

# **Health Consequences of Abuse in the Family: A Clinical Guide for Evidence-Based Practice**

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## **Chapter 11: Effects of Childhood Abuse on Childbearing and Perinatal Health By Deborah Issokson, Psy.D.**

### **Introduction**

The process of bearing a child, from conception and confirmed pregnancy to labor and delivery, and from the birth of the baby through the postpartum period, is one of enormous growth, change, challenge, and stress. It is a normative developmental life crisis that affects the physical, emotional, sexual, spiritual, relational and social realms of a woman's life. Vulnerability is inherent in such a transformation. For an abuse survivor, this vulnerability includes the possibility that memories of her abuse will be triggered by all of the concomitant physical changes, social and psychological tasks, medical procedures, and rituals of childbearing. For some women, the memories and their accompanying emotions will be familiar and will have been expected; other women may experience the intrusion of these memories as regressive in their healing process. For still other women, the memories and emotions, arising from what is perceived by many to be a joyous time in life, will be an unexpected and unfamiliar intrusion and may signal the first time such memories are coming to the surface. For these women, their childbearing time may be the life event that begins their acknowledgement of their abuse history and thus, the beginning of their healing process.

As a mental health provider, it is probable that you will encounter a client who is both a survivor of abuse and is childbearing. She may be pregnant or trying to conceive, she may have just experienced an unexpected pregnancy loss or is deciding whether to maintain or terminate a pregnancy or she may be a new mother disappointed with her birth experience or feeling challenged by breastfeeding and early mothering. If this woman is an acknowledged abuse survivor who has been involved in an active healing process, your task as the provider will be threefold: help her maintain her current level of functioning, help her contain the memories, facilitate further healing using the context of childbearing as the vehicle for growth. If this client is not aware of her abuse history, you may be in the position of suspecting an abuse

history or helping her explore her own inklings about an abuse history based on the feelings, concerns, fears and distress that she is experiencing and you are observing during her process of childbearing. It is important to note that obvious suspicion of an abuse history cannot be ignored, nor can a woman's intuition about her own history be ignored. However, the Pandora's box of sexual abuse memories must be opened delicately during the childbearing time. Ideally, pregnancy is a time of containment as a woman grows a baby inside her body and prepares psychologically and spiritually for motherhood. Though we have no control over what lessons a woman will learn during her childbearing experience, we can facilitate a gentle, well-paced, appropriate exploration of issues and history. With all childbearing clients, the ultimate goal is to aid the woman in having a childbearing experience that has a positive emotional outcome accompanied by a healthy psychological adjustment to motherhood.

This chapter will address the tasks at hand for you, the mental health provider working with abuse survivors who are bearing children. It will also highlight signals to look for during the childbearing time that might indicate that a woman is an abuse survivor. The chapter is broken down into seven sections, the first five addressing phases of childbearing: 1) pregnancy, 2) labor and delivery, 3) postpartum, 4) breastfeeding, 5) infertility and pregnancy loss. The sixth section will address ways in which mental health providers can work collaboratively with other perinatal care providers and educators. The final section will discuss resources available to the clinician as well as the client.

### **Pregnancy**

From the moment a pregnancy is confirmed, a woman begins to create fantasies and images of her baby and of herself as a mother. She tries to imagine her new life and the accompanying joys, responsibilities, and anxieties. Ambivalence is inherent, as it is in any undertaking of this magnitude, regardless of how planned and wanted the baby is. What follows is a description of the ways in which a woman who is an abuse survivor may experience the physical, medical, psychological, and social aspects of pregnancy. Keep in mind that this is a generalization. Not all survivors will have the same experience of pregnancy and not all women experiencing these difficulties in pregnancy are abuse survivors. However, if your client is exhibiting the difficulties being described, you may gently explore with her the meaning she ascribes to these difficulties and what she thinks she may be learning about herself from these difficulties.

Integrated into this description will be suggestions for ways in which you, as a mental health provider, can intervene to support the woman, helping her to maintain a healthy level of functioning, helping her contain her memories, and facilitating further healing in the context of her pregnancy.

### **Physical experience of pregnancy**

The physical experience of pregnancy can be one of mystery and fascination as well as one of discomfort and sickness. Nausea, vomiting, sore breasts, and weight gain that often accompany early pregnancy can cause an abuse survivor to feel out of control in her body very early on. Later in pregnancy, fetal movement can be experienced as intrusive. This lack of control and feeling of intrusion can be reminiscent of sexual abuse and trigger memories. A woman may cope with these physical challenges of pregnancy by becoming hypervigilant about her body changes and pregnancy symptoms. This hypervigilance and its accompanying anxiety can result in a worsening of the symptoms and may then cause her to contact her midwife or obstetrician multiple times between appointments, thus straining her relationship with her care providers. She may restrict her diet in order to avoid weight gain; this could result in the baby not growing properly. She may dissociate from the growing baby and not allow herself to bond with the baby, experiencing it as an intruder and the culprit in her pain and discomfort. She may reject her bodily changes because they are evidence of her sexuality.

