4

Maltreatment Trauma, Post-traumatic Stress, and the Embodied Experience of Pregnancy and Childbirth of Child Abuse Survivors

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Abstract When considering the impacts of trauma across the life span, the impacts on the critical window of the childbearing year cannot be overlooked. The trauma of childhood maltreatment is particularly salient to the first pregnancy, as traumatic birth may be to subsequent pregnancies. There are intergenerational patterns of continuity between parents who have histories of childhood maltreatment and abuse and neglect of their children. One in five individuals has experienced childhood maltreatment; although some are resilient, others develop post-traumatic stress disorder (PTSD). The rate of PTSD for those who are pregnant varies, depending on their circumstances. The PTSD rate can be similar to the 4% population rate in affluent perinatal care settings but 14%–32% in racially marginalized clients in disadvantaged settings. In addition to maternal mental health and parenting manifestations, there are physical manifestations associated with PTSD and complex PTSD that are now

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being researched in relation to pregnancy, including allostatic load effects on metabolic, immune, and cardiovascular status. Hypothalamic-pituitary-adrenal (HPA) axis, catecholamines, and oxytocin systems are all implicated in biobehavioral responses. Trauma-related dysregulations in these systems may be mechanisms of lower birthweight, shorter gestation, and loss of breastfeeding. Perinatal clinicians also may observe the fight-or-flight, freeze-or-faint post-traumatic stress reactions associated with reminders of past trauma or "triggers." Addressing "unresolved maternal trauma" ahead of parenting and avoiding retraumatization in the perinatal care relationship are two priority areas for improving perinatal care and outcomes. Perinatal professionals have been focused on depression and anxiety as common perinatal conditions but may only have been seeing the metaphorical tip of the iceberg. The submerged, broad base, in some instances, may be childhood trauma and its post-traumatic sequelae. Building knowledge, skill, and system capacity for integrating trauma-informed care into perinatal services is an opportunity for interprofessional education and teamwork.

Keywords Post-traumatic stress disorder • Perinatal care • Trauma-informed care • Childhood maltreatment • Pregnancy • Midwifery

Seeing Childbearing Through a Post-traumatic Stress Disorder Lens

When considering the impacts of trauma across the life span, the impacts on the critical window of the childbearing year for those who start a family cannot be overlooked. Childhood maltreatment history can affect the childbearing year in particular ways (Sperlich & Seng, 2008). Many survivors are resilient or recovered by the time they start their own families, but a significant proportion live under the shadow of post-traumatic stress sequelae (Alisic et al., 2014). Seeing clients'[1] concerns, needs, and efforts to cope through the lens of post-traumatic stress disorder (PTSD) can help the perinatal care team respond effectively.

[1] In this chapter we refer to clients who are expectant and postpartum mothers.

Although healthcare providers will likely want to use the PTSD diagnostic framing, there also are influential non-diagnostic frameworks. Chief among these is the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed care (TIC) framework (Huang et al., 2014). The TIC framework defines trauma as three E's (event, experience of it, and effects) rather than as a disorder. It proposes the four R's as vital practice-level behaviors (realizing the ubiquity of trauma among human service clients, recognizing signs and symptoms, responding to these, and focusing particularly on resisting retraumatization). Organizations providing TIC also operate under six key principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical, and gender issues. The SAMHSA framework and technical assistance are particularly useful in settings that address trauma and PTSD but are not medical in nature (e.g., detention facilities, schools, shelters, and housing services) or that focus on behavioral health. In healthcare settings, including perinatal services, diagnostic language and diagnoses themselves may be primary tools for interprofessional communication and obtaining resources to address client trauma-related needs. The SAMHSA framework can remain useful as a conceptual framing for interpersonal practice, speaking with clients in accessible language, and enhancing the workplace to consider traumatic experiences in work life (trauma-informed care is covered in more detail in Chap. 7.)

PTSD Is a Common Mental Health Condition, Including During Childbearing

Perinatal professionals have been focused on depression and anxiety as common perinatal conditions but may only have been seeing the metaphorical tip of the iceberg. The submerged, broad base may be childhood trauma and its post-traumatic sequelae. Enhancing our focus on PTSD during childbearing has strong potential to improve expectant mothers' experiences and outcomes. Expanding our clinical attention to trauma and PTSD may also improve our own professional satisfaction as we, as

clinicians, become more effective by addressing a previously unrecognized problem.

Importantly, the focus on depression and anxiety has not been wrong; rather, it is simply incomplete. Current diagnostic criteria of PTSD include aspects that look like depression and anxiety, that is, low mood or negative cognitions and autonomic hyperarousal, as well as avoidance of reminders, and the hallmark intrusive re-experiencing of the trauma (American Psychiatric Association, 2013; WHO, 2018). PTSD is also comorbid, with full major depressive disorder in approximately half of cases when PTSD becomes chronic (Kessler et al., 1995). Thus, depressed mood, worrying thoughts, and being physically on edge may be the manifestations perceived. But trauma may be a shared root cause. Because it has been taboo to talk about childhood and sexual trauma in particular (Herman, 1992), we have not had a lens to see clearly client struggles with intrusive re-experiencing and avoidance. Nor has it been the habit of perinatal providers to ask about links between current mental health morbidity and past trauma. To complicate matters, prolonged, repeated trauma, like maltreatment, may be shrouded in alterations in awareness and memory and kept secret or walled behind a deep zone of mistrust of others, especially caregivers (Herman, 1992). For these reasons, and because of the significant prevalence and health impact of PTSD, it is incumbent upon clinicians to realize the importance, recognize the signs and symptoms, and respond—including by avoiding retraumatizing clients (Huang et al., 2014).

