding. The calming womb technique from family therapy is able to provide tools for mother to use. Dance movement therapy uses verbal and nonverbal tools to attune and bond with their baby also to form this unit. It can aid in the bonding and attunement process through techniques and tools taught to mother during pregnancy. Using tension-flow rhythms from Kestenberg Movement Profile to help attune to their baby's rhythms in utero can help reduce mother's anxiety before meeting her baby. Shape-flow rhythms can help alleviate tension on mother's body and give space for her baby to grow. After birth, dance movement therapy should continue. It can continue to help the bonding process and future attachment style between mother and baby.

Keywords: pregnancy, prison, incarcerated, dance/movement therapy, attunement, bond, tension-flow rhythm, calming womb

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Introduction

Carolyn Sufrin (2019) of John Hopkins University stated in an interview, "Pregnant incarcerated people are one of the most marginalized and forgotten groups in our country…" (p. 1). In prison, a person's rights are completely ripped away from them. The life they knew is gone, and at times it is unknown if it will ever come back. Pregnancy is typically a time where one is pampered; being a new mom is supposed to be exciting. A woman's body is completely changing, inside and out. Not many people talk about how traumatic an experience this could be for one who does not have a support team or adequate care. When one is pregnant, they get the gift of having their baby afterwards. For most women who are incarcerated, that is not the case. This paper will address pregnancy in prisons, bonding/attachment in pregnancy, and Dance Movement Therapy (DMT) in conjunction with pregnancy. The topic under consideration is how DMT can help women form a stronger bond/attachment with their baby when they are pregnant during incarceration. Within this topic, there are two traumatic experiences happening at once, prison and pregnancy. This is an important topic because every woman deserves the right to adequate care and support in helping/guiding her through pregnancy. DMT can aid in guiding a woman by offering her a sense of control of her pregnancy during a time when she has no control over anything. When researching these topics, I hope to shine light on the gaps within prisons. I want to provide context as to how dance movement therapy can aid in the bonding and attunement process for women during pregnancy. This will allow me to show that women who are pregnant during incarceration should also be able to engage in this process. Not only this, but

bonding/attunement should be a right for these women: a right where DMT could help to fill in care gaps for those who are suffering.

Literature Review

Incarceration and Pregnant Women

The number of women in prisons is growing; the number of women who are pregnant in prisons is growing as well. As of 2017, over the past 37 years, the number of women incarcerated has increased a staggering 750%. There were 225,060 women who were incarcerated as of 2017 (The Sentencing Project, 2019). It is estimated that at least 6-10% of these women were pregnant during their intake (Ferszt & Erickson-Owens, 2008; Kelsey, Medel, Mullins, Dallaire, & Forestell, 2017). When thinking about the prison and jail system in general, we know they were originally designed to help maintain the care of men who broke the law. Now there is such a high percentage of women who are in these facilities. Then on top of that, there are women who are pregnant. It goes without saying that these women have greater numbers of health risks: substance use, chronic medical conditions, stress, depressive systems, exposure to physical violence, poor nutrition, sexually transmitted diseases, less reproductive care, and mental health problems (Ferszt & Clarke, 2012; Kelsey, et al., 2017).

With the number of women entering prison, and the number of pregnant women that could bring, one would think there would be policies put into place to help protect them. In addition to all of the health risks above, there are complications that can occur: miscarriage, preterm delivery, spontaneous abortions, low-birth-weight for babies, and pre-eclampsia (Ferszt & Clarke, 2012; Kelsey, et al., 2017). A study done in 1991 by Wooldredge and Masters surveyed all women and co-ed state facilities to see what kind of care was being offered for pregnant women. Only 61% of facilities responded back. Of these, only 29 facilities had any

form of written policy in place for inmates who are pregnant (Ferszt & Erickson-Owen, 2008). Many organizations, such as the American Public Health Association, the American College of Obstetricians and Gynecologists, and the National Commission on Correctional Health Care, have all shared their views on the standards of care that need to be in place for incarcerated women who are pregnant in order to limit the possibilities of the above complications (Ferszt & Erickson-Owens, 2008; Kelsey, et al, 2017). There are an array of different recommendations, including prenatal medical/ HIV screenings, diets, prenatal nutrition counseling, drug rehabilitation, prohibition of shackling during labor, access to the newborn, breastfeeding support, and storage for the milk (Ferszt & Clarke 2012, Kelsey, et al, 2017). Although these standards have been set up, facilities do not need to follow them. They are mere suggestions for providing adequate care for women during pregnancy, delivery, and postpartum. Unfortunately, little is known about how many facilities actually follow them, and there is no rule that states these facilities must follow simple steps that could protect the mental and physical wellbeing of mother and baby.

