The Trauma of the Perinatal Period

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The Role of Perinatal Influence

- "The neurosis is as a rule a pathological, one-sided development of the personality, the imperceptible beginnings of which can be traced back almost indefinitely into the earliest years of childhood. Only a very arbitrary judgment can say where the neurosis actually begins. If we were to relegate the determining cause as far back as the patient's prenatal life, thus involving the physical and psychic disposition of the parents at the time of conception and pregnancy—a view that seems not at all improbable in certain cases—such an attitude would be more justifiable than the arbitrary selection of a definite point of neurotic origin in the individual life of the patient" (Jung, CW 16, 257-258).

Psychology of the Perinatal Period

Psychology of Perinatal Period:

- Time of personal reorganization, transition, and development,
- Involves a normal period of increased anxiety, reevaluation of life, and the emergence of unconscious conflict.
- upheaval May encourage self-evaluation and sensitive care to newborn (Klaus, Kennel, & Klaus, 1995).
- "The ghosts in the nursery" experience (Fraiberg, 1975): The phenomena whereby a parent's unconscious memories of her childhood experiences impact her parenting style.
- When a baby is born, a mother is born: Time of "Maternal Rebirth" (Stern, 1988)
  - shifts in roles
  - encountering a different form of love
  - experiencing one's partner in new ways
  - a heightened awareness of, and change in, gender roles
  - developing a new identity
  - reevaluating lifestyle, goals, and priorities
  - reconciling work-family demands
  - an awakening or reawakening of early childhood issues especially one's relationship to her mother

Psychology of the Perinatal Period:

- "Facing issues that naturally emerge for a woman about her development including her experiences of being parented is a common perinatal challenge. Conflicts around nurturance, relationships, dependency, acceptance, trust, and love can surface. This frequently kindles negative and positive childhood memories, which trigger emotional responses" (Marlo, 2013).

Psychology of the Perinatal Period:

- "Challenging or traumatic memories are more likely to emerge now, in part, from the unpredictable, painful, vulnerable, and intrusive dimensions that naturally occur with pregnancy, birth, and infancy" (Marlo, 2013).

- They may be part of what psychoanalyst, Selma Fraiberg (1975), termed "the ghosts in the nursery" experience...the phenomena whereby a parent's often, unconscious memories of her childhood experiences impact her parenting style.

- Focusing on the "Ghosts in the Nursery" phenomena addresses how past experiences impact a mother's ability to form an attuned relationship with her child, herself and/or her partner, now, and provides a basis for understanding unhealthy forms of relating in the parent-child triad (marlo, 2013).

Perinatal Struggles

***Perinatal Struggles*:**

❖**Normal, universal, challenging,** and **influential** part of **developmental process.**

❖ **Severity** is on **continuum. Significant struggles** occur in over **25%** of women and often co-occur in partners and children.

❖Up to **75%** of mothers of preschoolers report **anxiety** and feelings of **entrapment** while **27%** experience some kind of **anxiety disorder** (Schreier, 2008; Maushart, 1999). Between **30-80%** of mothers complain of **depression** while **10-15%** develop a **mood disorder** (Beck, 2001; Maushart, 1999).

❖**Increased pregnancy fears and anxiety**, not general stress, relates to **pre-term births**—elevated corticotropin-releasing hormone may stimulate birth (Dunkel-Schetter & Mancuso, 2010

Psychological Themes in the Perinatal Period

- During the perinatal period, women grapple with "procreative mysteries" (Rafael-Leff, 2004, pp. 320-321).

•Anxieties of ***FORMATION***—about normality, creativity, adequacy, capacity for growth, destructiveness.

•Anxieties of ***CONTAINMENT***—about capacity for tolerance, engagement, attention, presence, intimacy, and connection. Concerns regarding personal space, intrusion, distance, and being occupied and known.

•Anxieties of ***PRESERVATION***—about ability to sustain, protect, provide, and nourish.

•Anxieties of ***TRANSFORMATION***—about capability to change and grow: "seed" into baby, bodily fluids into milk, fantasy into reality, daughter into mother, etc.

•Anxieties of ***SEPARATION***—about loss, deprivation, internal depletion, bodily changes.