Across societies, most people have experienced trauma of some type. One in five individuals has experienced childhood maltreatment. The conditional risk of PTSD after interpersonal trauma in childhood is approximately 25% overall, but 33% for girls (Alisic et al., 2014). Women experience PTSD at twice the rate of men. The all-cause (not just maltreatment-related) point-prevalence of PTSD in the general population of women is estimated to be 4.6%–9.7% (Mitchell et al., 2012; Resnick et al., 1993). However, the rate of PTSD for those who are pregnant varies, depending on circumstances. For example, it can be similar to the population rate in affluent samples, but 14%–32% in racially marginalized clients in disadvantaged settings (Gluck et al., 2021; Seng et al., 2009). Women with partial or subclinical PTSD have similar levels of

distress and impairment (Stein et al., 2000). During childbearing, even resilient survivors may have lower social support and concerns about keeping their child safe in the context of intergenerational intrafamilial abuse and neglect, consistent with the "loss of resources" model of complex PTSD (Hobfoll et al., 2011; Sperlich & Seng, 2008).

Etiology of PTSD

PTSD is a syndrome with multifactorial causation. Approximately one-third of the risk comes from each of three factors: genetics, family or origin context, and the impact of the trauma exposure itself (Koenen, 2007). The more life-threatening and physically intrusive the trauma, the greater the risk. In families with multiple generations of maltreatment, and in members of cultural groups with decades or centuries of historical trauma, the risk is even higher (Harnett & Ressler, 2021). But we are learning from the field of epigenetics that biology is not destiny. Maternal caregiving can effectively bend the arc of both individual outcomes and population health, changing both offspring mental health and development and the traits the offspring generation passes on to their offspring (Weaver et al., 2004).

Childhood Maltreatment and PTSD: An Embodied View of PTSD and Complex PTSD

Post-traumatic stress, especially the complex PTSD that is rooted in childhood maltreatment, affects the mind and body, as well as relationships (Herman, 1992; van der Kolk, 2014). If we take in a narrative understanding that the child suffering chronic abuse or neglect or both adapts to survive, it is easier to observe the adaptations. Mental health professionals tend to prioritize focus on the mental manifestations of trauma sequelae. Healthcare professionals could likely be equally effective addressing the physical manifestations. In primary care, the physical morbidity associated with PTSD and complex PTSD includes chronic

pain, somatic dysregulations such as irritable bowel syndrome, and ultimately a shortened life span due to metabolic, immune, and cardiovascular conditions (Felitti et al., 1998; Herzog & Schmahl, 2018; Seng et al., 2013a). Lower birth weight and shorter gestation are known outcomes of PTSD in pregnancy (Sanjuan et al., 2021; Seng et al., 2011). Other physical manifestations of maltreatment-related PTSD (e.g., hyperemesis, loss of breastfeeding) have been theorized and reported in small studies (Eagen-Torkko et al., 2017; Seng et al., 2013a); however, systematic research to fully characterize the embodied experience of pregnancy with PTSD, from symptoms to the allostatic load that causes metabolic, immune, and cardiovascular morbidity, remains to be undertaken.

A major conceptualization of PTSD is that it reflects the failure of extinction of the fear response (in "deficit" language) or maintenance of readiness to self-protect at any moment (Pitman et al., 2001). Fight-or-flight sympathetic nervous system responses reset homeostatic mechanisms to a higher level of readiness that can become an allostatic overload (McEwen & Stellar, 1993). Essentially the hypothalamic-pituitary-adrenal (HPA) axis works at a higher baseline and keeps the metabolic, cardiovascular, respiratory, and immune systems "revving" to be ready for danger all the time. This is coupled with behavioral and cognitive avoidance of any reminders of the trauma that can trigger fight-or-flight. In terms of client behavior, we see startle reactions, anger or combative stances, impulsiveness, and efforts to control situations. These fight-or-flight systems and avoidance efforts are predominant in "classic" PTSD, that is, PTSD occurring from single-episode or adulthood trauma exposures.

Freeze or faint reactions occur too. These naturally occur *during* any traumatic event and in the weeks of aftermath and recovery. But in 14% of people with PTSD, these peritraumatic reactions become overgeneralized and part of a complex PTSD or dissociative subtype of PTSD (Stein et al., 2013). Dissociative depersonalization or derealization (i.e., feeling out-of-body or like what is happening is not real) was for an abused child the escape when there is no escape (Putnam, 1992). But dissociation can be carried into adulthood and occur in response to stress, feeling overwhelmed, or reminders of trauma (i.e., triggers). Dissociation in labor

occurs among a minority of maltreatment survivors. It can be useful to think of dissociation in labor as a "state," with "trait" or pre-existing dissociation a predisposing factor (Choi & Seng, 2016). Although less is known of the physiology of freeze or faint responses, dissociation is thought to be a parasympathetic response, a form of self-anesthesia when injury or death is unavoidable. These reactions may be based in the oxytocin system (Porges, 2011).

Perinatal professionals are most familiar with oxytocin, which functions on smooth muscles engaged in orgasm, uterine contractions, and milk ejection. Oxytocin is also a neurotransmitter engaged in stress reduction, pro-social, caregiving, and pair bond relationships, and the daily functions that help species, including humans, to thrive: play, exploration, relationships, digesting, growing, and wound healing (Moberg & Moberg, 2003).

Cascade theory tells us that a maltreated child experiences a series of physiological adaptations in cascading order, from oxytocin system to HPA axis and catecholamines (Teicher et al., 2003). In a healthy state, these systems are mutually regulating. In clients with maltreatment-related PTSD, it is useful to think that these body systems are likely mutually *dys*regulated. Much more perinatal research is needed, but theory is useful as a lens. If anger or fear (fight-or-flight) is sensed in client behavior or felt in the client-provider relationship, might we also see HPA-mediated physical alterations? If there is mistrust, a lack of ability to rest, be calm, or care for the self, a sense of disconnection or "surrender" in labor (Rhodes & Hutchinson, 1994), might we also see oxytocin-mediated physical alterations? We have long known that stress responses disrupt labor progress. Using a trauma and PTSD lens, this view can extend to watch for relational challenges in perinatal care and make sense of problems in pregnancy, labor, breastfeeding, and parenting that may be oxytocin mediated.