Between June 2014 and January 2015, a study was initiated to look at how many jail facilities follow these standards of care. There were 384 facilities that were contacted; however, only 53 responded. The responses came pretty evenly from across the United States:17 from the West, 18 from the Midwest, 18 from the East, 26 from the North, and 27 from the South (Kelsey, et al, 2017). The survey was split into different categories based on a previous study that had been conducted for prison facilities: pregnancy tests conducted, women informed about pregnancy options, opioid addiction practices ascertained, accommodations needed, delivery rules/regulations carried out, restraints used, and postpartum difficulties addressed. A striking 37.7 percent of facilities test women upon arrival to jail. Most of the jail facilities just “trust” the

judgment of the women themselves. The hypothesized reason as to why jails just trust their judgment is that women in jails are there for shorter periods of time than in other correctional institutions. The survey further reveals that 28.3 discuss adoption and 26.1 discuss termination. Almost half of facilities (45.7%) have women who are withdrawing from opioids, but only 21.7% have Methadone therapy. When discussing accommodations, most of the facilities followed the standards of care by proving bunks. Regarding providing bottom bunks, 98.1% provided the option; 92.3% had food supplements; and 96.2% offered prenatal vitamins. The screening rate for infectious disease was 68.0%. More than half of the women had options for fluid supplements (56.9) and for healthier food options (51.0%). Delivery was also divided into smaller categories, starting first with granted furlough, which would give the pregnant woman a leave of absence while delivering. Just under half of the facilities (47.8%) offered this possibility. If the moms were not granted furlough, then 95.5% of facilities had a corrections officer present at the birth. This is where the numbers start to drop where in any other situation, a woman would be allowed the following delivery accommodations: The father was only allowed 10% of the time, a family member 19%, and a companion/doula 4.8%. When discussing restraints, 17.4% of facilities said that they use them during labor, and 56.5 % use them right after delivery. The last portion of the survey discussed postpartum. Only 68.2% of facilities allow women to provide breast milk for their infant, and only 27.9% allow them to have contact visitation with their babies. The study concluded that "the high rates of withdrawal for opioid-addicted pregnant inmates and the high rates of shackling and lack of healthful food options" (Kelsey, et al, 2017, p. 1265) show only "some examples of lack of adherence to the standards of care of pregnant incarcerated women" (p. 1265).

Some women who give birth while incarcerated are separated from their babies almost immediately (Chang & Sufrin, 2019; Kelsey, et al, 2017). A person entering prison already has possible mental health issues to deal with: psychosocial distress, trauma from sexual/ physical abuse, substance abuse, and more (Ferszt & Erickson-Owens, 2008). Then there is the stressful addition of being pregnant when entering prison— a place that was originally established to contain men. Women have to try and survive conditions such as over-"crowding, monotony, lack of privacy, loss of freedom, absence of personal goods/services, isolation from family and friends, and concerns about safety" (Ferszt & Erickson-Owens, 2008 p. 5). The only constant is their pregnancy. But then there is the traumatic experience of giving birth, just to have the baby taken away immediately in most cases. Pregnant women in correctional facilities are faced with surviving on their own when facilities do not follow standards of care for physical and mental health. There are many things that cannot be changed in this situation. A woman who is incarcerated while pregnant will most likely give birth while incarcerated (Fritz & Whiteacre, 2016). However, there are programs to help mother and baby, so they do not need to feel that they are surviving alone.

Programs Being Implemented in Prison. There are programs that are implemented within some prisons to help pregnant women navigate their pregnancy journey: doula birth-support, women and infants at risk, camp share, the Titus 2 birthing program, and mothers and infants nurturing together (Hotelling, 2008). Although there are some programs that help women who are pregnant while incarcerated live through this life-changing journey, there is little education and psychosocial support and much more that needs to be done (Ferszt & Clarke, 2012). A study done by Judith Merenda Wismont (2000) states that there are four themes that pregnant women in prison relate to: apprehension, grief, subjugation, and relatedness. This

relatedness comes from the specific program that was put into place. However, if the policies and procedures were to be looked at and changed, the other themes might change as well. Many of the programs that are in effect in prisons depend strictly on volunteers, grants, community, medical and religious organizations, and university programs. The standards of care need to be improved to make sure every prison is required to have programs in place for pregnant women. Until that happens, an important lesson that Ferszt and Erickson-Owens (2008) learned throughout this process was the need to form relationships with the individuals on the "inside"—not the women with whom one is serving, but the correctional facility members like the warden, nurses, physicians, correctional officers, and counselors. They are the individuals who can help out—especially pregnant women—when their needs are not being met.

