When a PTSD Survivor Becomes Pregnant: Implications For EMDR Treatment

*(by **Carol Forgash, CSW, BCD** [8/6/00])*

There are many questions and issues concerning the use of EMDR in the treatment of pregnant PTSD survivors. I think Tom Cloyd's EMDR Portal summary of the issues involved in the EMDR treatment of pregnant women who suffer from PTSD is a wonderful opening to an in-depth discussion of this subject. Since approximately one out of four women (USA national Child Abuse statistics) are survivors of childhood sexual abuse, and many of these have a diagnosis of PTSD, a not inconsiderable number of pregnant women at any given time are going to have PTSD symptoms.

I have treated a large population of survivors in the 20 years that I have been in practice. I have lectured and written about the health needs of sexual abuse survivors including pregnant women ("Enhancing the Healthcare Experiences of Adult Female Survivors of Childhood Sexual Abuse". Women and Health, Vol.30, No.4, in press). Additionally, I have treated about 10 pregnant survivors with EMDR over the past 6 years.

I would like to mention several issues that I think are important to this discussion. As with all practice issues, you have to use your clinical judgment when you decide to utilize EMDR to treat anyone. This conflict (to treat the trauma in pregnant clients, or not, because of fears of harming the client or fetus) is very similar to the one between psychotherapists and substance abuse counselors. The latter say that you cannot treat the trauma in a person who is in early sobriety because the person will be triggered into drinking. The psychotherapists note that if you do not treat the PTSD /trauma, the person may return to the drugs to block, numb etc...Each of us has to deal with this kind of decision making if we work with abuse survivors.

If you are not familiar with the issues of survivors during pregnancy, read the literature (which is at present somewhat limited--nursing journals have some information and John Briere has also written on the subject). There may be a very complicated clinical picture developing during the pregnancy of sexual abuse/trauma survivors. A treatment plan will have to deal with intrapsychic, behavioral, interpersonal and even trauma issues. I will mention a few that are just the tip of the iceberg.

When a sexual abuse survivor with PTSD becomes pregnant, she may develop feelings of body betrayal (even if the pregnancy is planned) and experience feelings of intrusion and invasion. These are triggers that can result in flashbacks to the original abuse, symptoms of depression, anxiety and even panic disorder. She may have abuse memories for the first time. Both the mother and fetus may experience distress from the triggers and subsequent chemical responses (in addition to the normal, but powerful hormonal changes that take place over 9 months in the mother's system).

Additionally, she may develop antagonistic, hostile feelings towards the expected child, often projecting her feelings about the abuser onto the child. Simultaneously, she may feel guilt about these feelings and also shame concerning her body changes. This is especially problematic if she already has hatred of self, her body etc. These negative feelings may also be frightening in their intensity. Superstitiously, she may begin to fear that the child will be born deformed (like her), or even dead (i.e. as punishment, wish fulfillment or self fulfilling prophesy). She may begin to believe that she will be an incompetent or even abusive parent. There are similar issues in all the above areas re: the father of the child/partner/spouse that need to be dealt with.

Issues about dealing with an obstetrician/midwife/hospital staff include; authority/control/terror/and flashback triggers. Much work concerning preparation and rehearsal is necessary in dealing with these caregivers, so that the birth experience is not retraumatizing. With some clients, the use of EMDR for stability, relaxation and stress reduction and visualization work, RD, dealing with traumatized and other ego states, dealing with the doctors etc. precede any trauma protocol work.

Much depends on the length of your relationship with the client (does it precede the pregnancy?) and the kind of supports that she has internally and from family, community etc. How much trust has the client developed in the therapeutic relationship? How much education have you provided her about the health needs and problems of the sexual abuse survivor? Have you developed a collegial relationship with the health provider? I could continue indefinitely. You will have to continue to help the client get information and/or sometimes provide information about each stage in the pregnancy including what to expect afterwards. (Unfortunately, even today, many doctors etc., don't educate their patients or know about the sequelae of sexual abuse for the survivor).

Given all of these variables, I have only chosen not to offer EMDR to a pregnant client once--one with a very unstable history, a Dissociative Identity Disorder diagnosis, and a serious substance abuse problem. I believed she would be seriously destabilized by working on the traumas. All of the other clients elected to work on the trauma with EMDR because they could not tolerate the disruptive nature of the PTSD and saw that as more harmful to their child. I had a good relationship with each one prior to their pregnancy...and we accomplished much trauma resolution during the pregnancy (with the knowledge and approval of their physician and spouse), without additional distress.

(for related information, see Clinical Applications Note: Pregnancy and EMDR -- is ANY form of EMDR safe in the context of pregnancy?)

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