PTSD and dissociation are also associated with amnesia for all or part of the trauma. This amnesia can begin to subside in adulthood as the utility of knowing what happened to them as a child becomes greater than the utility of not knowing (Freyd, 1996). Major life events, such as the death of a perpetrator or becoming a parent, are known to cause this

balance to shift. Triggers are also known to cause this balance to shift (Freyd, 1996; Herman, 1992). Thus, birth attendants may be present at significant moments of loss of amnesia—flashbacks, sudden realizations that they remember a trauma—and so birth attendants may witness the delayed onset of PTSD. Perinatal providers who recognize this trauma reaction are in a position to turn a horrible moment into a healing one (Sperlich & Seng, 2008).

In addition to thinking about PTSD and complex PTSD in terms of mutually regulating and dysregulating hormones, functional neuroimaging studies shed light on brain patterns that are useful as well. In PTSD reactions, where fight-or-flight dominates, we see *under-modulation* (i.e., assessment of the reality of the situation goes offline, and we prepare to ensure survival if we can) of fear reactions. In complex PTSD reactions characterized by dissociation and freeze or faint responses, we see *over-modulation* (i.e., the brain is working to mute the response, playing dead to survive or self-anesthetizing to be numb to the death blow) of fear reactions (Lanius et al., 2010).

These embodied post-traumatic reactions are noxious. People with PTSD are known to try to mute the symptoms with substances or self-harming behaviors as efforts at self-medication (Hawn et al., 2020). In pregnancy clinicians see clients they are concerned about—those smoking, drinking, using drugs, overeating, and with violent partners—are strongly clustered among those with PTSD (Morland et al., 2007; Seng et al., 2008). Trauma-informed perinatal care (described below) may be more successful than earlier approaches for mitigating addiction and family violence that have not considered trauma or post-traumatic stress as the root cause of the presenting problem (Morland et al., 2007).

Other Sources of Perinatal PTSD

PTSD that is activated in pregnancy can have roots in trauma exposures other than maltreatment. Previous medical trauma, prior perinatal loss, or traumatic birth all have the potential to trigger PTSD during subsequent pregnancies. It is important to realize that there is a potential

overlap between childhood trauma and subsequent trauma exposure and risk for PTSD from the subsequent exposure. So, some perinatal or medical trauma survivors may also be survivors of childhood trauma with more complex presentations. This can be illustrated from research on PTSD following childbirth, that is, PTSD occurring postpartum, where the birth experience was the ostensible trauma exposure. Childhood sexual abuse and prior psychiatric treatment are known predisposing factors for experiencing birth as traumatic and becoming symptomatic with PTSD (Ayers et al., 2016; Grekin & O'Hara, 2014). Subjective experience, including perceiving the care in labor as uncaring or incompetent (i.e., negligent or abusive), is also a precipitating factor, as well as obstetric emergencies and instrumented or surgical deliveries (Czarnocka & Slade, 2000; Dikmen-Yildiz et al., 2017). But in prospective research, among those who exhibit full PTSD postpartum, most individuals appear to have had PTSD prenatally, and a minority have new-onset PTSD (Seng et al., 2013b).

PTSD and Disparities

There is a saying, "If it's not racially just, it's not trauma-informed" (Dhaliwal, 2016, Fig. 1). PTSD in pregnancy and adverse birth outcomes both occur at much higher rates in cultural groups that experience racism, discrimination, or other forms of marginalization. Rates of childhood maltreatment are similar across racial groups, but rates of resilience are lower, as are resources for recovery (Seng et al., 2011). Although the focus of this chapter is on intergenerational trauma in the form of childhood maltreatment, it is likely that cumulative, multigenerational trauma in the form of racism also contributes to risk for PTSD (Conching & Thayer, 2019), as well as risk for adverse perinatal outcomes (Sotero, 2006). The toll is not only in the form of stressed relationships between minority clients and most often dominant-culture healthcare providers and less satisfying prenatal and birth care, it is also manifested in the bodily health status of minority clients. Traumatic stress, that is pervasive and ongoing, causes premature aging (i.e., weathering) (Geronimus,

1992; Jones et al., 2019). It may also make minority women more vulnerable to having the demands of pregnancy on the body tip allostatic overload into manifesting disease and affecting the fetus. Active changes to practice and systems are needed (Hardeman et al., 2020; Scott et al., 2019), as is research to learn what trauma-informed, equitable, and anti-racist care can do to mitigate the syndemic effects of trauma, racism, and PTSD.

PTSD and Perinatal Providers' Trauma

Of course, providers and other perinatal team members are subject to trauma and PTSD as well. This can be either from childhood maltreatment or secondary to work-related traumatic events (e.g., Slade et al., 2020) or both. Failure of fear extinction or maintaining readiness to self-protect at any moment (whether a danger is present or not) may be a post-traumatic manifestation affecting perinatal providers too. Work-related trauma exposure and vicarious trauma are almost inevitable exposures in this field. Yet there is scant support for clinicians to honor our needs to recover and return to a healthy level of vigilance rather than to respond with persistent fight-or-flight and avoidance that may affect our practice. The U.S. Substance Abuse and Mental Health services Administration (SAMHSA) framework for trauma-informed care emphasizes the clients' needs. It only addresses secondarily the providers may have trauma-related needs too and that these should be considered in systems change efforts (Huang et al., 2014). Another influential definition of trauma-informed care proposed by Hopper et al. (2010) makes the need for balancing attention to clients and providers more explicit:

> Trauma-informed care is a strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety *for both providers and survivors* [emphasis added], and that creates opportunities for survivors to rebuild a sense of control and empowerment. (p. 82)

PTSD and Complex PTSD Diagnostic Criteria

In a trauma-informed system of perinatal care, it will sometimes be necessary to refer clients (or clinicians) to mental health professionals who can provide evidence-based treatments for PTSD (Forbes et al., 2020; Ford & Courtois, 2020). Diagnosis of PTSD and complex PTSD is not necessary to respond to client needs at the bedside in perinatal care. However, knowing the vocabulary and criteria for diagnosing may help make referrals. In places where mental healthcare specific to PTSD is scarce, consultation or teamwork may be enhanced by speaking the same language.