Psychological Struggles in the Perinatal Period

Personality Characteristics and Patterns:

- Perfectionism
- High Expectations
- Critical
- Obsessive
- Compulsive
- Rigidity
- Jealous
- Helpless/dependent
- Self-reliant/independent “”
- Avoidant
- Self-negligent
- Self-absorbed

Psychological Challenges in Perinatal Period:

- anxiety
- Trauma including Post-Traumatic Stress Disorder
- Bonding and Attachment Problems:
  - Detached or overly, inconsistently, or chaotically attached
- Developmental challenges and transitions
- Grief and loss
- Depression
- Relationship/Marital/Partner Issues
- Unresolved Past Issues
- Concerns about Parenting
- Pregnancy Related Concerns
- Psychosomatic Problems
- Eating Disturbances
- Substance Abuse
- Addictions

Factors Associated with Perinatal Distress

- **Physical factors:**
  - Previous psychiatric history and care
  - Physical problems: thyroid, hormones, nutrients, neurotransmitters, anemia
  - Fatigue and disrupted sleep
- **Socio-cultural factors:**
  - Inadequate social/cultural/familial recognition
  - Absence of traditions/rituals
  - Insufficient social support and social isolation
  - Socioeconomic problems
- **Birth and Infant Factors:**
  - History of obstetric problems and treatment for infertility, stillbirth, or miscarriage
  - Difficult or traumatic pregnancy, labor or birth
  - Twins and multiple births
  - Discrepancy between expectations and subsequent experience
  - Disappointment with birth and birth professionals
  - Problems with infant
  - Infant characteristics especially when poor match with mother
  - Complications, dissatisfaction, or disliking breastfeeding

Factors Associated with Perinatal Distress

- **Psychological Factors:**
  - Poor relationship with partner/marriage
  - Negative perceptions of parental care during one's childhood
  - Poor relationship with parents
  - Absent/poor mother-daughter relationship
  - Less paternal involvement and support of infant's care
  - Ignorance of infant development
  - Distorted self-esteem and self-efficacy (high or low)
  - Unrealistic expectations
  - Lack of satisfaction with educational or professional achievement
  - Little previous contact with babies
  - Prolonged conception period
  - History of sexual or physical trauma and abuse
  - Fear of childbirth
  - Unresolved traumas or losses
  - Stressful events
  - Maternal age (younger and older)
  - Lack of control over returning to work
  - Parenting style

PERINATAL ANXIETY, TRAUMA, & POST-PARTUM POST TRAUMATIC STRESS SYMPTOMS/DISORDER (PTSS/PTSD):

➢An experience of childbirth where one believes her life or her baby's life was threatened; and includes feeling helpless, out of control, alone, and unsupported.

- ω Core symptoms revolve around re-experiencing, avoidance, and arousal.
- ω **When Survivors Give Birth** (2004) by Penny Simkin and Phyllis Klaus

➢Rates of postpartum post-traumatic stress disorder (PTSD) range from 1.5-9%.

- ◆Between **25%-34%** of women report **traumatic births** and 1.5-3% of women with normal births developed **PTSD** (Soet, et al, 2003, Creedy, et al, 2002, Czarnocka, et al, 2000, Beck, 2005, 2006, Ayers, 2007).
- ω A review of **31 studies on post-traumatic stress after childbirth** concluded it is **common** and **under-recognized** (Olde, 2005).

➢**PTSD/PTSS** have significant, **negative, long-term impact** on patient: mood, behavior, relationships, sexuality, relationship with physician, future pregnancy and childbirth, mother-baby bonding and attachment (especially avoidant or anxious attachments), and **breastfeeding.**

➢**PTSD** and **PTSS** can result from or be **kindled** and **re-stimulated** by events during **birth.**

Perinatal Post-Traumatic Stress Disorder

- Nationwide study of 1,573 postpartum women found (Beck, 2011):
  - **9%** met diagnostic criteria for **PTSD**
  - **18%** had significantly **elevated posttraumatic stress symptoms—PTSS**
- Significant relationship between women with significantly higher ptss and breastfeeding:
  - Did not breastfeed as long as they wanted
  - Did not exclusively breastfeed one month after birth
- Additional variables associated with higher ptss:
  - Low partner support
  - Elevated postpartum depressive symptoms
  - More physical problems since giving birth
  - Less health promoting behaviors
    - » (Beck, et., Al, 2011)