Unfortunately, programs that are specifically designed to help women who are pregnant deal with the psychological problems that they might experience during this journey are absent (Ferszt & Erickson-Owens, 2008). Ferszt and Erickson-Owens (2008) created a pilot group of nine women conducted in a Northeast women's state correctional facility. When creating this group, the members came up with topics they wanted to discuss: labor and delivery process, fetal development, the effects of drugs and alcohol on the baby, procedures the prison has on transportation to the hospital, and dealing with separation of baby and mother. The group quickly became a safe place for the women to have their questions answered and where they could share any fear/frustrations along with the positives of their pregnancy. With the inconsistency of correctional institutions, the group dynamic was always changing. However, by the end of the pilot study, women described the group as being supportive, giving them the chance to feel less alone, allowing them to ask questions and receive education. These women said that they were better prepared for delivery because of the breathing and relaxation techniques that were taught.

They learned that they could advocate for themselves when feeling physical discomfort and learned strategies that could help with the sadness of leaving their babies. The group continued for 22 months because of the positive response. Within this period, the creators of the pilot study added maternal/child health nurses, and a goal is to add a doula in the future.

This specific program was for women who were pregnant. At times, women who were postpartum would come to group. Sometimes they would come for a few sessions after giving birth because of the bond they had built, but some would only come once after. They could not stand the loss of their baby while being around others who still had theirs. Although counseling programs are being set up to help postpartum women deal with the trauma of separation from their infants, what if women did not need to have this form of loss?

Nurseries. Many women have symptoms of grief and experience profound amounts of loss after delivering their babies (Ferszt & Clarke, 2012). Incarcerated women will miss a critical time in their baby's life, a critical time when they can bond with their baby. A term that comes as a surprise to many people is *nurseries in prisons.* This term has been around since 1901 (Fritz & Whiteacre, 2016). Most prisons within the United States do not have this as an option. Ferszt and Clarke (2012) found there were only nine states that had facilities that allowed mothers to have their babies with them until the age of 12-24 months. Ferszt and Clarte underlined the importance of bonding: "A healthy birth outcome and the parenting ability of the mother are essential to the well-being of the child and to the reintegration of the mother back into society" (p. 2).

Prisons are about rehabilitation. They are facilities to help people who have committed a crime to rehabilitate for the day they are able to enter back into society, so they do not commit a crime again. Having a place where the baby is not just ripped away from their mother after she

has given birth could help in the rehabilitation. There are three benefits to nurseries in prisons: they can increase the attachment between mom and baby, improve parenting efficacy, and reduce recidivism rates (Fritz & Whiteacre, 2016). In England, if mothers expect to give birth while in prison or have a baby who is 18 months or younger, they are able to apply to be placed in a mother-and-baby unit (MBU) (Dolan, Hann, Edge, & Shaw, 2019). Nurseries offer a time where bonding can occur. This gives the mother time to see herself as a mom and provide care for her baby in a healthy way. There are also findings that say this improves a mother's confidence in parenting, her knowledge, and parenting efficacy (Fritz & Whiteacre, 2016). Having mother spend time with baby is not just a time where mom can benefit, though. Babies also suffer when they are taken away from their mothers so early. Children who have been in prison nurseries are more likely to be securely attached; they have lower incidences of depression and lower anxiety rates (2016). The overall atmosphere of nurseries in prison is also said to be more desirable than other prison environments. However, they are still criticized for having inadequate facilities and medical care. They are said to be overcrowded; they lack clean water; and have low amounts of nutritious foods (Ferszt & Clarke, 2012). It is also said the mother possibly has stress due to the staff's lack in adequate training, limited access/contact with family, and the lack of stimulation for babies (2012). This leads to the question, "Is allowing time for bonding important for both mom and baby?"

Connections Being Made

Redshaw and Martin (2013) discuss when building connections are important: "What goes on between parents and babies during pregnancy is important and what goes on in delivery rooms and the early days at home is important too" (p. 219). The important part is what forms between the two whether this is during pregnancy or after delivery. The words that describe the

thing that happens between the two (mother and baby), although similar, are different and have different connotations. For the purpose of this thesis, the terms *attachment, bonding,* and *attunement* will be addressed. When discussing how DMT can provide help, I will look closely at *bonding* and *attunement*. I believe that attachment is extremely important and can affect one's life when they do not feel *secure*. There are 4 main forms of attachment. These are formed after a child is born. Given that most incarceration facilities do not provide nurseries, the attachment the child makes is out of the hands of incarcerated mothers.

