The Crossroads of Birth & Trauma: An Overview

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Introduction

My Background

Catherine McDonald
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Perinatal therapist in Glastonbury, CT specializing in all things motherhood.

I am passionate about empowering women to improve their wellness as they navigate motherhood and work-life balance. By training I am a Licensed Professional Counselor and Certified Family Life Educator. I have a Bachelor of Science in Family Studies & Psychology and a Master of Science in Community Counseling.

A founding member of Postpartum Support International’s Connecticut Chapter, former board member, current chapter member and volunteer.

On a personal note, I am a wife, a mom to three kids, three dogs and one hamster. I aspire to be a dedicated gardener and yogi. I love to prepare semi-homemade meals, buy books I plan to read one day and love a good latte.
Overview

• Expanding understanding of trauma in the perinatal context
• This clinician’s model of birth trauma
  • Reactivated Trauma
  • Unavoidable Trauma
  • Avoidable Trauma
• Special Considerations for Certain Populations
• Provider Trauma
Birth trauma is in the eye of the beholder” – Cheryl T. Beck

Subjective
To individual’s experience

Exceeds Coping Capacity
Ability to integrate emotional experience is overwhelmed

Real or Perceived Threat
To self or loved one

Man Made or Natural Intent?
Avoidable?
Is there blame?

Single vs Recurrent
One traumatic incident or repeated exposures to trauma (intimate)
Ongoing
Unpredictable
Multi-faceted
Childhood
Significant meaning
With medical complications
Impacting more than one family member

Human-Caused
Significance impacted by caregiver status
Someone of trust

Repeated
Ongoing
Unpredictable

Trauma Severity

✓ Likelihood of lingering symptoms
✓ Likely impact to functional capacity
WHAT COMES TO MIND WHEN YOU HEAR, “BIRTH TRAUMA”?
This Clinician’s Model of Birth Trauma

Reactivated Previous Trauma
- Trauma or Abuse History
- Past Traumatic Birth

Unavoidable Trauma
- Unrelated Trauma or Loss in Peripartum
- IPV
- Medical complications

Avoidable Trauma
- Non-Evidence-Based Care & Provider-Focused Policies
- Obstetric Violence
Defining Childhood Sexual Abuse (CSA)

“Childhood sexual abuse occurs between a child under 18 and someone the child perceives as more powerful than the child herself.” (Simkin & Klaus, 2004)

- Estimated 25-40% of girls, 20-25% of boys are abused at some point
- Most perpetrators are male
- >80% are known to the child

Childhood Sexual Abuse causes sexual arousal in a perpetrator or someone else and can be any combination of:

- Physical
- Psychological
- Verbal
Similar Sensations

- Childhood sexual abuse often includes
  - Restraint
  - Fear
  - Pain and/or bleeding in genitals
  - Overall physical pain
  - Helplessness
  - Pressure on the body
  - Inability to breathe, vomiting

*Many physical experiences of birth mirror those of abuse*
Disclosure of Abuse to Healthcare Providers

- Many providers don’t ask
- Many who do ask in print, easy for a woman to check NO
- Many women exhibit signs of abuse Hx but deny
- Consider HCP background, HCP may be a survivor
- HCP may be uncomfortable discussing
- Systemic considerations, practice size
- Fear of confidentiality breach
- Fear of blame or shame
Perinatal Loss & Termination

• Abortion, wanted vs. needed
• Terminology, “fetal tissue” and “fetal demise”
• Pressure to or lack of choice in termination due to abnormalities, risk
• Vanishing twin
• Reduction of pregnancy
• Logistics, repeated or incomplete procedures
• Hospital policies, provider objections
• Disclosing to family, friends, coworkers
• Relevant dates, anniversaries
• Impacts to family planning
Unrelated Trauma in the Peripartum

- Losses, relationship, job, financial
  - May exacerbate normative anxieties re: adding a family member
- Death of a loved one
  - Hormones may heighten emotional reaction
  - Grief of lost happy moments in pregnancy, milestones, attention/recognition of baby
  - May leave others unavailable to support mom & baby
- New medical diagnosis in pregnancy
Pressure to procreate - divorce, abuse, infidelity

At what point is a loss considered a health event vs. a baby passing away?

Assisted Reproductive Technology may be shunned or banned by a religion - religion may blame ART on a loss or anomaly

Islam directs ART to be only mother + father’s DNA - what if they need a donor?

What implications do frozen embryos have in a religion that bans all abortion?