Perinatal Posttraumatic stress

disorder

- **Variables that significantly differentiated women with elevated ptss from those who did not:**
  - No private health insurance
  - Unplanned pregnancy
  - Pressure to have an induction and epidural analgesia
  - Planned cesarean birth
  - Consulted with a clinician about mental well being since birth
  - Not breastfeeding as long as wanted
  - Not exclusively breastfeeding at one month
    - » (Beck, et., Al, 2011)

- "postpartum posttraumatic stress symptoms may develop following a negative childbirth experience. It frequently manifests when the childbirth experience is emotionally overwhelming, does not meet expectations, and kindles or re-stimulates sexual, physical, and emotional traumas" (Marlo, 2013).

PERINATAL POST-TRAUMATIC STRESS SYMPTOMS/DISORDER RISK FACTORS:

(Beck, 2011; Waldenstrom 2004; Soet, 2003;Creedy, 2000; Thom, 2007; Soderquist, Wijma 2002; Olde 2005: Ayers, 2007 Gamble, 2005; Gross, 2005; Cigoli, 200)

- Unexpected medical problems
- Unplanned pregnancy
- High level of obstetric intervention
- Cesarean birth especially planned cesarean
- Pressure to have labor induced or pressured into epidural
- Perception of inadequate labor support
- Instrumental delivery
- Infant in NICU
- Poor experience with pain
- Lack of choice and loss of control over labor
- Unmet expectations especially without explanation
- Negative interactions with hospital professionals and staff
- Poor partner support
- Feelings: powerless, alone, defeated, thoughts of death
- Prenatal depression and anxiety
- Traumatic life events and (childhood) sexual trauma history
- Dissociative Tendencies or Dissociation
- Prenatal depression and anxiety
- Negative reactions to breastfeeding or minimal/no breastfeeding

TRANSITIONING TO MOTHERHOOD:

"The mother having been a child and having introjected the memory traces of being… cared for…relives with her infant the pleasures and pains of infancy… Parents meet.. not only the projections of their own conflicts incorporated in the child, but also the promise of their hopes and ambitions." (Benedek, 1959)

"Motherhood is earned first through an intense physical and psychic rite of passage—pregnancy and childbirth—then through learning to nurture, which does not come by instinct." (Rich, 1995)

Motherhood is characterized by paradox, contradictions, and opposites
(deMarneffe, 2004; Maushart, 1999; Raphael-Leff, 1993)

- Mothers feel love and hatred towards their children
- Motherhood is marked with profound gains and losses.
- Motherhood is revered and devalued.
- Mothers are powerful and powerless.
- Motherhood is instinctive and natural yet profoundly difficult and complex.
- Mothers can have innate capacities for nurturing and yet sustained nurturance over time is learned.
- Mothers may feel instantly connected with their child (or disconnected) yet genuine bonding and attachment is a long-term process.

➢Pregnancy and birth is often a time of **maternal rebirth.** A vulnerable time, it triggers a process of self-reorganization and **personal evaluation**. (Stern, 2002).

➢**Imagined mother meeting real mother**: Will I be like my mother? Will I be better or worse than my mother/parents? Will I replicate my childhood?

➢**Imagined baby meeting real baby**: "good" or "bad;" divine or devil; flawless or deformed

➢**Imagined birth meeting real birth**: perfectly as planned; "perfectly" natural or "perfectly" medicated; completely in control or completely out of control

➢**Imagined baby's effect on mother meeting real effect**: unconditional love; replacement baby; antidepressant; conciliator for family of origin; restoring and stimulating new relationship with mother; escaping the destiny of one's past

➢**Imagined baby's effect on marriage meeting real effect**: marital glue or marital threat

➢**Imagined family meeting real family**: baby as carrier of flaws; baby as gift; role in family mythology; baby as agent for social/psychological mobility

TRANSITIONING TO PARENTHOOD:

Birth into motherhood is filled with **personal evaluation** and powerful **myths, images** and **expectations**, that are often sanctioned by **cultural assumptions** about motherhood and "**good mothers:**"

- **Marital conflict increases** dramatically, and marital quality decreases for 40-67% of couples within the first year of baby's life.