Attachment. John Bowlby was one of the first psychologists who studied attachment patterns, and he argued that every behavior created by a baby has a single goal in mind, although they do not know that goal (Frick-Horbury, 2019; Rieser-Danner & Slaughter, 2019). They all want to be in close contact with their mothers/caregivers due to needs for survival: food, shelter, and protection (Rieser-Danner & Slaughter, 2019). The attachment style the baby forms early on will affect them throughout their whole life. Attachment theory relates to the relationship that grows from the baby and parent/caregiver. It is how the parent responds to the child: if they are able to make them feel safe, secure, and protected (Frick-Horbury, 2019; Redshaw & Martin, 2013). If the mother/caregiver is able to make them feel safe, secure, and protected, the baby will have a stronger desire to maintain close contact with them (Rieser-Danner & Slaughter, 2019). There are four types of attachment the baby can form: secure, insecure-avoidant, insecure-resistant, and insecure-disorganized. The baby's attachment can be assessed by their first birthday and only starts after the baby is born. If they are unable to feel safe and secure, emotional and social behavioral problems can occur (Redshaw & Martine, 2013).

Maternal-fetal attachment is a term coined to describe the attachment that is forming while the baby is still in the mother's womb. This reflects the attitudes, projections, and

emotional responses the mother has to the pregnancy itself and to her baby. Research has been done to determine the attachment level during this period. There are scales such as the Maternal Foetal Attachment Scale, Maternal Antenatal Attachment Scale, and the Prenatal Attachment Inventory (Redshaw & Martin, 2013). Maternal-fetal attachment is important because "it seems intuitively likely that the feelings parents have during pregnancy about their baby are likely to be associated with later parental and infant behavior" (p. 221).

Bonding. The mom and baby are one, a unit. Bonding with baby can occur right away, though it may take time to form this bond. The term bond can be used in many ways. However, in terms of bonds with people, it is an emotional tie (Rieser-Danner & Slaughter, 2019). This is the connection that a mother makes after delivery. Oxytocin is a hormonal chemical that is released in the body during pregnancy and labor. This hormone is known for assisting in the bonding process (2019). Bonding in a way is similar to the maternal-fetal attachment because they both happen during pregnancy and can allow for an easier transition from pregnancy to motherhood. Some believe that bonding happens right after the baby is born, saying the biologically-based emotional response that occurs when mom holds baby for the first time is the bonding, and this can not happen during pregnancy. Others think that the initial hours after the baby is born seem to be the most important since there are prolonged times of alertness (Redshaw & Martin, 2013). However, it then becomes even more important for mother to form this bond if she is in a facility that does not allow visitation with baby or has a nursery. If mother is not allowed to see her baby after giving birth, the bond she formed while pregnant can help aid in the grieving process. The term *bonding* at times can cause parental anxiety around worrying if mother has done *enough* to create the bond during pregnancy and the first time they are face-to-face with their baby (2013).

As one can see, there are many different opinions about the term *bonding*: what it is, what is looks like, and when it happens. I believe that bonding can occur as soon as a woman finds out she is pregnant. She is coming to learn about her new, growing body and her baby to come. "The way in which 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" (Cortizo, 2019, pg. 208). This bonding does not just occur with the growing baby. I believe this bonding needs to occur within the pregnant woman. Since this change is happening inside of her, it is important that she feels *one* with herself. Feeling this *oneness* through bonding offers a sense of control.

In family therapy, there is a model called the calming womb. This model focuses on the bond and attachment between mother and baby during pregnancy up until a year after delivery (Cortizo, 2019). There are many ways in which a mother can bond with her baby in order to feel less anxious: talk to the baby frequently, engage the baby in the activities she is doing, interact with the baby (read, sing, dance), experience mindfulness, use/receive words of love, let the baby feel wanted/released from responsibility, participate in forms of movement (yoga/Tai-Chi), experience fun, engage in a meditative *peace* state with the baby, and acknowledge the baby at birth (2019).

Although doing any one of those activities will help a mother bond with baby the way mother feels about herself will greatly impact the bonding. The calming womb model also has a list of activities a mother could practice, such as working with professionals who specialize in pregnancy to help with overall health, monitoring self-talk and practicing gratitude and groundedness, understanding and repairing her own attachment, and using play and humor (Cortizo, 2019). Allowing and helping mothers to participate in these activities starts the *dancing dialogue*, a term coined by Suzi Tortora (Hopkins, 2015), between mother and baby: the

bonding. This dialogue is an attentive, reflective, and connected interaction between the *unit* (2014).

Attunement. The dialogue discussed above concerns the mother and baby becoming a unit. This is the result of attunement. Attunement is a form of non-verbal communication that comes from being aware and responsive to another being, in this case the baby. Attunement to others helps build and maintain relationships (Stern, 2009). Early attunement with the fetus can help provide a solid basis for empathic understanding (Loman, 2016). For the purpose of this thesis, I will focus on attunement during infancy. Ways for a mother to have attunement with her baby involve meeting the baby's basic needs: body, safety, security, love, and affection.