In response to your client's challenges with the physical aspects of pregnancy, there are several interventions that will be therapeutic and healing. First, review coping strategies she has employed in the past when issues from her abuse have been triggered. This is not the time to abandon tried and true coping mechanisms. Rather, this is a time to be aware of potential triggers, increase self-care, and keep on track with the coping and healing process. This is a time to garner extra support from a therapist, a partner, friends, a support network and healthcare providers. (This will be true for all phases of childbearing and will be referred to in subsequent sections of this chapter.) Second, you can help your client stay grounded by contextualizing her physical changes and discomforts. Have her bring in a book on pregnancy and review with her the real and appropriate changes happening in her body, reflecting on the health, resilience,

and brilliance of her body in adjusting and adapting to the growing baby inside her. Suggest that her body knows exactly what to do to grow this baby and that she can be proud, increasing her respect for her body. Continue to reinforce this belief throughout her pregnancy. Pregnancy can be a time of enormous healing in terms of a woman reclaiming the health, strength, and wisdom of her body. You might suggest she create a ritual to honor her body as it holds life. Third, you can help her pace herself with regard to adjusting to the changes as they happen in her body. Help her anticipate the changes, strategize for coping with the changes, and normalize the changes. Yoga, swimming and massage as well as any other form of exercise that the woman likes can facilitate the woman's feeling more at home in her body and accepting of the physical changes happening in her body. Visualization, meditation and deep relaxation with the assistance of relaxation tapes or guided light hypnosis may be helpful in reinforcing in her mind the health of her body, her new awareness of her body, and may quell the hypervigilance and stimulation that triggers memories of the abuse.

### **Choosing a perinatal healthcare provider**

In order to ensure the health and well being of mother and baby, your client will choose a care provider to follow her throughout the pregnancy and to attend her birth. She may choose a midwife, an obstetrician or a family practitioner. She may choose to birth at home, at a birth center, or in a hospital. Her choice of provider and the manner in which she makes her choice may be affected by her history of abuse and by the gender of her abuser. She may purposely choose a provider and a place of birth that could facilitate a healing experience for her. On the other hand, she may unconsciously recreate the dynamics she experienced with her abuser. You can be instrumental in helping her explore her choices and the factors she is weighing in her decision-making. Keep in mind that it is not uncommon for a woman to change providers in the midst of a pregnancy. This may be a sign of healing as she makes a more appropriate choice for herself following exploration, insight and a sense of empowerment or entitlement.

I encourage clients to inform their caregivers of their abuse history. While it is not necessary to tell the entire story, it can be helpful for a provider to have a general sense of the history so that she or he can be sensitized to the client's issues as they pertain to prenatal care, labor and delivery, and postpartum care. It is important to know that your client may be dealing with a group practice of providers rather than a

single caregiver. This means that she may see a variety of providers over the course of her pregnancy. This also means that the provider attending her birth may be someone she has never met. If she is working with a group practice, she may not want to repeat her story over and over for each provider she encounters. In this case, I advise clients to tell one provider with whom they feel the most comfortable and then ask that a brief note be put in their chart in order to inform the other providers. A woman can even write a brief statement herself, which can be put in her medical chart. It may also be advisable that you speak with her healthcare provider during her pregnancy in order to sensitize her or him to the special needs of this woman given her history.

As mentioned earlier, the dynamics between the woman and her provider can either be healing and empowering or repetitive of the abuse. For example, a woman may choose a female provider in hopes that she will have a nurturing experience. She may project fantasies of the all-loving, all-knowing, available, protective mother onto this care provider. She may be fortunate to have a wonderfully healing experience with the provider. However, as a result of projections and unrealistic expectations, this pairing could trigger disappointment, anger, and a sense of betrayal as the woman remembers her mother who did not adequately protect her during her childhood. If a woman chooses a male provider, it may be in the hopes of finding a loving, nurturing father figure. However, she may soon find herself in the throes of a power differential reminiscent of the abusive relationship. As the therapist, it is helpful to periodically check in with your client about her relationship with her perinatal care provider. How is she feeling about the relationship? Does she feel respected, heard, and validated? Does she feel safe? Does she have a voice in the relationship? Does she feel there is partnership between herself and the provider in the care of her pregnancy and preparation for birth? Does she doubt her choice? Is she afraid to leave the practice in search of a more appropriate match? You can be instrumental in facilitating her empowerment as she navigates the healthcare system, all the time encouraging her to trust her instincts as she makes her decisions regarding providers. Given the vulnerability inherent in the childbearing process, and given the vulnerability inherent in the power differential in most provider-patient relationships, establishing a safe, supportive partnership with open communication is crucial for the pregnant abuse survivor.

### **Choosing a place to birth**

Your client's choice for place of birth may have a connection to her abuse history. A woman may choose a homebirth with a midwife, feeling most safe and comfortable in her own environment surrounded by family or friends. She may feel that this is the place in which she can have the most control, the place where she can have her voice and best protect herself and her baby. This woman may feel strongly about not having any medical interventions, wanting to be present physically and emotionally for the entire labor and birth experience. She may perceive that there will be pressure in a medical setting to have drugs for the pain. The choice of a homebirth will ensure the same provider will be with her for the entire experience, from the beginning of prenatal care through the postpartum period. This continuity of care may feel essential for this woman. On the other end of the continuum is the woman who chooses a hospital birth with a medical doctor. She may perceive this to be the best way for her to take care of herself and her baby, she may feel more comfortable in a more passive role by deferring to her doctor, feeling protected by the authority of the hospital. She may feel strongly that it will be healing for her to use drugs for the pain, thus choosing, perhaps for the first time, to say "no" to physical pain. While all of the above issues can be universal to any pregnant woman deciding where to birth her baby, you can explore these issues in the context of your client's abuse history. In the next section of this chapter, we will look more closely at the process of labor and birth for the woman who is an abuse survivor.