DSM-5 and ICD-11 have more similarities than differences, as shown in Table 4.1 (American Psychiatric Association, 2013; WHO, 2018). DSM-5 defines a trauma criterion, four PTSD symptom clusters, and it is possible to add a dissociative subtype specifier. The fourth symptoms cluster, not shared with ICD-11, involves exaggerated negative beliefs or persistent negative emotions. ICD-11 PTSD diagnosis requires symptoms in three clusters shared with the DSM-5 (i.e., intrusions and re-experiencing, avoidance, and arousal and reactivity). For complex PTSD, ICD-11 requires these three, and three more, symptoms considered to reflect disorganization of the self (i.e., affect dysregulation, negative beliefs about oneself, difficulty sustaining relationships). These are not entirely different from the fourth DSM-5 PTSD cluster. Both taxonomies require significant distress and impairment in role functioning as well.

The Role of Perinatal Care Team Members in Addressing PTSD During the Childbearing Year

While it is not generally the role of perinatal care providers to treat PTSD, we are beginning to know that they *do* need to step up to address unmet maltreatment—or PTSD-related needs (Nagle-Yang et al., 2022). The question at this time is how to conceptualize this work, create approaches or interventions, and study their effects.

Table 4.1 Comparison of DSM-5 and ICD-11 criteria for diagnosis of PTSD and complex PTSD

Source	Criterion
Both DSM-5 and ICD-11	*Trauma exposure* DSM-5: Exposure to actual or threatened death, serious injury, or sexual violence ICD-11: Exposure to extremely threatening or horrific event or series of events
Both DSM-5 and ICD-11	*Intrusions or re-experiencing of the event* (such as intrusive memories, repetitive play in which the events or aspects of it are expressed, nightmares, flashbacks, distress triggered by reminders of the event or events) *Avoidance* (such as avoiding thoughts, feelings or memories of the event or events, or avoiding people, places, conversations, or situations that are associated with the event or the events) *Arousal and reactivity* or sense of current threat (such as irritability, being overly vigilant, being easily startled, concentration problems, sleep problems)
Additional DSM-5 criterion for PTSD	*Exaggerated negative beliefs* about themselves, the world, or other people; having distorted thoughts about what caused the event or events and the consequences; *or persistent negative emotions*; less interest in significant events; feeling detached or estranged from others and finding it impossible to experience positive emotions
Additional ICD-11 criteria for Complex PTSD (CPTSD)	*Problems in affect regulation* (such as marked irritability or anger, feeling emotionally numb) *Beliefs about oneself* as diminished, defeated, or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event *Difficulties in sustaining relationships* and in feeling close to others
DSM-5 specifier for dissociative subtype (PTSD-D)	*Definition of dissociation generally*: a disruption, interruption, and/or discontinuity of the normal, subjective integration of behavior, memory, identity, consciousness, emotion, perception, body representation, and motor control. *Depersonalization and derealization* specifically: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).

Table 4.1 is modified from the comparative explanation on the UK Trauma Council website, https://uktraumacouncil.org/trauma/ptsd-and-complex-ptsd accessed 6 August 2022 and from the WHO ICD-11 and American Psychiatric Association DSM-5

There are perhaps many ways to conceptualize, but theory and qualitative research suggest two imperatives clinicians can address. The first involves three of the four R's of the trauma-informed approach: "realize, recognize, and respond." In perinatal care, this can take the shape of becoming an ally to the person as they name, understand, and start to work on any "unresolved maternal trauma" that may be affecting them. The second involves the fourth R: resisting retraumatizing. (Note that Chap. 6 explains trauma-informed care in more depth.)

A First Imperative: To Address "Unresolved Maternal Trauma" Ahead of Parenting

Women psychoanalysts from the middle of the twentieth century, Helene Deutsch and Greta Bibring, noted that childhood maltreatment trauma loomed large when their survivor patients became pregnant and that therapy during pregnancy progressed very well (Bibring, 1959; Deutsch, 1945). By the 1970s, this phenomenon was referred to by Selma Fraiberg and others as "ghosts in the nursery" and "unresolved maternal trauma" (Fraiberg et al., 1975). These threads of thought have been carried forward by contemporary psychology writers, but in works more often of use to psychotherapists than to perinatal healthcare providers (e.g., Raphael-Leff, 2018; Weinstein, 2016).

Qualitative reports have included statements from women's perspectives that tell the same story, but in simpler words. They often realized at some level during pregnancy that their maltreatment history presented challenges to becoming a parent that they felt compelled to confront "right now" (Sperlich & Seng, 2008). In a nutshell, they wanted to stop the cycle of maltreatment and become a good-enough parent (i.e., sensitive, reflective, safe) in time to raise a child in a better way than they were raised. When asked what they wanted maternity care providers to do, their answers varied based on where they were in the recovery process. Generally, they wanted to know they were not the only one, that maternity care providers would be allies in this effort, would address their risk behaviors in a trauma-informed way, and would lay the groundwork for

getting mental health treatment at some point, when they were ready or if their trauma coping became overwhelmed by childbearing. They wanted perinatal caregivers to focus on addressing their trauma for the sake of having a positive birth experience and acquiring solid maternal role development despite the shadow of maltreatment trauma (Seng et al., 2002).