The mother's attachment plays a big role in whether she is able to have attunement with her baby. Wendy Haft and Arietta Slade (1989), found that mothers who were securely attached were more attuned to their babies and those who were insecure were not attuned to all aspects of their babies, and rather mis-attuned to them.

Dance Movement Therapy During Pregnancy

Welling (2014) explains that "Dance/movement therapy (DMT) is defined by the American Dance Therapy Association (ADTA) as the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual, for the purpose of improving health and well-being" (para 1). DMT is based on the premise that "changes in the body reflect changes in the mind" (2014, para. 2). Erica Hornthal (2019) states that dance can help symptoms of depression and anxiety. When dealing with pregnancy, the mother's experience is bodily-based. Dance helps mothers be present with their mind-body connection and mood/behavior changes during this journey (2019). Nonverbal/movement communication begins before we even remember: in utero. This communication does not stop

there; it continues to grow throughout one's life. As one becomes older, verbal communication becomes stronger because that is the form of communication that is relied on the most. DMT helps people focus back on the instinctive form of non-verbal/movement communication that was used before they were even born. Although DMT uses the body in non-verbal communicative ways, it can also incorporate verbal ways to help individuals feel an interconnectedness between mind and body. The mix between verbal and non-verbal techniques makes DMT a great tool to use while helping a pregnant woman form a bond/attunement with her baby.

In the early 1970s, Judith S. Kestenberg founded the Prenatal Project, along with her colleagues. This organization focuses on helping mothers and nurses to become aware of the movement preferences of the baby both during utero and after the baby is born. The idea of this organization is that if the mother could learn her baby's movement preferences during pregnancy, she would already be beginning the process of attunement (Loman, 2016; Johnson, 2018). This helps the mother learn about her baby, which starts the mother-child bonding. The Kestenberg Movement Profile (KMP) is an assessment tool that is used to help mother learn these preferences (Koch & Rautner, 2017; Loman, 1998; Loman & Foley, 1996; The KMP in dance movement therapy, n.d.). There are 10 movement rhythms that fall under the tension-flow system and two different categories that separate the movement rhythms: *indulging* and *fighting*. Other words that are sometimes used are *libidinal* and *separating* (Koch & Rautner, 2017). These developmental rhythms express the needs and drives of individuals in a nonverbal manner that follows us throughout life and is unique to each personal personality.

Tension-flow rhythms. There are five indulging rhythms and five fighting rhythms as shown in figure 1 (Koch & Rautner, 2017). Each developmental stage begins with an indulging

rhythm that is smooth, ends with a fighting rhythm that indicates a wish for separation, and transitions into the next stage (Koch & Rautner, 2017). Although these rhythms follow a developmental pattern, they have the potential be to accessed during utero and present during birth (Loman, 1998). However, the specific rhythm comes to the front during the specific developmental state, with the oral stage occurring throughout the first year of life. The first of the rhythms is *sucking*. This first indulging rhythm is known for self-soothing. The opposite side of that is the first fighting rhythm, *biting*. This rhythm is for separation, focusing, or concentration (Koch & Rautner, 2017; Loman, 1998). The next stage is called the anal stage, which consists of *twisting* being indulging and *straining-releasing* being fighting. The following stage is urethral, consisting of *running/drifting* being indulging and *starting* and *stopping* being fighting. The next stage is known as the innergenital stage, consisting of *swaying* being indulging and *birthing/surging* being fighting. Lastly is the outergenital stage, which wraps up the ninth and tenth movement rhythm: *jumping* being indulging and *spurting/ramming* being fighting (Loman, 1998; Loman, 2016; Koch & Rautner, 2017).

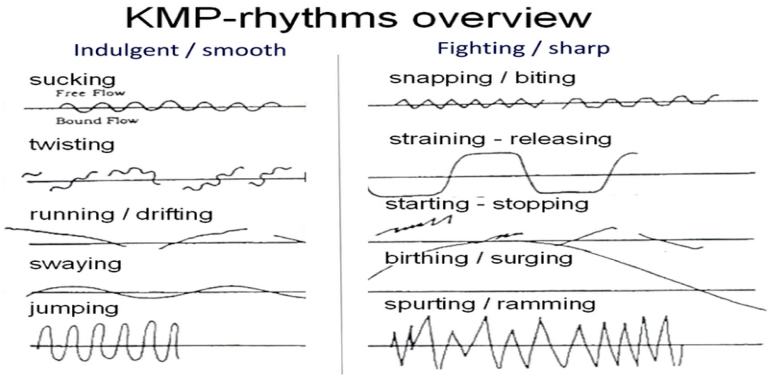

Figure 1, KMP tension-flow rhythms

The reason why KMP is used for the bonding/attunement process during pregnancy is that "attunement, through sharing muscle tension rhythms, produces feelings of mutuality and responsiveness to needs and feelings, as expressed through muscular tension-flow" (Loman,