### **Prenatal medical procedures**

For some women, the relationships with the provider will be the trigger for dynamics and memories connected to her abuse history. For other women, the actual medical procedures that are standard during prenatal care may be cause for anxiety, may trigger memories, or may be experienced as intolerable or intrusive. Pelvic exams, blood pressure checks and blood draws are the most typical of procedures that cause angst. Some women experience ultrasound as intrusive. Working with your client on anticipating the procedures, employing relaxation and desensitization techniques, and having your client communicate with her provider can help to make these procedures less traumatic. If the provider knows of the woman's history, then she or he has a context for the patient's fears and anxieties. This shared knowledge can

facilitate a more effective working relationship. You can help your client rehearse good communication so that she is prepared to negotiate the ways in which the difficult medical procedures will be carried out.

### **Psychological tasks of pregnancy**

The psychological tasks of pregnancy are universal and yet are always affected by a woman's past and present. (For the purposes of this section and for the entire chapter, I am assuming the woman is keeping her baby regardless of whether this was a planned or unplanned/unwanted pregnancy. Space does not permit me to explore issues specific to birthmothers who will relinquishing their babies for adoption.) For a trauma survivor, the overlay of the abuse experience brings with it issues unique to each woman's story and her level of healing. The following is an overview of some of these psychological tasks, the accompanying challenges that your client may experience, and suggestions for intervention in the therapy. (For a more thorough description of these psychological tasks in pregnancy, see Lederman's *Psychosocial Adaptation in Pregnancy*, 1996, and Stern's and Bruschiweiler-Stern's *The Birth of a Mother*, 1998.)

Acceptance of pregnancy is the first psychological task. This includes coming to a place of wanting the pregnancy and the baby, having a positive demeanor during most of the pregnancy, seeking out appropriate healthcare, being proactive in addressing the discomforts of pregnancy, accepting bodily changes, and allowing for normal ambivalence (Lederman, 1996.) For an abuse survivor, there may be several challenges in this task. Despite wanting a baby and planning a pregnancy, an abuse survivor may experience doubt early on as to her ability to care for or protect a baby or child. She is all too aware of the dangers of the world and the ways in which adults cannot or do not protect children. In response to her doubts and fears, she may hesitate in embracing the reality of her pregnancy. She may ignore her physical changes, she may dismiss self-care, and postpone prenatal care. Though her doubts and questions about her ability to parent make sense in the context of her history, she may look for any sign that points to the wrongness of her decision to parent.

Depending on your client's level of self-esteem, she may believe that in spite of her wish to parent, she does not deserve to be a parent. She may vacillate between joy and excitement and dread and regret. Ambivalence is normal in pregnancy. However, this is unbeknownst to many women, and as a result, there is often accompanying shame and secrecy, two potent and familiar experiences for an abuse

survivor. Ambivalence may be experienced by the survivor as proof that she should not be a parent. Your task in this phase of pregnancy is to help your client explore her feelings about her pregnancy, placing them in the context of her history when appropriate. Educate her about the normalcy of ambivalence. Remind her that she has the entire length of the pregnancy to integrate the pregnancy experience. Empower her to set the pace. As will be true with each phase of the childbearing experience, containment of affect, management of memories and flashbacks, and maintenance of a healthy level of functioning remain a priority. As stated earlier, tried and true coping strategies work best, creating new ones when necessary.

The social aspects of pregnancy and the public nature of pregnancy present psychological challenges to the pregnant abuse survivor. Once she starts showing, her pregnancy is clear evidence that she has been sexual (although she may have conceived with the help of reproductive technology.) Depending on her relationship to her sexuality, she may feel self-conscious, ashamed, or proud. While some women will want public attention and even a touch to the belly; other women will find this intrusive and reminiscent of poor boundaries regarding body integrity and sexuality. If this latter response is the case with your client, you can help her practice different responses she can give to people as a way of setting healthy and safe boundaries for herself.

At some time in her pregnancy, a pregnant woman must begin to see herself as a mother and begin to connect with her growing child. This happens at varying times for each woman and at varying paces. As stated above, abuse survivors may have fears about being able to adequately protect a child. These fears can interfere with the developing parental self-concept. From the beginning of pregnancy, a woman who is an abuse survivor may hope for a male child, believing males are less vulnerable and easier to protect. On the other hand, she may hope for a female child with fantasies of correcting her own childhood experience of abuse through parenting a daughter. These gender preferences may complicate her process of bonding with her pregnancy and her baby. Gender preferences can postpone the bonding process, often until after an ultrasound or amniocentesis can confirm the sex of the baby. Depending on the news, there can be resultant joy and accompanying fantasies of the mother child relationship or this can result in distress, anxiety, and concern about not loving this baby. Gender preferences, fears and fantasies are an important topic of exploration in therapy.



As with all pregnant women, the woman's relationship with her own mother influences the process of maternal identity formation. If your client's mother was not appropriately protective or if she was the perpetrator of abuse, this can be an important time in therapy for the abuse survivor to differentiate herself from her mother. Help your client explore her notions of "good mother" and encourage her to seek out positive, healthy maternal role models.

Your client may struggle with the notion that her perpetrator and perhaps the person who did not protect her will be a relative of the baby's, either as a grandparent, aunt, uncle or cousin. She will need to spend some time sorting out her feelings. She will need to decide if and how she wants to facilitate a relationship between this person and the baby. If she does choose to cultivate this relationship, she can spend some time in therapy working on setting appropriate boundaries so that she can keep herself safe emotionally and her baby safe physically.

Throughout pregnancy, a woman with a history of depression, anxiety or post-traumatic stress disorder is at risk for a recurrence of depression or anxiety (Sichel and Driscoll, *Women's Moods*, 1999). This means that an abuse survivor is at high risk for these difficulties. It is incumbent upon you, the therapist, to be vigilant concerning symptoms of mental health problems and to intervene and treat them as soon as possible. Depression and anxiety are detrimental to the pregnant woman and the growing baby. Psychotropic medication is an option during pregnancy. Be sure to cultivate relationships with psychopharmacologists in your community who are knowledgeable about treating pregnant and lactating women.