Termination

Ultra-Orthodox Jewish community: Forbidden > 40 days

Many Muslim Arab communities >120 days

Catholic faith - under no circumstances

Consider exploring abortion doula supports for client

What unique customs or beliefs influence your practice?
Intimate Partner Violence (IPV)

- 1 in 6 pregnant women have been abused by a partner
- Consider Reproductive Coercion
  - Can be male or female-incited
- Pregnancy can escalate or lead to a hiatus of abuse
  - Create opportunities for screening without partner
  - Partners who lead conversations in visits, answer for patient can be a red flag
  - Was this pregnancy Planned? Is it [currently] Wanted?
- Pregnancy complicates a woman’s capacity to leave a relationship
  - Sense of responsibility to baby
  - Financial and housing concerns
- Some factors increase likelihood/risk of IPV
  - Young age
  - Older partner
  - Low Income
  - Marital status
Unavoidable Traumas – Maternal Medical Complications

- Key to consider mom/couple’s experience—what is routine or non-urgent to medical providers could be perceived as life-threatening to patient
- Actual or threatened preterm labor
- Miscarriage, stillbirth, neonatal loss
- Placental issues
- Weak cervix, bleeding
- Home birth to hospital transfer
- Unwanted/unplanned c-section
- False positives on monitors, baby in distress
- HTN, Preeclampsia, AFE
- Hemorrhage, even minor under medical considerations
- Infection of mom (or baby)
- Retained placenta, retained tissue from a loss
Neonatal Medical Complications

• Viability possible as early as 23 weeks gestation means more sick babies, longer stay
• Many factors influence viability & duration of NICU stay
• Transfers & separations
• Elements of helplessness, trauma
• Guilt, self-blame, questioning
• Abstract losses
• Lifestyle disruption, logistics, expenses
• Bonding
• Sensory experience of NICU, lack of privacy
Trauma and Preterm Birth

- Women with likely diagnoses of both PTSD and MDE are at a 4-fold increased risk of preterm birth (Yonkers, et al, 2014)
- One in 20 U.S. pregnancies is likely in women affected by PTSD (Shaw, et al, 2014)
- Depression in both mothers and fathers is associated with an increased risk of preterm birth - Dad or Partner’s trauma history and mental health matter, too! (Liu, et al, 2015)
Avoidable Trauma in the Peripartum

- Birth wishes ignored, patronized in some cases
- Not being informed or updated, lack of choices
- Preferred provider not present
- Unsupportive nurses, understaffed hospital
- Feeling unprepared, blindly trusting a provider
- Being pressured into interventions
- Multi-day inductions
- Procedures without consent
- Medical complications
- Pressure for cesarean, *failure to progress*

Client experience is KEY
How we’ve always done things…

Non-Evidence-Based Care & Provider Focused Policy

• Routine vs. individualized care
• Scheduled c-sections, *9 to 5 births*
  • *Daily weekend birth rates are 35% lower than weekday*
• Required monitoring, wearing hospital gown, withholding food, restricted to bed- Routine can be traumatizing to some
• Labor induction for non-medical reasons
• Unwilling to offer VBAC or TOLAC
• Low percentages of unmedicated support choices
• *Cascade of interventions*
• 7 in 10 women give birth in lithotomy position
• Episiotomy without consent
Common Experiences in the U.S.- LTM findings

• 30% of women felt HCP was rushed
• 22% of women wanted something different & didn’t feel they could speak up
• 41% report HCP wanted to induce
• 2 in 5 women did **ANY** walking in labor, 3 in 5 did **none**
• 62% of women had an IV
• 51% had 1 or more vaginal exams
• 47% had catheters in place
• 31% given Pitocin to speed up labor
• 20% had membranes broken by a provider
Providers’ Role in Avoidable Trauma

- Women may be at increased risk of birth trauma when they interact with providers in a way that leaves them uncomfortable, defensive or offended
  - Frequent or many questions
  - Questioning, declining or disagreeing with HCP plan
  - Challenging HCP plans
  - Feeling disrespected or as though authority is disregarded
  - Patient actions require re-evaluation of HCP plans, increased time and/or increased documentation of provider

- This can lead to dehumanizing, berating, or ‘othering’- separating oneself from the patient
  - “The angry induction down the hall wants an epi.”
  - “She’s going to get cut [cesarean]” (Tillman, 2017)
CASE EXAMPLE: Caroline Malatesta

Awarded $16M when she sued the Alabama hospital where she reports she was misled by advertising for a natural birth focus. In labor Caroline reported being restrained and her crowning newborn being forcefully held inside her vagina for 6 minutes until a doctor arrived, causing PSTD and chronic pain.
"When I walked in, I was sent to a hospital room and a gown thrown on the bed. I was crawling around and couldn’t change. They found out later I got to a 9 by myself at home. I think they assumed since I was very young and it was my first that I was being dramatic."