So, a first conceptualization of the role of perinatal providers could be that of allies in the metaphorical act of turning a light on to banish the ghosts in the nursery. This won't be an overnight accomplishment. But naming the issues; providing information, skills, and emotional support; and being in a relationship are practices that can be deployed from within our scope of practice.

The caregiver role with an infant involves dyadic emotion regulation and providing a secure holding environment (Rowe et al., 2015). Any perinatal client, especially those having a first birth, may need this sort of generativity from the midwife or obstetrician during moments of vulnerability or uncertainty. Clinicians probably do this without any special attention to such exchanges. For clients who have survived maltreatment, these normal moments of vulnerability or uncertainty may feel intense and trigger symptoms of PTSD. If they become symptomatic, we can expect them to be physically dysregulated during fight-flight-freeze reactions or by hypervigilance and to have feelings of being in danger and needing to be mistrustful. If we can imagine the lack of dyadic emotion regulation and secure holding that survivors may have received as a young child, it suggests these maternal tasks could be used as templates for useful responses to clients (Rowe et al., 2015). We can help them regulate emotions that are out of proportion to what is happening. We can give them a safe space in which to express fears of what lies ahead and doubts about themselves and provide encouragement. But to do this, we must be aware of clients' trauma history and the extent of their post-traumatic mental health sequelae. And we have to have a practice environment that supports the work within the six key principles of a trauma-informed approach applied to the workforce as well as clients.

A Second Imperative: To Provide Perinatal Care that Resists Retraumatization

The work of supporting clients with maltreatment history is not at all likely to succeed if we (as clinicians) cannot resist retraumatization. At its most basic, retraumatizing a maltreatment survivor involves acting or relating in a manner that *is* similar to, or that is perceived to be similar to, the acts or relational behavior of the perpetrator of the original abuse or neglect.

Neither the healthcare system nor the staff want to think of their environment, routines, or ways of relating as traumagenic. But we need only look through the lenses of childhood maltreatment to see blatant and subtle ways in which the context and behaviors that we accept as normal have the potential to retraumatize those who have experienced sexual abuse, physical abuse, physical neglect, emotional abuse, or emotional neglect at the hands of caregivers. The clinical literature has examples of how internal examinations can retraumatize sexual abuse survivors (e.g., Rose, 1992) and also suggestions for how to change the environment, actions, and relational dynamic to be collaborative and empowering (e.g., Simkin & Klaus, 2004). Examples for the latter include providing progressive, repeated rather than one-time or assumed informed consent and asking for permission to conduct an internal examination of their body, providing chaperones, and asking about preferences for privacy, positioning, and draping. Explaining what a trigger is and asking clients if they have noticed things that trigger them, then collaborating to make plans to avoid those triggers is another example.

In perinatal care, we do not focus as much on retraumatization related to physical abuse. It is not hard to see though that environments and practice behaviors that diminish dignity, humiliate, and show disregard for pain or the need for body integrity could be retraumatizing. An example could be the medical routine of having patients undress and sit on the exam table, waiting for the provider to enter the room, which can resemble the experience of a child waiting in their room for a parent to arrive and use corporal punishment. Neglect of physical needs occurs as well, though we may not give it that name. For example, from the perspective

of a maltreatment survivor, having food and water withheld in labor, being required to wear an inadequate gown, or having needed support withheld inequitably (e.g., having epidural anesthesia or lactation help or doula support depends on insured status or location of the hospital) would be likely to anger or disempower them. It is true that any person might be adversely affected by these experiences; maltreatment survivors with post-traumatic sequelae may experience PTSD reactions that are distressing and impair their ability to question authorities or advocate for themselves.

More subtle, perhaps, but no less important, is the potential for emotional abuse and neglect to happen or be perceived in client-provider-team relationships. So, providers who ignore or dismiss survivors' needs may be triggering survivors to engage in fight-or-flight, freeze or faint reactions rather than strengthening them to engage purposefully in mutual collaboration to address the trauma and resist retraumatization together.

Two theories of what causes PTSD or complex PTSD are relational theories. Judith Herman's (1992) point that maltreatment is an injury to the attachment system and Jennifer Freyd's (1996) view that it is a betrayal can guide providers and staff to focus on the quality of their caring. If we know that the provider relationship is significant for the client—one where they will be vulnerable and need our care in a time of pain and existential transition—then we can strive to be trustworthy and reliably connected. If we understand how betrayal traumatizes, we can be transparent about limitations, shortcomings, or injustices and form alliances with clients to advocate, call out, and work for change.

Providers cannot carry the responsibility of resisting retraumatization alone. The needs of pregnant and early parenting survivors can be numerous and complex if we see them fully and assess for them systematically. Needs can include mental health, substance use, violence-related services, parenting education, social support, and care for the physical health decrements that are found with PTSD. It is worth this comprehensive psychosocial and health status assessment if we want to see improvements in the health of individual parents, children of the next generation, and the overall population. But this would require political will to add resources

and redesign our service delivery models to be trauma-informed and address perinatal and post-traumatic needs in tandem.