2016, para 3). It is important to remember that, although the oral stage happens first developmentally, during the period in utero all rhythms can be accessed. Since the mothers were not certified in using the assessment tool, and they were using it during pregnancy, the assessment tool was adjusted to focus on their baby's specific movements. Although these movements could easily be identified with specific KMP tension-flow rhythm words, that was not the important aspect of this process. Instead, mothers were taught how attune to their baby's movements; bubbles, flutters, twisting, kicks, and pressing/pushing (Loman, 2016). They were also taught how to notate these movements shown below in figure 2 (2016). All of the movements can be notated with being free flow or bound flow shown below in figure 3 (2016). Above the neutral line is free flow, such as fluttering, floating, and guiding. Below the neutral line is bound flow, such as pressing, wringing, and holding (2016). When the notation is close to the neutral line, there is a low intensity, and when it is further away, there is a higher intensity.

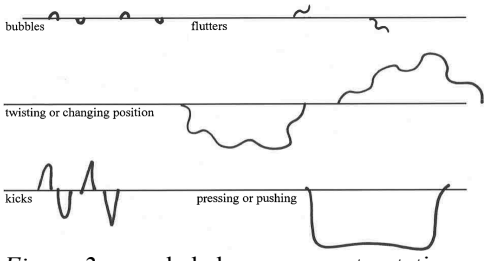

Figure 2, sample baby movement notation

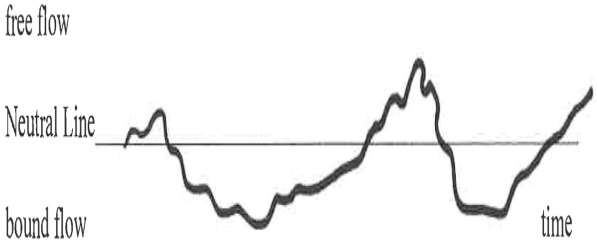

Figure 3, intensity of baby movement

For the purpose of helping mothers gain the ability to bond and have attunement during pregnancy. Loman (2016) states that Kestenberg requested the mothers to keep a journal. In this journal are their notations of the movements they feel within their body from their babies and any feelings the mother is having, such as physical symptoms, thoughts, and emotions. Another reason for the notations is to start building empathy with their baby. Once they have learned to pay attention to their baby's movements and are able to notate, the next step is to reciprocate these movements. This is something challenging at times because one is learning by just their

sense of touch; a type of learning western culture is not use to. A way to help learn through the felt experience is to simulate different tension-flow rhythms on the mother's back and have her notate them. After awhile woman are able to first reciprocate them on their own hands but then also back to their baby on their bellies when they feel their movement. This relationship that the mother is building allows for "the safety for trust to flourish and for creativity, spontaneity and dynamics to be contained with the consistent structure" (Loman, 1998, p. 114).

Although the mother might just now be feeling her baby, the baby has been moving all along. Having this duplication of the baby's movements back on the belly can start the non-verbal communication and help form the bond and attunement between mother and baby. The mother is able to start learning her who baby is before she even meets her or him. Once the baby is born, the mother is more prepared for the baby's movement preferences and the baby is already familiar with their mother. The mother is more ready to respond to the needs of the baby, which helps in growing the ability for the baby to feel safe and secure.

Making space with KMP. During pregnancy, a woman's body is completely changing. It is adjusting and taking over areas in the body that it needs for the baby. Women do not get a say in this change. It is as if it is happening to them. However, through the use of DMT and KMP, Kestenberg was able to help woman feel they have control in a matter where they have no control. Kestenberg used Shape-Flow Rhythms from KMP. The shape-flow rhythms focus on growing and shrinking (Koch & Rautner, 2017; Loman and Foley, 1996). There are two forms of shape-flow: bipolar and unipolar. Bipolar shape-flow is symmetrical in its growing and shrinking towards its environment by expressing its emotional response (comfort/discomfort). With unipolar shape-flow, there is an asymmetrical growing and shrinking with the attraction or repulsion of stimulus because of reflexive behavior (Chaiklin & Wengrower, 2016; Loman &

Foley, 1996). Koch and Rautner (2017) gives an example of a baby leaning towards their mother's breast when hungry (growing) and leaning away from mother's breast when non-hungry (shrinking) for bipolar shape-flow. If the mother is attuned with her baby, she should be able to read these nonverbal cues. As stated above, the use of tension-flow rhythms during pregnancy can help start the development of attunement in utero so there is a bond when baby is born.