“The third day into my induction I felt like something was wrong, I asked to see the doctor who sauntered in and coolly asked, "You give up yet? Time for a c-section?" It turns out my baby had aspirated meconium and was in distress when he was delivered in the OR. He just got whisked away and I didn’t see him, I didn’t know if he was alive.”

I was in the pushing phase of a week long induction, where my OB and I had argued about me not wanting an episiotomy through out. 3 hours into pushing my OB said, "if I cut you now you'll have your son in your arms on your next push." I was exhausted and she took advantage of my mental state and vulnerability. I said "ok, whatever", and she cut me. I did not have my son on my next push. I ended up with gloves filled with ice packed inside of my body due to extensive tearing at the site of the episiotomy.

My race definitely influenced my care. I went in two days before giving birth with contractions at 5 minutes apart and was sent home after the most condescending visits I have ever had. I was spoken to like I was mentally challenged and questions were directed to my husband, who is white, rather than me. It both left us with a distaste for the hospital staff, and made us consider moving hospitals.

After 3 hours of pushing an OB said "your pelvis is so narrow, you will never ever have a vaginal birth. I'm prepping the OR.” Wrong!
Healthcare Provider Vicarious Trauma

• Importance of remembering WHY this provider [nurse, OB, midwife] entered into OB care
• Is the patient’s behavior related to them or not?
• Frustration and confusion
• Urgency in the face of resistance
• Is provider unaware of Hx of trauma
• Is provider a trauma survivor themselves?
• How do providers feed off one another?
• Few settings offer debriefing
Trauma in the Non-Birthing Parent

• Few studies re: secondary parent experience
• Elements of helplessness, exclusion
• Often report being disregarded
• May be excluded in crisis, not updated, not included, no de-briefed
• Non-traditional families may be subject to discrimination or maltreatment

What are your policies around supporting a non-birthing parent?
LGBT Birthing Families

• 33% of transgender individuals have had 1 or more negative experiences with a medical professional
• Many report having to teach their provider about transgender people to receive needed care
• 20% of transgender individuals have been denied care by a medical provider
• ¼ of transgender individuals report being asked irrelevant questions about gender at medical visits
• Pregnancy can be a time of gender fluidity, dysphoria related to body changes & hormones
• Increased risk of PPD (35% of trans men who gave birth)
• Lesbian cisgender women also have higher rates of PMADs compared to heterosexual cisgender counterparts
• Non-gestational parents at risk for PMADs similar to heterosexual cisgender couples
Cultural Considerations in Birth Trauma

• Meaning of pain, vocalizing vs. silence
• Modesty and exposure, support person presence
• Cultural considerations neglected or overlooked
• Cultural norms for passivity and patient voice
• Hospital routines with cultural implications-Rx, food,
• Rituals and customs that may conflict w/policy
• Shame in seeking help
• Comfort level in speaking up

What are some cultural customs you honor in your practice or at your hospital?
Perinatal Care of the Hmong Woman

• Strong family histories of trauma PTSD
• Systemic mistrust of Western Medicine
  • Less likely to initiate prenatal care early
  • May limit attendance to routine prenatal care
• Cultural preferences for home birth
• Discomfort in multiple providers

Photo Credit: G. Jenkins
Trauma Presentations in the Intrapartum Period

A woman with a trauma history may

• Experience unconscious stalling of labor, body cannot relax/release
• Refuse examination or interventions
• Behave in a defensive, demanding or hostile manner
• Dissociate, thrash her body, cry uncontrollably

→ All of these can lead to vicarious trauma for HCPs
→ Some HCPs may feel defensive or attempt to exert authority

**Rethinking:** What does the term, “Failure to progress,” mean here?
Providers Matter, Too! Vicarious Trauma

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• How do providers feed off one another?
• Few settings offer debriefing---what about when debriefing is inadequate?
Trauma Complications Postpartum

- Breastfeeding difficulties, nursing itself may be a trigger
- Diaper changes, seeing infant’s genitals
- Physical recovery from birth, flashbacks
- Mom or baby may have injuries or healing that impact bonding, emotional wellness
- Difficulty bonding
- Sensory sensitivities, pain in genitals, nipple soreness, audio sensitivities to baby’s cry
- Trauma related to provider may deter from PP follow up
- Is abuser still in client’s life? Does he/she want to see baby?
- Longer-Term- may impact family planning/size
Final Thoughts

This is difficult material to dive into.
Thank you for being here today!
Thank you for acknowledging that birth matters.
Thank you for all the lives you have touched
Thank you for all the patients you haven’t met yet and will help heal

Thank you for all you do!
THANK YOU!

ANY QUESTIONS?

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