At some point in pregnancy, a woman must begin to think about labor and delivery. There are many different ways to prepare for birth and each woman must find what suits her best. There are books to read and classes to take. Many abuse survivors feel that their unique needs and concerns cannot be addressed in a group class and opt for private classes instead. Some abuse survivors will choose not to participate in any class. In this case, some time can be spent in the therapy helping the woman create a vision of birth, empowering her to see herself birthing, and ensuring that she has lined up appropriate support for the birth. The next section on labor and delivery will go into more detail and the final section of this chapter will list books you can use as a resource in helping your client with her birth preparations.

The benefit of the length of pregnancy is that it provides ample opportunity for the pregnant survivor to adjust to the pregnancy and the idea of motherhood. There is time to anticipate the issues that might arise given her history of abuse and to put coping strategies into place. There is time to deal with any issues that arise unexpectedly. Pregnancy can be a time of challenge for survivors of abuse; it can also be a time of great healing. As in all phases of childbearing, it may be helpful for you to collaborate with the perinatal care providers. A later section of this chapter will address the issue of collaborative work in order to provide comprehensive care to your clients.

## **Labor and delivery**

### **Preparation**

As was just mentioned, preparation for labor and delivery is an essential part of the pregnancy process. Preparation includes becoming knowledgeable about the process of labor and birth, anticipating and addressing fears associated with birthing, anticipating ways of coping with the physical and emotional challenge of giving birth, and ultimately embracing the notion that soon a baby will arrive and life will permanently change. Although the mechanisms of labor and birth are universal, the ways in which the birthing process unfolds and is experienced is shaped, in part, by a woman's history. For an abuse survivor, the normal fears, anxieties and concerns about labor and delivery can take on an additional psychic charge due to the physical and sexual nature of birth. On one end of the continuum is the abuse survivor who experiences giving birth as the ultimate healing experience; on the other end of the continuum is the woman who feels that her birthing experience is tantamount to a recurrence of sexual abuse. In between are many shades of gray. As a woman delves into psychological preparation for birth, her history of sexual abuse will undoubtedly have an influence, though this influence may remain unconscious, depending on her level of healing.

As a therapist, you are not a childbirth educator nor are you a doula (a professional labor support companion.) You will probably not be attending your client's birth as one of her support people. However, in the course of therapy, you can help her prepare for the birth experience by being aware of the issues that may arise for her. You can help her anticipate the potential triggers for her memories and help her develop a means for staying grounded and present if there is an intrusion of memories or flashbacks. You can help

her create strategies for coping with the pain of labor. This is also a time to review coping strategies that she already has in place for dealing with emotional and physical pain. Though there are specific tools that can be useful in working with the challenges of labor and birth, most women will instinctively rely upon familiar coping skills. (For ideas about nonpharmacological pain relief measures and other information on the phases and stages of labor and delivery, see the list in the Resources section of this chapter.) You can encourage her to keep self-care a priority. As part of self-care, empower her to ask for and accept support.

### **Birth support**

Part of self-care includes lining up appropriate support for the birth. This will probably include her partner (if she has one), and perhaps a friend or other relative with whom she is comfortable. She may want to consider hiring a doula, a professional labor support companion who remains with her for the entirety of the labor and birth process. Studies have shown that the presence of a doula can decrease the length of labor and decrease the need for medical intervention including pain medication (Klaus, Kennell and Klaus, *Mothering the Mother*, 1993). The doula can act as an advocate on behalf of the woman and will ensure continuity of care from at least one birthing professional. Doulas are helpful for all women; for a survivor of sexual abuse, a doula can be her voice if she loses it, her guardian angel so that she does not have to dissociate and instead, can stay present for the birth experience. A doula can also support the partner as he or she supports the birthing woman.

### **Potential triggers during labor and birth**

Given the physical and sexual nature of labor and delivery, there is great potential for memories, both body memories and cognitive memories, to be triggered during the birthing process. For some women who are well into their healing process, these triggers can be concretely prepared for, with strategies in place for coping. For women unaware of their history, the birthing process may be the launching pad for their first memories of their abuse. Unfortunately, this situation cannot be prepared for in therapy but will need to be processed in the therapy during the postpartum period. The following is a brief description of the kinds of stimuli present in the birthing process that can trigger abuse memories, flashbacks, and their attendant reactions and responses. Not all women will respond in the same way to these stimuli, but it will

be helpful for you, as the therapist, to keep this list in mind as you help your client prepare realistically for birth.

The physicality of the labor and delivery speaks for itself, in many ways, as a primary potential trigger. This physicality includes nakedness, vaginal exams, and pain in the pelvic and genital areas of the body, blood and other bodily secretions, body odors, changes in breathing, crying, and moaning. It involves exposure of body parts to other people, many of whom are in positions of authority, some of whom are even strangers. Labor and birth take on a life of their own, often feeling out of control to the birthing woman. Though the woman can say “no” to the pain and ask for medication, she cannot say “no” to the birth process; she must complete it. A woman may fear pain medication or anesthesia because it feels frightening to be numbed out from the physical sensations of birth. She feels less in control and more vulnerable. In response to the physical experience of birthing, some abuse survivors will perceive the process to be similar to rape. Some women will fear their bodies are being mutilated; some women fear they are dying. The baby moving through the vagina can be experienced as forced penetration. Many abuse survivors will employ dissociation as a coping strategy. Other coping styles involve include passivity, belligerence and counterdependence. Some women may experience anxiety attacks; others will become controlling and uncooperative with caregivers.

