Clinical Challenges and Possible Solutions

Clinical Challenge or Complication	Possible Psychological Causes	Possible Solutions
1. Prolonged prodromal labor (non-progressing contractions).	1. Reluctance to enter the process that results in parenthood. 2. Recognition that she is out of control over her body. 3. Self-fulfilling prophecy: Her body won't do this correctly because it is damaged, defective.	1. Talk it over. "Why do you think it is taking so long to get into labor?" 2. Help her shift control from her body to her conscious responses to her contractions, which she *can* control. 3. Reassurance that prelabor often takes a long time, while the cervix ripens, effaces, and moves forward. 4. Patience, nourishment, help with sleep (bath, massage, sleeping medications).
2. Resistance to or inability to tolerate vaginal exams, blood draws, IV's, catheters, etc. (physical struggle, tension, panic, fainting).	1. Association with rape or genital pain, especially if done by same gender as her perpetrator. 2. Phobia over blood. 3. "Invasion" of body boundaries may represent a metaphor for rape, defenselessness, etc. 4. Fear of having genitals exposed, visible to strangers.	1. Do as few of these procedures as possible and tell her that. 2. Should have been discovered before labor and noted prominently in the chart. 3. Get the woman's permission. 4. Proceed slowly, step by step, regulated by the woman. 5. Have a trusted, kind, familiar person with her. 6. Respect her modesty as much as possible.
3. Strong preference for one careprovider or gender of careprovider ("wrong" gender is on call). This may apply to doctor, midwife, nurse, anesthesiologist, pediatrician.	1. Distrust of authority figures of that gender (associated with gender of perpetrator). 2. Client may believe other women are, like her or like her mother, weak, incompetent, untrustworthy or evil.	1. Validate her need and try very hard to honor this need (and, if impossible, tell her that you tried). 2. Should have been discovered ahead of time. 3. If possible, arrange for person of client's desired gender to do vaginal exams and other invasive procedures. 4. Use active listening; try not to take it personally.
4. Labor progress stalls in active phase.	1. Labor pain is reaching a point where she can no longer remain "in control." Deep fear of pain behaviors (screaming, thrashing, panicking) associated with being helpless and out-of-control during abuse. She keeps the labor at a level where she can remain in control. 2. Deep fear of vaginal birth, preference for a cesarean for "failure to progress." 3. Fear leads to increased production of stress hormones (catecholamines), known to slow labor.	1. Talk it over: "Why do you think your progress has stalled?" 2. Pain medications or an epidural may diminish the output of catecholamines, and enable further interventions, such as oxytocin or second stage interventions.
5. Struggling during administration of epidural, even though she requested it.	1. Anesthesia placed by unseen person at her back, may remind her of abuse from behind at night. 2. Reminders to "lie still and it will be over sooner," may be what she heard before. 3. If partner is asked to leave for the procedures, it magnifies her helplessness.	1. Speak to her face-to-face before beginning procedure. 2. Describe every step. 3. Ask her for feedback. 4. Have her partner or doula at her face and the nurse offering encouragement and praise. 5. If necessary, speak firmly and confidently. No coaxing or sweet-talking.
6. Woman appears "out-of-touch," in a	1. This may be a survival technique, used since	1. If possible, find out ahead of time if she sometimes dissociates, and how she

trance. Difficult or impossible to speak with her (dissociation, blanking out). "Coming back" may be either a shattering, upsetting process, or merely like gradually waking up.	childhood to "leave" during pain or terror. 2. Dissociation blocks not only the experience, but any memory of it as well.	feels about it for labor. 2. If she doesn't want to dissociate, partner, doula, nurse, or caregiver should maintain eye contact, keep talking to her and asking her to respond by words, actions. Keep her in the present.
7. Delay or failure in descent in second stage.	1. Fear of vaginal birth: the pain, stretching, possible tearing, episiotomy. 2. Perception of baby as "perpetrator," hurting and damaging her. 3. Reluctance to become a parent. 4. "Holding back" – tension in perineum. 5. Fear of exposure or expelling feces.	1. Reassurance. 2. Hot compresses. 3. Associate birth more with bowel movement than rape. Ask her to sit on the toilet for a few contractions. It often helps a woman relax her perineum and bear down effectively. 4. Remind her that the pain is coming out of her body; the baby is her ally in getting rid of the pain. If abuse history is known to both woman and caregiver, tell her, "This is not the pain of invasion or rape. Push the pain out, along with your baby." 5. Cover her vaginal outlet and perineum with a hot compress. The cover feels safer, the heat helps her relax, the pressure gives her feedback on how and where to push, and hides fecal material and eases wiping it away. 6. Ask her why she thinks the baby is not coming. If she answers that she doesn't want it to come out or that the baby doesn't want to come out, try to hell her that holding the baby in will not take care of the problem. Let the baby out and we'll figure out what to do. 7. Episiotomy, vacuum extractor, forceps (will not solve underlying emotional etiology_.
8. Lack of interest in the newborn; wants father or others to hold baby; resists attempts by staff to give baby mother.	1. Baby as perpetrator. 2. Dissociation during birth may delay bonding. 3. Traumatic birth may override thoughts for baby. 4. Abuse in childhood may have left woman with little instinct of mothering.	1. Allow expressions of anger, lack of confidence, dislike toward baby. Encourage a more positive family member to be with baby. 2. Don't rush contact between mother and baby. Give mother time to recognize that labor is over, to "come back." Most abuse survivors do "take in" the baby. 3. Model ways to hold child; encourage positive gestures by mother; point out how baby responds to her; show her infant cues. 4. Make sure mother has resources and follow-up after leaving hospital.
9. Reluctance or inability to breastfeed (extreme pain, disgust, lack of milk supply).	1. Flashbacks to abuse brought on by baby having access to breasts, sucking and hurting them> 2. Baby as perpetrator, manipulative, willful, hurtful, selfish. 3. Modesty issues around exposure of breasts.	1. Recognize that sometimes abuse survivors cannot breastfeed. Follow their lead. 2. If a woman really wants to breastfeed but cannot, pumping and feeding by bottle may be acceptable. 3. Help mother recognize that a young baby cannot manipulate or deliberately hurt her. Help her frame her perceptions. 4. Refrain from touching woman's breasts; allow privacy. Teach latch techniques without making her expose her breast. Let her try in private.