Where to Begin? Structure, Process, Outcome

Achieving changes to outcomes can require changes at the systems level (White & Griffith, 2019), requiring attention to existing structures and processes and planning modifications or adaptations to achieve the preferred outcomes. Interprofessional work in perinatal services—where physical, psychosocial, and mental health services are integrated—provides a structure that should be capable of providing care adequate to address perinatal needs rooted in maltreatment-related trauma holistically. The process of change may be slow. Perinatal pathways to specialist mental health treatment may not currently include evidence-based treatment for PTSD (which still lacks evidence for safety during pregnancy) (Baas et al., 2020; Stevens et al., 2021). Screening efforts may not yet be smooth. A "don't ask, don't tell" mindset will prevail if there are not feasible, acceptable, or satisfying offerings in response to disclosure. It will take a process of trial, error, evaluation, revision, and success to get to a point where the team is confident in what they can do for survivors—at universal, targeted, and specialist levels. The outcomes will be both easy and hard to see. Based on theory, addressing post-traumatic stress and other sequelae from childhood maltreatment should yield a host of population health improvements, none of which may be evident at the individual level. Pregnancy PTSD is associated with shorter gestation and lower birth weight, less breastfeeding despite a greater intention to breastfeed, a greater burden from traumatic birth and postpartum PTSD and depression, impaired bonding, and difficulties in infant regulation and development (Eagen-Torkko et al., 2017; Enlow et al., 2011; Sanjuan et al., 2021; Seng et al., 2013b). Pregnancy PTSD may also be a critical intra-uterine transmission point for life span health risks conceptualized as developmental origins of health and disease (Seng et al., 2018). But it would take quantifiable interventions and large-scale research to model the impact of trauma-informed perinatal care on most of these outcomes.

We could make a start on this. But we cannot wait for evidence of the impact on the population.

At the individual level, evaluation of our interventions—practice behaviors and programs or treatments—might suffice to indicate we are going in the right direction. Proximal outcomes such as positive appraisals of experience, satisfying ratings of alliance and relationships, decreased burden of perinatal mental health and substance use, increased parenting sense of competence, and ability to enjoy the postpartum period are all potential good outcomes for clients. For providers, growth in competence, shared trauma-informed work, shared triumphs in system changes, and even our own personal increase in professional quality of life are potential good outcomes (Geoffrion et al., 2019). All these—client and provider outcomes—have measurable indicators that would be sensitive to change at a reasonable time in the future.

A Hallmark of Trauma-Informed Change for the Perinatal Professions

A change in a staff member's habit of mind is a commonly understood hallmark of trauma-informed mental health and addiction care. This shift is from wondering about a client, "What is *wrong* with you?" to wondering "What *happened* to you?" There may be a similarly brief way to state what could be a hallmark of trauma-informed perinatal care. We would be enacting a trauma-informed approach in perinatal care if we shifted from locating the problem in the client as "*unresolved* maternal trauma" to locating it in our system and professional care as "*unaddressed* maternal trauma."

We can use mind-body and relational understandings of maltreatment-related post-traumatic stress to spot physical, psychological, and maternal development problems rooted in childhood trauma. We have expertise in the bodily experiences of pregnancy, birth, breastfeeding, and early parenting. We can name the numerous sequelae of maltreatment trauma that impinge on good childbearing processes and outcomes as significant clinical problems. We can state the reality that some responses are indeed within our domain as childbearing care providers—and make it so. We

can make a claim for adequate resources and a trauma-informed system of perinatal services. We cannot control whether our care will have the effect of fully resolving any individual's unresolved maternal trauma, but we can take some control over whether we have addressed it well.

References

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *The British Journal of Psychiatry, 204*(5), 335–340. https://doi.org/10.1192/bjp.bp.113.131227

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine, 46*(6), 1121–1134. https://doi.org/10.1017/S0033291715002706

Baas, M. A., van Pampus, M. G., Braam, L., Stramrood, C. A., & de Jongh, A. (2020). The effects of PTSD treatment during pregnancy: Systematic review and case study. *European Journal of Psychotraumatology, 11*(1), 1762310. https://doi.org/10.1080/20008198.2020.1762310

Bibring, G. L. (1959). Some considerations of the psychological processes in pregnancy. *The Psychoanalytic Study of the Child, 14*, 113–121. https://doi.org/10.1080/00797308.1959.11822824

Choi, K. R., & Seng, J. S. (2016). Predisposing and precipitating factors for dissociation during labor in a cohort study of posttraumatic stress disorder and childbearing outcomes. *Journal of Midwifery & Women's Health, 61*(1), 68–76. https://doi.org/10.1111/jmwh.12364

Conching, A. K. S., & Thayer, Z. (2019). Biological pathways for historical trauma to affect health: A conceptual model focusing on epigenetic modifications. *Social Science & Medicine, 230*, 74–82. https://doi.org/10.1016/j.socscimed.2019.04.001

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology, 39*(1), 35–51. https://doi.org/10.1348/014466500163095

Deutsch, H. (1945). *The psychology of women* (Vol. 2). Grune & Stratton.

Dhaliwal, K. (2016, October 24). Racing ACEs gathering and reflection: If it's not racially just, it's not trauma-informed. *ACES Too High* blog post. https://acestoohigh.com/2016/10/24/racing-aces-gathering-and-reflection-if-its-not-racially-just-its-not-trauma-informed/

Dikmen-Yildiz, P., Ayers, S., & Phillips, L. (2017). Factors associated with post-traumatic stress symptoms (PTSS) 4-6 weeks and 6 months after birth: A longitudinal population-based study. *Journal of Affective Disorders, 221*, 238–245. https://doi.org/10.1016/j.jad.2017.06.049

Eagen-Torkko, M., Low, L. K., Zielinski, R., & Seng, J. S. (2017). Prevalence and predictors of breastfeeding after childhood abuse. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 46*(3), 465–479. https://doi.org/10.1016/j.jogn.2017.01.002

Enlow, M. B., Kitts, R. L., Blood, E., Bizarro, A., Hofmeister, M., & Wright, R. J. (2011). Maternal posttraumatic stress symptoms and infant emotional reactivity and emotion regulation. *Infant Behavior and Development, 34*(4), 487–503. https://doi.org/10.1016/j.infbeh.2011.07.007

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

Forbes, D., Bisson, J. I., Monson, C. M., & Berliner, L. (Eds.). (2020). *Effective treatments for PTSD*. Guilford Publications.