Again, the presence of a doula can be invaluable during these times. Typically, a doula has spent some time getting to know the woman prior to the birth and has had time to develop a relationship that is trusting. You can encourage your client to hire a doula and to talk with the doula about her abuse history, to the extent that it is necessary, in order for the doula to be informed of potential triggers for that particular woman. You may even include the doula in a therapy session to ensure good communication and to answer any questions the doula may have about helping the birthing woman to stay grounded and present during the birthing process. Because a doula is trained and has attended many births, she is in a good position to help the woman anticipate the process and to pace herself through it emotionally. Depending on your client’s issues with trust, she may need to do some work regarding being able to trust that her entire birth team can keep her safe during this vulnerable experience and will do everything possible to protect her from harm. Again, the goal is to help the woman contain her memories, to continue functioning in a healthy manner throughout the process of birth and into the postpartum period, and to facilitate further growth.

Though most births have healthy and uncomplicated physical outcomes, the emotional outcome is not so predictable. Despite great preparation and anticipatory work, there is no way to know how a woman will experience the psychic process of birthing. There is no way to know ahead of time what life lessons she will learn, what historical issues will be stirred up, and how she will make meaning of this experience. While her partner, doula, or other healthcare providers may perceive the birth to have been wonderful, empowering and successful, the woman, herself, may have a completely different emotional experience and perception of the same event. Furthermore, the emotional outcome is an unfolding process for the postpartum woman. As will be discussed in the next section, the new mother spends a part of her postpartum time reviewing and dissecting her birthing experience. It is not unusual for the survivor of abuse, years later, to have a new perspective on her experience. Sometimes it is a more healing perspective; other times it is a perspective that now includes deeper understanding and connection to the relationship between her abuse history and her birthing experience.

## **Postpartum**

### **Adjustment to parenting**

The postpartum period consists of the whole first year after the birth of a baby, a year of enormous adjustment. There is the adjustment to parenthood and to a new person and a relationship with this person. There is adjustment to relationship changes, both in the primary relationship with a partner and in friendships and extended family. There is a process of review and integration of the birth experience. Most women feel a new sense of vulnerability to loss in a way not previously experienced. For an abuse survivor, the postpartum period can be a time of consolidation of past healing efforts as she enters a phase of parenting and protecting a new human being. For other women who are survivors of abuse, parenting can be the catalyst for new memories and flashbacks, new conflicts with extended family, and even regression in the healing process. As in the other phases of childbearing, your task as therapist is to help your client maintain a healthy level of functioning, contain her memories so that they are manageable, and facilitate further growth and healing in the context of new parenthood. Having said that, the following is a description of some particular issues that may arise for abuse survivors who are new mothers.

### **Mother-infant bonding**

Just as the pregnant survivor questions her ability to mother and protect her baby, so too will the postpartum survivor. The difference is that now that the baby is here, it is a real and present task. Depending on her level of self-esteem and her identification as a victim, she may question whether she has anything to offer to her baby. Some women will have difficulties bonding with their babies. This difficulty may be related to the gender of the baby or who the baby looks like. In response to the baby's constant needs and demands, the mother may project adult characteristics onto the baby and see the baby as a perpetrator, always needing something from her, always wanting physical contact, not knowing any boundaries. The new mother may have fears of hurting her baby and perpetrating abuse herself. This can be triggered by feeling angry and frustrated with a crying or inconsolable baby; it can be triggered as the mother changes and washes the baby and questions the appropriateness of touching the baby's genitals. She may feel frightened to be left alone with the baby. All new mothers reflect on their own experience of being mothered. Some new mothers describe a new sense of connectedness with their own mothers or a new sense of empathy with their mothers. For an abuse survivor who was not protected by her mother or for a woman whose perpetrator may have been her own mother or a mother figure, new motherhood may raise new feelings, memories, flashbacks, and fears that will need to be processed and worked out in the therapy.

### **Maternal identity formation**

Just as it was helpful during pregnancy to encourage your client to seek out good mothering role models, it continues to be helpful in the postpartum period. Encourage your client to take an inventory of her talents, skills, values, and strengths that she brings to bear on mothering. Remind her that she does not need to know how to do it all right now. Mothering is a process and the mother child relationship is one that she will grow into over time; she can set the pace. Give her permission to feel vulnerable and clumsy. It is vital that she seek out postpartum support groups for peer support. There may be a specific group for new mothers who are survivors. She may feel most comfortable in a group of women with this shared history. You may even decide to start such a group yourself. If there is no such group available, keep in mind that she will have much in common with all new mothers and in fact, being in a general postpartum

group may help her to normalize her feelings and experiences, thus feeling more connected to the general population of new mothers.

### **Family relationships**

As was mentioned in the previous section, new mothers who are abuse survivors often need to revisit the issue of family boundaries regarding relationships with family members who may have been part of the abuse history. Boundaries previously set may need to be reworked; new boundaries may need to be put in place in order to ensure the baby's safety. If a mother is clear that she does not want certain extended family members to have contact with the baby, then she may need to grieve any fantasies she may have held of the kind of relationships she would have wished for her baby to have with extended family. This may mean not having a relationship with grandparents or uncles or cousins.