•"Bringing Baby Home" program **decreased postpartum depression** (22.5% versus 66.5% in control group) by **targetting couples relationship**, **educating** on **infant development, involving fathers** in infant care.
(Shapiro & Gottman, 2005).

Research on Mentalizing [Reflectiveness] and Narrative:

- The **un-narrated past**, not the past, **impacts the present**. Meets the human need to be heard, seen, and valued.

- A mother who **develops** and **articulates** a "**coherent narrative**" of her **life story** has **greater mental health**, **healthier parenting**, **improved relationships** with partner and children, and more secure children with better interpersonal relations (Siegel, 2003).

- **Narration** fosters **neural integration** of the right and left hemispheres (Teicher, 2002), which leads to improved emotional regulation, and **more conscious choices**.

- **Pregnant mothers** who were **self-reflective** ["mentalizing"] about their early histories and able to **share a coherent story** of their early life ["narrating"], when three months pregnant, had **less anxious children** who demonstrated secure attachment at eighteen months (Fonagy, et. al, 1993).

- **Mothers** with significant **adversity and deprivation**, but **high reflectiveness** ratings, demonstrated **secure attachment relationships with their children**, while only one of seventeen deprived mothers, with low reflectiveness ratings had secure children (Fonagy, Steele, Moran, Steele, and Higgitt, 1991a)

Intervention and Treatment

- Incorporate an understanding of a woman's biological, psychological, sociocultural, and spiritual development, and an understanding of the psychology of birth, pregnancy, and motherhood.
  - **www.Emergencementalhealth.com**

- **Preventive care:** Preparation before/during pregnancy. Address family of origin issues, unresolved traumas, losses, relationship patterns.

- **Professionally facilitated support groups** have been especially helpful with perinatal problems (Jaffe & Diamond, 2011).

- **Integrative Treatment:** Psychosocial and educational interventions, **individual** and **group psychotherapy, medication, peer interventions, trauma therapies; somatic work and somatic psychotherapies**; and **integrative/complementary medical** and **psychological treatments** including relaxation therapy, **yoga, massage, mindfulness, meditation**, and **hypnosis** are effective with perinatal problems (Jaffe & Diamond, 2011; Siegel, 2003).

- **Psychotherapy: Brief** to **long-term**. May involve **individual; parent-infant psychotherapy; couple**; or **family** and include integrative or complementary treatments.

Intervention and Treatment

- Women who struggle with a couple of issues are often responsive to self-help strategies or concrete interventions.
  - support groups: Mentoring Mothers
  - developing a relationship with a trusted health professional
  - addressing nutritional depletion
  - improving sleep
  - herbs, supplements, and psychiatric medications
  - yoga
  - massage
  - learning about infant development (in contrast to a parenting method) and involving the partner/father
  - addressing marital/couples issues
  - incorporating touch and massage; meditation
  - practicing mindfulness
  - developing emotional attunement and empathy
  - enhancing emotional development and intelligence
  - connecting with spiritual practices
  - cultivating one's creative imagination

Intervention and Treatment

- Women who struggle more intensively may experience more healing from integrative, in-depth, professional treatment that includes individual or group psychotherapy.
  - Promote an **integrated approach** to her health: Help target one area that is within her capacity to influence.
  - Recognize **PTSD** symptoms: re-experiencing; avoidance; or arousal symptoms. Affirm benefits of earlier treatment to her and her child.
  - address the "ghosts in the nursery"
  - Affirm the influence of "**the reproductive story:**" The, "at times conscious, but largely unconscious, narrative" created "about parenthood." (Jaffe & Diamond, 2011) and the value of working mindfully with it.
  - Name the **healing power of telling her story**. create a "coherent narrative." An emotionally intense task, this differs from the life story one may readily know or tell. It is a story born out of an emotionally engaging process with another human being that includes having a more conscious experience of how memories, feelings, patterns, experiences, and relationships emerge, in the here and now.