Ford, J. D., & Courtois, C. A. (2020). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models*. Guilford Publications.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. *Journal of the American Academy of Child Psychiatry, 14*(3), 387–421. https://doi.org/10.1016/S0002-7138(09)61442-4

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Harvard University Press.

Geoffrion, S., Lamothe, J., Morizot, J., & Giguère, C. É. (2019). Construct validity of the professional quality of life (ProQoL) scale in a sample of child protection workers. *Journal of Traumatic Stress, 32*(4), 566–576. https://doi.org/10.1002/jts.22410

Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity & Disease, 2*(3), 207–221.

Gluck, R. L., Hartzell, G. E., Dixon, H. D., Michopoulos, V., Powers, A., Stevens, J. S., Fani, N., Carter, S., Schwartz, A. C., Jovanovic, T., Ressler, K. J., Bradley, B., & Gillespie, C. F. (2021). Trauma exposure and stress-related disorders in a large, urban, predominantly African-American, female sample. *Archives of Women's Mental Health, 24*(6), 893–901. https://doi.org/10.1007/s00737-021-01141-4

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review, 34*(5), 389–401. https://doi.org/10.1016/j.cpr.2014.05.003

Hardeman, R. R., Karbeah, J. M., & Kozhimannil, K. B. (2020). Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. *Birth, 47*(1), 3–7. https://doi.org/10.1111/birt.12462

Harnett, N. G., & Ressler, K. J. (2021). Structural racism as a proximal cause for race-related differences in psychiatric disorders. *American Journal of Psychiatry, 178*(7), 579–581. https://doi.org/10.1176/appi.ajp.2021.21050486

Hawn, S. E., Cusack, S. E., & Amstadter, A. B. (2020). A systematic review of the self-medication hypothesis in the context of posttraumatic stress disorder and comorbid problematic alcohol use. *Journal of Traumatic Stress, 33*(5), 699–708. https://doi.org/10.1002/jts.22521

Herman, J. L. (1992). *Trauma and recovery*. Basic Books.

Herzog, J. I., & Schmahl, C. (2018). Adverse childhood experiences and the consequences on neurobiological, psychosocial, and somatic conditions across the lifespan. *Frontiers in Psychiatry, 9*, 420. https://doi.org/10.3389/fpsyt.2018.00420

Hobfoll, S. E., Mancini, A. D., Hall, B. J., Canetti, D., & Bonanno, G. A. (2011). The limits of resilience: Distress following chronic political violence among Palestinians. *Social Science & Medicine, 72*(8), 1400–1408. https://doi.org/10.1016/j.socscimed.2011.02.022

Hopper, K., Bassuk, E., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1), 80–100. https://doi.org/10.2174/1874924001003010080

Huang, L. N., Flatow, R., Biggs, T., Afayee, S., Smith, K., Clark, T., & Blake, M. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.*

Jones, N. L., Gilman, S. E., Cheng, T. L., Drury, S. S., Hill, C. V., & Geronimus, A. T. (2019). Life course approaches to the causes of health disparities.

American Journal of Public Health, 109(S1), S48–S55. https://doi.org/10.2105/AJPH.2018.304738

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048–1060. https://doi.org/10.1001/archpsyc.1995.03950240066012

Koenen, K. C. (2007). Genetics of posttraumatic stress disorder: Review and recommendations for future studies. *Journal of Traumatic Stress, 20*(5), 737–750. https://doi.org/10.1002/jts.20205

Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D., & Spiegel, D. (2010). Emotion modulation in PTSD: Clinical and neurobiological evidence for a dissociative subtype. *American Journal of Psychiatry, 167*(6), 640–647. https://doi.org/10.1176/appi.ajp.2009.09081168

McEwen, B. S., & Stellar, E. (1993). Stress and the individual: Mechanisms leading to disease. *Archives of Internal Medicine, 153*(18), 2093–2101. https://doi.org/10.1001/archinte.1993.00410180039004

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold PTSD among men and women with eating disorders in the National Comorbidity Survey-Replication Study. *International Journal of Eating Disorders, 45*, 307–315. https://doi.org/10.1002/eat.20965

Moberg, K. U., & Moberg, K. (2003). *The oxytocin factor: Tapping the hormone of calm, love, and healing*. Da Capo Press.

Morland, L., Goebert, D., Onoye, J., Frattarelli, L., Derauf, C., Herbst, M., Matsu, C., & Friedman, M. (2007). Posttraumatic stress disorder and pregnancy health: Preliminary update and implications. *Psychosomatics, 48*(4), 304–308. https://doi.org/10.1176/appi.psy.48.4.304

Nagle-Yang, S., Sachdeva, J., Zhao, L. X., Shenai, N., Shirvani, N., Worley, L. L., Gopalan, P., Albertini, E. S., Spada, M., Mittal, L., Moore Simas, T. A., & Byatt, N. (2022). Trauma-informed care for obstetric and gynecologic settings. *Maternal and Child Health Journal, 26*, 2362–2369. https://doi.org/10.1007/s10995-022-03518-y

Pitman, R. K., Shin, L. M., & Rauch, S. L. (2001). Investigating the pathogenesis of posttraumatic stress disorder with neuroimaging. *Journal of Clinical Psychiatry, 62*(Suppl 17), 47–54.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation (Norton series on interpersonal neurobiology)*. W. W. Norton & Company.

Putnam, F. W. (1992). Discussion: Are alter personalities fragments or figments? *Psychoanalytic Inquiry, 12*, 95.

Raphael-Leff, J. (2018). *The psychological processes of childbearing*. Routledge.

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*(6), 984. https://doi.org/10.1037/0022-006X.61.6.984

Rhodes, N., & Hutchinson, S. (1994). Labor experiences of childhood sexual abuse survivors. *Birth, 21*(4), 213–220. https://doi.org/10.1111/j.1523-536X.1994.tb00532.x

Rose, A. (1992). Effects of childhood sexual abuse on childbirth: One woman's story. *Birth, 19*(4), 214–218.