### **Integration of the birth experience**

All women review and integrate their birth experience over time. If your client had a satisfying experience, you can use her reflections on her birth experience as a catalyst for further growth regarding strength, empowerment, ability to rise to challenges, trust in self and body, and ability to take risks. If your client had a dissatisfying or traumatic birth experience, your task is to help her process the experience, grieve her disappointments and learn from it. You may need to encourage her to talk with her healthcare providers or members of her birth support team. You may need to help her differentiate between disappointment in herself versus disappointment and anger at her caregivers, keeping in mind the possibility of her projections onto her caregivers. The integration of the birth experience takes time and may not happen right away. Your client will reflect on her birth experience for a long time to come.

### **Postpartum mental health**

Risk factors for postpartum mental health problems include previous history of depression or anxiety, history of abuse, relationship problems, social isolation, traumatic birth experience, and health problems in the mother or baby. Survivors of abuse are at high risk for experiencing postpartum depressive and anxiety disorders. These are mental health issues that require attention and treatment as soon as possible as they have a detrimental impact not only on the woman, but also on her baby and her entire family. Postpartum depression and postpartum anxiety can occur at any point during the postpartum year.

Studies indicate that 10 –20% of new mothers will experience one of these disorders. One in a thousand will experience postpartum psychosis, which requires immediate hospitalization and medication. (Sichel and Driscoll, *Women's Mood Disorders*, 1999.)

For a complete description and discussion on postpartum mental health issues, please see the list in the Resources section of this chapter. What you need to know is the following: it is important not to underestimate the impact of the stresses of new motherhood on mood and mental health; shame may keep a new mother from disclosing how miserable or overwhelmed she feels; early detection and intervention can change the course of family functioning; treatment of postpartum mental health disorders is successful. Be sure to have a collaborative relationship with a psychopharmacologist in your community who is knowledgeable about postpartum issues. Err on the side of caution and suggest an evaluation for your client if you have concerns about her postpartum mental health.

All new mothers need to be mothered themselves. As they make this transition to motherhood, they need support, both practical and emotional. This help can come from relatives, friends, or hired help. It may come from support groups, home-visiting resources, and on-line chat rooms. You will do your client a great service by encouraging and promoting these networks of support, even suggesting that your client arrange for them prior to giving birth. They are vital to a new mother's wellbeing. Anticipatory work and preventive interventions during the prenatal period is ideal. However, if you do not begin working with your client until after she has given birth, it is never too late to provide postpartum support and resources. Interventions on behalf of the mother benefit the baby and the entire family system.

### **Breastfeeding**

Breastmilk is the ideal source of nutrition for babies; nursing a baby is part of the ideal vision of mothering for many women. Common challenges in the early weeks of breastfeeding include sore nipples, positioning difficulties, and milk supply concerns. For abuse survivors, the challenges can multiply. The physical contact at the breast may trigger flashbacks; these reactions and emotions may be intensified if nursing is painful, which is common at the outset. Having the support of a good lactation consultant may be helpful. However, an abuse survivor may feel inhibited and uncomfortable having this person be so close to her breasts, touching her breasts, and putting the baby to her breast in an attempt to teach good



positioning. The consultant may be able to help the woman reduce her pain with better nursing techniques. She may also be able to help the mother talk through her discomforts and concerns, thus reframing the breastfeeding experience in a way that makes it tolerable for the mother.

The nursing experience may also be fraught with concerns, fears, and confusions about the breastfeeding relationship with the baby. Some women feel confused about the dual function of their breasts as both the source of nutrition for their babies and a source of sexual pleasure for themselves and their partners. They may feel ashamed and dumbfounded if they experience any feelings of arousal during breastfeeding, though it is completely normal. A woman may feel uncomfortable if her baby interacts playfully with her breasts during feedings. You and the lactation consultant can help the mother talk about these issues, can help her differentiate between the baby and her perpetrator, perhaps encouraging her to reclaim the health and resourcefulness of her body in a way that will serve her well as a mother to her infant.

Nursing in public may feel awkward, inappropriate, exhibitionistic, or immodest. If your client has any of these experiences, she will limit herself to nursing in the privacy of her home; this will make social forays prohibitive which can then lead to social isolation. Encourage attendance at La Leche League meetings or other breastfeeding support groups. At these gatherings, your client will see the ways in which other new mothers manage public breastfeeding, they will have the nursing experience normalized for them, and they will be in a safe place to talk about the breastfeeding experience.

Breastpumps are a common tool to aid in breastfeeding. They are used to express milk in the case of an over-abundant milk supply, to express milk so that the baby can be fed breastmilk via a bottle in the mothers absence, and to provide stimulation to the breasts to keep a milk supply flowing in the absence of effective and efficient nursing from the baby. Many women find the breastpump painful. Some women feel that it objectifies their breasts and makes them feel like a milking machine. Some women find it freeing because it allows alternative methods of feeding and it allows for someone else to feed the baby. This is a huge relief for many women as it ensures the baby receives breastmilk while at the same time, giving her some space and time for herself.

If a woman's abuse happened in the evenings while the house was dark and quiet, then late night and early morning feedings may be especially emotionally charged. You may want to encourage your client to create a safe place for nursing during these particular feedings. Good lighting, perhaps some soothing music or the television, or perhaps the company of another person will enable her to tolerate these feeding sessions that happen while it is still dark outside. An alternative would be to have someone else do these feedings with a bottle of expressed breastmilk or formula.