However, for the purpose of using shape-flow rhythms during pregnancy, Kestenberg put the focus on growing; more specifically *giving room to the baby*. During pregnancy, as early as the first trimester, the mother wants to strengthen and firm her pelvic floor as well as pull her lower abdominals up. Mothers can practice *lengthening* and stretching *upwards* and *downwards* from the middle of their bodies. Mothers can also engage in exercises that create *widening* and *bulging*. It is said that doing these exercises with the image of *giving the baby room* helps promote relaxation and comfort for mother (Loman, 2016). Mothers are also taught to feel grounded and continue to feel this all the way to the baby to help support her belly and let the baby feel grounded as well. All of this helps support the pelvic floor and abdominal muscles, as well as relieve physical symptoms such as back or bladder pain. Women can be taught to breathe into the areas of pain (Loman, 2016). This will allow images of growing, which allows room for the baby to grow.

All of these exercises are taught to help the mother feel control over her body. They are used to help mother see she has an active role in *making* and *giving room* to her baby. Throughout this process it is important to think that she has an active role in holding her baby up and not being pulled down (Loman, 2016). These exercises can also be expressed in the mother's journal along with any feelings she has towards them. The soothing, holding, and support of

every exercise through the space-flow rhythms allow mothers to let go and gain confidence (2016). This is an important part of the process because the *calming womb* from family therapy discusses the importance and most effective way of taking care of the baby during pregnancy and stresses that mothers need to take care of themselves (Cortizo, 2019).

Bringing this all together, unipolar shape-flow can occur in utero (Loman & Foley, 1996). This is important to note because if the mother is able to attune to her baby's tension-flow rhythms, as well as what is happening in her environment during those rhythms, she can begin to attune with what stimuli baby grows with. Attuning to this information during utero can aid in the bonding of mother and baby after she/he is born. The mother will know what stimuli the baby enjoys, which will help the baby feel safe and secure.

Frick-Horbury (2019) state the "Mother-child relationships begin as an interactive dance in which each party responds to the other with a set of behaviors meant to result in a synchronized pattern of love" (para. 2). A program that begins this interactive dance early on is the Awareness of Body and Child program (A-B-C), founded by Suzi Tottora. The A-B-C program believes that motherhood does not begin once one gives birth, but rather while one is still pregnant. The goal of this program is to support the bonding process of mother and baby (Dancing Dialogue Licensed Creative Arts Therapy Licensed Mental Health Counseling PLLC, n.d.). The Dancing Dialogue integrates emotional and physical aspects by incorporating dance, exercise, and movement meditation and relaxation. These techniques are used to always maintain the mother's overall physical condition throughout her pregnancy. They focus on reducing stress and increasing balance, coordination, and mobility. Lastly, A-B-C helps the mother increase her awareness of her pregnancy, which allows her to develop a deeper bond. A-B-C helps the mother use this formed bond to create personal mother-baby improvisational dances (n.d.).

Dance Movement Therapy with Mother and Baby

Frances Doonan and Iris Bräuninger (2015) developed a study on enhancing the mother-infant attachment and experience through dance movement therapy. They created sessions including basic dance movement therapy techniques such as opening and closing rituals, sitting in circles, warming up the body (check-in with body), mirroring, and music. They found that mothers who participated believe that social interaction, mother-baby interaction, bonding, opportunity for attunement, and fun were supported by the dance movement therapy sessions. A variety of babies participated with their mothers. Doonan and Bräuninger (2015) saw that there was a trend in age and development.. To build trust and have increased eye contact they used techniques such as rocking, rolling, and twisting for babies age 0 to 6 months. With ages 8-9 months they engaged in mirroring and allowing babies to *move with* their mothers rather then being *moved by* their mothers. This showed there was in increase in attunement and autonomy between mother and baby by increasing the trust and security within the relationship through the dance movement therapy sessions. With ages 10-16 months, bonding was formed by baby's being able to leave mom but being able to come back to the safe and secure environment of the mother-infant dyad. The overall conclusion showed that dance movement therapy can enhance mother-infant attachment and experience in a number of different ways (Doonan & Bräuninger, 2015).

Doonan & Bräuninger (2015) also recorded that on the mother's end, there was an increase in positive affect and a decrease in their negative affect. This positive affect can be presumed to show that the mothers were less stressed. When a parent is stressed, their abilities to engage in attunement are decreased (Weissberg, 2017). This decreased ability can result in a number of issues for the parent child relationship as well as insecure attachment (2017). Hornthal

(2019) state that dance can help in fluctuations of stress that are brought on by hormonal changes during pregnancy.