Rowe, H., Seng, J., Acton, C., & Fisher, J. (2015). The postnatal period-opportunities for creating change. In *Trauma informed care in the perinatal period* (pp. 74–92). Academic Press.

Sanjuan, P. M., Fokas, K., Tonigan, J. S., Henry, M. C., Christian, K., Rodriguez, A., et al. (2021). Prenatal maternal posttraumatic stress disorder as a risk factor for adverse birth weight and gestational age outcomes: A systematic review and meta-analysis. *Journal of Affective Disorders, 295*, 530–540. https://doi.org/10.1016/j.jad.2021.08.079

Scott, K. A., Britton, L., & McLemore, M. R. (2019). The ethics of perinatal care for black women: Dismantling the structural racism in "mother blame" narratives. *The Journal of Perinatal & Neonatal Nursing, 33*(2), 108–115. https://doi.org/10.1097/JPN.0000000000000394

Seng, J., Miller, J., Sperlich, M., van de Ven, C. J., Brown, S., Carter, C. S., & Liberzon, I. (2013a). Exploring dissociation and oxytocin as pathways between trauma exposure and trauma-related hyperemesis gravidarum: A test-of-concept pilot. *Journal of Trauma & Dissociation, 14*(1), 40–55. https://doi.org/10.1080/15299732.2012.694594

Seng, J. S., Kohn-Wood, L. P., McPherson, M. D., & Sperlich, M. (2011). Disparity in posttraumatic stress disorder diagnosis among African American pregnant women. *Archives of Women's Mental Health, 14*(4), 295–306. https://doi.org/10.1007/s00737-011-0218-2

Seng, J. S., Li, Y., Yang, J. J., King, A. P., Low, L. M. K., Sperlich, M., et al. (2018). Gestational and postnatal cortisol profiles of women with posttraumatic stress disorder and the dissociative subtype. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 47*(1), 12–22. https://doi.org/10.1016/j.jogn.2017.10.008

Seng, J. S., Low, L. M. K., Sperlich, M., Ronis, D. L., & Liberzon, I. (2009). Prevalence, trauma history, and risk for posttraumatic stress disorder among nulliparous women in maternity care. *Obstetrics and Gynecology, 114*(4), 839. https://doi.org/10.1097/AOG.0b013e3181b8f8a2

Seng, J. S., Sparbel, K. J., Low, L. K., & Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery & Women's Health, 47*(5), 360–370. https://doi.org/10.1016/S1526-9523(02)00284-2

Seng, J. S., Sperlich, M., & Low, L. K. (2008). Mental health, demographic, and risk behavior profiles of pregnant survivors of childhood and adult abuse. *Journal of Midwifery & Women's Health, 53*(6), 511–521. https://doi.org/10.1016/j.jmwh.2008.04.013

Seng, J. S., Sperlich, M., Low, L. K., Ronis, D. L., Muzik, M., & Liberzon, I. (2013b). Childhood abuse history, posttraumatic stress disorder, postpartum mental health, and bonding: A prospective cohort study. *Journal of Midwifery & Women's Health, 58*(1), 57–68. https://doi.org/10.1111/j.1542-2011.2012.00237.x

Simkin, P., & Klaus, P. (2004). *When survivors give birth*. Classic Day.

Slade, P., Balling, K., Sheen, K., Goodfellow, L., Rymer, J., Spiby, H., & Weeks, A. (2020). Work-related post-traumatic stress symptoms in obstetricians and gynaecologists: Findings from INDIGO, a mixed-methods study with a cross-sectional survey and in-depth interviews. *BJOG: An International Journal of Obstetrics & Gynaecology, 127*(5), 600–608. https://doi.org/10.1111/1471-0528.16076

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice, 1*(1), 93–10. https://ssrn.com/abstract=1350062

Sperlich, M., & Seng, J. S. (2008). *Survivor moms: Women's stories of birthing, mothering and healing after sexual abuse*. Motherbaby Press.

Stein, D. J., Koenen, K. C., Friedman, M. J., Hill, E., McLaughlin, K. A., Petukhova, M., et al. (2013). Dissociation in posttraumatic stress disorder: Evidence from the world mental health surveys. *Biological Psychiatry, 73*(4), 302–312. https://doi.org/10.1016/j.biopsych.2012.08.022

Stein, M. B., McQuaid, J. R., Pedrelli, P., Lenox, R., & McCahill, M. E. (2000). Posttraumatic stress disorder in the primary care medical setting. *General Hospital Psychiatry, 22*(4), 261–269. https://doi.org/10.1016/S0163-8343(00)00080-3

Stevens, N. R., Miller, M. L., Puetz, A. K., Padin, A. C., Adams, N., & Meyer, D. J. (2021). Psychological intervention and treatment for posttraumatic stress disorder during pregnancy: A systematic review and call to action. *Journal of Traumatic Stress, 34*(3), 575–585. https://doi.org/10.1002/jts.22641

Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., Navalta, C. P., & Kim, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience & Biobehavioral Reviews, 27*(1–2), 33–44. https://doi.org/10.1016/S0149-7634(03)00007-1

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Press.

Weaver, I. C., Cervoni, N., Champagne, F. A., D'Alessio, A. C., Sharma, S., Seckl, J. R., et al. (2004). Epigenetic programming by maternal behavior. *Nature Neuroscience, 7*(8), 847–854. https://doi.org/10.1038/nn1276

Weinstein, A. D. (2016). *Prenatal development and parents' lived experiences: How early events shape our psychophysiology and relationships*. W. W. Norton & Company.

White, K. R., & Griffith, J. R. (2019). *The well-managed healthcare organization*. Health Administration Press.

World Health Organization. (2018). *ICD-11 for mortality and morbidity statistics*. https://icd.who.int/browse11/l-m/en