As mentioned in the beginning of this section, for many women the breastfeeding relationship is the quintessential vision of early mothering. As such, there is great emphasis on successful and satisfying breastfeeding. For all women, and in this case for abuse survivors, the temptation to cease nursing in the face of physical, social and emotional difficulties is fraught with conflict. If a woman decides to stop nursing because of difficulties, she is often racked by guilt and shame. If she continues on in with stoicism and pain, she may dissociate during nursing or become resentful towards her baby. With the help of a lactation consultant, the woman may be able to come up with a plan for modified breastfeeding augmented by a few bottles of expressed milk or formula. If the breastfeeding experience proves to be too emotionally laden for your client to be able to provide a healthy feeding experience for her and her baby, then give her permission to bottle-feed. Ultimately, it is most important that she be emotionally available to her baby and if bottle-feeding will facilitate this bonding, then that is the priority.

As a therapist, you can support your client's breastfeeding intentions and efforts and at the same time, assist her in making healthy decisions for herself and her relationship with her baby. This may entail some work concerning setting limits and boundaries so that she is not providing mothering at her own emotional expense. Help her make the appropriate connections between her challenges with nursing and her abuse history. Normalize her experience. Encourage her to seek out good lactation support from a certified lactation consultant, a La Leche League leader, her midwife or doula. With your client's permission, it may be helpful for you to speak with the breastfeeding support person so that you can ensure that you are both in sync with the feeding plan. The early feeding experience is primal for a new mother; the idea that she may not be able to nourish her baby sufficiently can be emotionally devastating. Conversely, mothers who see their babies plump up before their very eyes beam a level of satisfaction and pride that is beyond words.

### **Infertility and pregnancy loss**

For many women, the ability to conceive and carry a pregnancy to term is a milestone in terms of securing a sense of confidence in their bodies. Women who are abuse survivors may already have a conflictual relationship with their bodies and their sexuality. They may question the functioning and adequacy of their bodies. Difficulty either in conceiving or in carrying a pregnancy to term can trigger issues of body betrayal and failure as a woman and as a sexual being.

Infertility diagnosis and treatment involves many invasive procedures over a prolonged period of time. It involves reliance on medical personnel who are often given great authority over a woman's reproductive fate. This is a challenge for any woman. Superimpose issues common to abuse survivors, and the process of conceiving a child through reproductive technology is not only stressful but also ripe for triggering memories of abuse and symptoms of PTSD.

As the therapist, there are several ways to be helpful to a client who is struggling with any form of infertility, including pregnancy loss. First, be sure that your client employs stress management and relaxation techniques. Infertility is stressful psychologically, interpersonally, sexually and physically. Relationships often suffer during infertility treatment as well as during decision-making concerning ongoing treatment or the cessation of treatment. Sexual intimacy is often scheduled, regardless of desire. The treatments, particularly the hormonal drug treatments, can wreak havoc on a woman's mood and lability. Psychologically, she is often in a state of limbo, waiting for a menstrual period, waiting to begin a cycle of drugs, waiting for a positive pregnancy test or a call from a clinic about the viability of embryos. Encourage participation in a peer support group. Make room in the therapy for her and her partner to discuss fears, anxieties, goals, and thresholds for treatment. When appropriate, help her make connections between her current challenges and her abuse history and as always, use this context as a vehicle for further healing.

### **Collaborative Care**

In order to provide comprehensive care to women during their childbearing time, therapists must have an adequate understanding not only of the psychological and developmental processes a woman

undergoes, but also an adequate understanding of the physiological processes and medical procedures that are part and parcel of pregnancy, birth, and the postpartum period. This is particularly important when working with survivors of abuse who are childbearing, for we know that the sequelae of sexual abuse can have a far-reaching impact not only on mental health but on physical and sexual health as well (Moeller, Bachman, and Moeller, 1993). A multidisciplinary approach to the provision of care for childbearing women would be ideal, one in which mental health providers work alongside obstetrical providers. However, since these arrangements are few and far between, you can consider developing a collaborative relationship with healthcare and childbirth professionals in your community.

The following is a list of the various professionals a pregnant or postpartum woman might encounter: midwife, obstetrician or family practitioner, childbirth educator, nutritionist, doula (professional labor support companion), postpartum doula, breastfeeding counselor, lactation consultant, baby nurse and pediatrician. Create a working relationship with these providers in your community as well as with a psychopharmacologist in your area who is knowledgeable about medications during pregnancy and lactation. These colleagues will be a vital resource to you and your clients. Offer to do an in-service training for the healthcare professionals in your area on the issues of PTSD and in exchange, use these healthcare providers as a resource for your medical questions and concerns as they relate to working with your pregnant clients.

For women whose lives were chaotic due to the abuse and for women who have concerns that their issues are “too big” for any one provider, collaborative care on their behalf can feel comforting. They feel protected, as if all their bases will be covered. Collaborating with colleagues during this time of heightened vulnerability for your client can be relieving for you, the therapist, as well. It allows you to share the responsibility of facilitating a positive childbearing experience for your client and ensuring her healthy adjustment to motherhood. It models for her the act of reaching out for help and creating a community of support which is ultimately what she needs to do for herself and her growing family.

### **Resources**

If you try to do a search for psychological literature on the issue of abuse survivors and childbearing, you will immediately notice a dearth of material. You may be able to locate it within the

nursing or midwifery literature and yet, even there, you will find a scarcity of information. Under these circumstances, it becomes necessary for you, the clinician, to engage in the creative task of synthesizing your knowledge regarding therapy work with abuse survivors with information you can gather on childbearing and the perinatal period. As mentioned in the previous section on collaborative care, your colleagues within the maternal and child health and obstetrical professions can be of enormous support in answering your medical questions and providing information on the physiology of childbearing. There are also numerous books that you will find informative and helpful to you and in turn, you will be able to recommend to your clients.