Hadas Vered Weissberg (2017) used the Dyad Bonding Dance (DBD) to help improve nonverbal communication skills for mothers who have been exposed to stressful life events. This technique of dance movement therapy was created to help mothers create a better bond and attunement with their babies. The goal is to reduce the stress that is transmitted by the mother to the baby and allow a place for the mother to have support from peers to share thoughts and feelings. DBD incorporates group psychotherapy to help decrease the sense of isolation and increase the mother's sense of worth. One hopes that it will enable mothers to make positive changes in their lives, which will effect change in their baby's lives. DMT techniques such as mirroring are also used to strengthen empathy between mother and baby and improve nonverbal communication, which can be translated into interactions with their babies. Improving the mother's nonverbal communication skills is hoped to be the key to limiting further trauma and stress passed on to the baby.

Discussion

During pregnancy, a woman's life is in constant change. At times she may feel completely out of control; everything she thought she knew is different. It is important for women to feel in control and empowered during this life-changing, sometimes traumatic experience. There are many programs that help women feel strong and allow them to have the pregnancy they want and deserve their way. Pregnant women in prison, however, are still being forgotten. Although there is a standard of care for pregnant women, their emotional, physical, and mental needs are still not being served, and they do not have the control and empowerment they need and deserve. As previously discussed, most women who are incarcerated do not have

access to their babies after delivery. The bonding and attunement process for mother and baby must occur while the woman is still pregnant. Anxiety and stress during pregnancy do not just affect the woman; they can transfer to their baby and cause future emotional and behavioral problems (Dolan, Hann, Edge, & Shaw, 2019). The process of connecting with baby may alleviate that anxiety and stress. However, it is important to keep the programs that are already established in prisons because in most cases, counseling programs which deal specifically with psychological problem that pregnant women deal with, are absent (Ferszt &Erikson-Owens, 2008). These programs are being seen through the lens of pregnant women, not just inmates. This is important because the emotional, physical, and mental needs of pregnant and non-pregnant inmates are extremely different. However, since most of the programs are volunteer/grant based, there is no guarantee that they will continue open-ended (Hoteling, 2008).

Through my research, I discovered many things: the first being the extreme importance of bonding and attunement of mother and baby while the mother is still pregnant. This process allows for a deeper connection and involvement during the pregnancy. Involving DMT techniques to help the bonding and attunement process allows for women to have control in their journey. Specifically using KMP techniques such as *tension-flow rhythm.* This tool should be incorporated in the everyday life of women who are pregnant for many reasons. It gives women permission to take the time to start focusing on their pregnancy. It starts to create a bond, which might not have been there otherwise. This bond helps the women become closer to her baby. The reason why this tool should be incorporated for pregnant women in prisons specifically is because this starts to become a therapeutic process for mother. She is spending more time attuning to the movements happening within her. She may start to feel she received more time to spend with her baby. This may be because she spent the time attuning and learning about her

baby during pregnancy. After she gives birth, it may not feel like they are meeting for the first time because mother recognized the babies natural rhythms.

The second item that I was pleased to find was the number of DMT programs and techniques that are available to help women bond and attain attunement through pregnancy. These programs can start while individuals are pregnant and continue through the birthing process. The literature gave prime examples of ways to engage in this connection through learning baby's movements and replaying them for baby and engaging in mediation/relaxation. The third topic of importance is the mental health of the mother. Although the connection with the baby during pregnancy is important for future mother/baby bonding and attunement, mental stability opens the space for mother to be able to forge this connection. With unresolved trauma, this stress can have a direct impact on the baby. The literature gave examples such as mirroring and psychotherapy groups as interventions. But before any programs or interventions can be initiated, changes need to be made within the prison system. Without serious changes, the bonding and attunement process will suffer. Often, women hold onto stress throughout their pregnancies. The subsequent lack of desire to bond with their baby is due to their knowledge that they will not see their babies after they give birth.

The lack of desire could be changed with access to nurseries for every mother. Other changes that prisons could implement are regular doctor visits and having private births with loved ones present. By making these important changes, along with incorporating DMT into the daily lives of incarcerated pregnant women, prisons will positively impact the lives of both the women and their wonderful babies. This topic is important because all women deserve control in their lives during a period of time that they do not have control over. In the future I hope to continue this research. I will expand it to examine how DMT can also help during the birthing

process. I hope that by that time, changes will have been made to better serve these women. However, if they have not, I am ready for the challenge to help make the change. Women who are pregnant while incarcerated deserve the right to have a mentally and physically healthy birth journey.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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