The following is a list of suggested books, websites, and organization for both you and your client. These books are easily accessible in most bookstores. For additional reading, including articles from journals, please refer to the bibliography and references at the end of this chapter.

#### **Pregnancy and Childbirth:**

Balaskas, J. and Peterson, G. 1999. *New natural pregnancy: Practical wellbeing from conception to birth*. Northampton, MA: Interlink Publishing Group.

Campbell, L.K., 1996. *Journey into motherhood*. New York: Riverhead Books.

Capacchione, L. and Bardsley, S. 1994. *Creating a joyful birth experience*. New York: Fireside.

England, P. and Horowitz, R. 1998. *Birthing from within*. New Mexico: Partera Press.

Peterson, G. 1993. *An easier childbirth*. Berkeley, CA: Mindbody Press.

Simkin, P., Whalley, J. and Keppler, A., 1991. *Pregnancy, childbirth and the newborn: The complete Guide*. New York: Meadowbrook Press.

[www.reproheart.com](http://www.reproheart.com)

[www.parentsplace.com/pregnancy](http://www.parentsplace.com/pregnancy)

[www.pregnancytoday.com](http://www.pregnancytoday.com)

[www.babycenter.com](http://www.babycenter.com)

[www.childbirth.org](http://www.childbirth.org)

#### **Labor Support and Doulas:**

Klaus, M., Kennell, J. and Klaus, P., 1993. *Mothering the mother*. MA: Addison-Wesley Publishing Company.

Simkin, P. 1989: *The birth partner*. Boston, MA: Harvard Common Press.

Association of Labor Assistants and Childbirth Educators

617-441-2500

[www.alace.org](http://www.alace.org)

Doulas of North America

801-756-7331

[www.dona.org](http://www.dona.org)

**Postpartum:**

Bing, E. and Colman, L. 1997. *Laughter and tears*. New York: Henry Holt and Company.

Kleiman, K. and Raskin, V. 1994. *This isn't what I expected*. New York: Bantam Books.

Placksin, S. 1994. *Mothering the new mother*. New York: Newmarket Press.

Sichel, D. and Driscoll, J.W., 1999. *Women's mood disorders*. New York: William Morrow and Company.

[www.postpartumstress.com](http://www.postpartumstress.com)

[www.sbpep.org](http://www.sbpep.org)

[www.parentsplace.com](http://www.parentsplace.com)

Postpartum Support International

805-967-7636

[www.iup.edu/an/postpartum](http://www.iup.edu/an/postpartum)

Depression After Delivery

1-800-944-4773

[www.depressionafterdelivery.com](http://www.depressionafterdelivery.com)

**Breastfeeding:**

Huggins, K., 1990. *The nursing mother's companion*. Boston, MA: The Harvard Common Press.

La Leche League International, 1991. *The womanly art of breastfeeding*. Illinois: A Plume Book.

La Leche League

847-519-7730

[www.la lecheleague.org](http://www.la lecheleague.org)

**Pregnancy and Birth Loss:**

Berman, M. 2001. *Parenthood lost*. Westport, CT: Bergin and Garvey.

Friedman, R. and Gradstein, B., 1992. *Surviving pregnancy loss*. Boston, MA: Little, Brown and Company.

Kohn, I. and Moffitt, P. 1992. *Silent sorrow*. New York: Dell Publishing.

[www.hygeia.org](http://www.hygeia.org)

[www.aheartbreakingchoice.com](http://www.aheartbreakingchoice.com)

[www.shareatlanta.org](http://www.shareatlanta.org)

**Infertility:**

Cooper, S.L. and Glazer, E.S., 1999. *Choosing assisted reproduction: Social, emotional and ethical considerations*. Indiana. Perspective Press.

Peoples, D. and Ferguson, H.R., 1999. *Experiencing infertility: An essential resource*. New York: W.W. Norton and Company.

Resolve, Inc.

617-623-0744

[www.resolve.org](http://www.resolve.org)

[www.ihr.com/infertility](http://www.ihr.com/infertility)

[www.fertilethoughts.net](http://www.fertilethoughts.net)

**Abortion:**

De Puy, C. and Dovitch, D., 1997. *The healing choice*. New York: Fireside.

Freed, L. and Salazar, P.Y., 1993. *A season to heal*. Nashville, TN: Cumberland House Publishing.

[www.afterabortion.com](http://www.afterabortion.com)

[www.peaceafterabortion.com](http://www.peaceafterabortion.com)

**Conclusion**

Throughout this chapter, I have emphasized the importance of helping your childbearing client contain her abuse memories, maintain a healthy level of functioning, and further her healing and growth in the context of her childbearing experience. This happens as you explore together the connections between her abuse history and the issues arising for her during pregnancy, birth, and postpartum. Her task is to make meaning of her symptoms, her feelings, and her experience. Let her set the pace for this exploration. When working with a client who has already completed a fair amount of healing work, remind her that a recurrence of PTSD symptoms is not necessarily a sign of regression. Rather, it is an indication that this new experience of childbearing is touching on some new or unexplored aspects of her history that she did not have to previously confront. With the client who has had little or no knowledge of having been abused, move gently with her as she explores her associations and concerns during childbearing, allowing her to make her own connections to her history at her own pace.

Empower your client to shape this childbearing experience for herself. Anticipate potential triggers. Remind her of her existent coping strategies. Help her create a safe and egalitarian working relationship with her healthcare provider. Encourage her to gather a support network of family, friends and professionals that can assist her in her journey into motherhood. Ideally, your work together can culminate in a positive emotional experience of pregnancy and birth, a healthy connection between mother and baby, and a sense of self-efficacy as a mother.



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