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Traumatic Birth Experiences and Maternal Empowerment: A Rehabilitation Counseling Perspective

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Abstract

It is predicted that every 4.5 minutes an infant is born with a birth defect, and, on average, 1 in 33 infants are born with some type of birth defect. The rehabilitation literature is replete with studies signifying the importance of adjustment to disability among clients and consumers and their families. Discussions surrounding maternal empowerment, maternal adjustment, and trauma associated with traumatic birth, birth defects, and childhood disability and related clinical implications follow.

Keywords: birth, trauma, empowerment, maternal

Lear (2006) stated that childbirth is a uniquely female experience and likely influences most women's overall identity development. According to Nilsson, Bondas and Lundgren (2010), the process of childbirth is defined as a distinctively existential event, affecting the mother, child, and family at large (Elmir, Schmied, Wilkes, & Jackson, 2010). Generally speaking, perceptions are that pregnant women live healthier lifestyles, seek appropriate health care during pregnancy, and engage in best practices to reduce exposure to harmful substances that may be injurious to their unborn children (Sauber-Schatz, 2008). Nonetheless, mothers often report fears of an unfavorable or unforeseen outcome occurring during pregnancy or at birth (Hojeberg, 2000). These fears may be further exacerbated by poor social support systems and maternal temperament vulnerable to the onset of anxiety or depression (Nilsson et al., 2010). Giving birth to a child with a mental or physical disability, or dual diagnosis, potentially increases maternal and family stress levels (Abrams & Kaslow, 1977). Parents of children with disabilities describe lower levels of self-efficacy, decreased satisfaction within their

parental roles, elevated levels of depression, declining marital happiness, and increased divorce rates (Shechtman & Gilat, 2005).

As a result of adverse birth experiences, mothers may experience trauma. This makes sense from the point of view of lived traumatic experiences and trauma-related events. According to the Substance Abuse and Mental Health Services Administration (SAMHSA; 2014), trauma is caused by experiences that instigate physical and psychological stress reactions. Trauma can result from a single event, multiple events, or a set of circumstances that are emotionally or physically harmful, negatively impacting an individual's physical, social, emotional, or spiritual well-being (SAMHSA, 2014). Trauma impedes a person's ability to cope, generating feelings of fear, vulnerability, and emotional weakness (SAMHSA, 2014).

Mothers, together with their infants, may experience difficulties during pregnancy and/or delivery that could have lasting effects on the mother and her child, including impaired fetal and child development, developmental disabilities, and complications that are eventually observed within adulthood. Sauber-Schatz (2008) estimated that 150,000 infants born in the United States each year are born with birth defects. Elmir and colleagues (2010) stated that there is no clear description of birth trauma, taking a broad view of the construct, to include intervention(s) utilized during delivery, as well as the way health care personnel provide personal care. By contrast, Linder and colleagues (2013) defined birth trauma as any type of injury experienced by the infant during the labor and delivery process. Sauber-Schatz went on to describe birth defects as a deformity in structure or function identified at birth that influence physical or mental disabilities, and in some instances, threaten death. Compared to infants born without birth defects, infants of traumatic birth who survive are more likely to live with long-term disability and decreased quality of life.

When trauma surrounding the birth process occurs, parents and families typically experience high levels of psychological anguish and emotional grief, especially in instances when the infant is transferred to the neonatal intensive care unit (NICU). Women who have survived traumatic birth report (a) feeling physically unwell, (b) having depressed mood, (c) avoiding social engagement, and (d) fearing future pregnancy and childbirth. Other concerns relate to sexual dysfunction and feelings of self-blame for what happened to the baby or reluctance to attach and bond with the baby (Ayers, Eagle, & Waring, 2006). These reports are particularly worrisome in view of corresponding research indicating that positive body image, physical well-being, enhanced marital/partner relationships, sexual responsiveness, readiness to bond with the baby, and hopefulness for future pregnancies are strong predictors for positive adjustment to childbirth (Kumar, Robson, & Smith, 1984).

Relevant Statistics

In 2013, 3,932,181 children were born in the United States (Martin, Hamilton, Osterman, Curtin, & Matthews, 2015). During the first year of an infant's life, one in five parents experiences the death of an infant due to a birth defect (Centers for Disease Control [CDC], 2014). According to the CDC, the associated cost of birth defects and hospitalization exceeds \$2.6 billion annually, and an estimated 12% of all pediatric hospital visits are a result of a birth defect or a genetic condition.

Infants who survive traumatic birth and associated birth defects are more likely to live with mental and physical disabilities, social difficulties, long-term effects of disability, and decreased quality of life (Sauber-Schatz, 2008). The direct and indirect costs associated with caring for a child with a disability, from birth through adulthood, have been estimated at \$30,000 annually. Associated costs include health care expenditures, educational or therapeutic services, transportation, and caregiver supports, to name a few. According to D. Anderson, Dumont, Jacobs, and Azarria (2007), most families caring for a child with a disability do not receive reimbursement for disability-related services obtained on behalf of the child. As well, an estimated 40% of families report financial hardships due to special needs costs (D. Anderson et al., 2007), and within this group, the typical household consists of low-income jobs, normally held by a single parent, residing in poorer neighborhoods. Parents are often forced to request significant amounts of time off from work with decreasing weekly work hours and related income (Stabile & Allin, 2012). Three of the most frequently occurring birth defects include: (a) spina bifida (Hispanic women—4.17% per 10,000 births; non-Hispanic, African American women—2.64% per 10,000 births; non-Hispanic, Caucasian women—3.22% per 10,000 births); (b) brachial plexus injury (1–4 per 1,000 births); and (c) cerebral palsy (1.5–4 per 1,000 births; CDC, 2014; Ridgeway, Valicenti-McDermott, Kornhaber, Kathirithamby, & Wieder, 2013).

The Construct of Empowerment

Empowerment is an important construct in rehabilitation counseling (Kosciulek, 1999). Rehabilitation practitioners who utilize this theory forward the notion that empowered individuals experience feelings of self-efficacy and control of their life situations and are more likely to reach personal goals (Fisher & Howell, 2010). Empowerment may be conceived as a compilation of self-efficacy, control, and participation, all of which impact personal choice. Empowerment is also viewed as a critical variable within rehabilitation research (National Institute on Disability and Rehabilitation Research, 1991), whereby individual resources, independence, and autonomy (rather than deficits) are deemed fundamental and constant to the counseling process.

According to Feste and Anderson (1995), positive health education is a mixture of individual self-awareness, values and beliefs, clearly-identified goals, and personal skills. Aujoulat, d'Hore, and Deccache (2007) stated that empowerment likely derives from personal change, bringing about greater understanding of personal morals and priorities and an increased sense of self-efficacy. Freire (1973) explained that powerlessness is the opposite of empowerment. Powerlessness comes about when an individual feels vulnerable to external circumstances beyond his or her control (Aujoulat et al., 2007). On the contrary, empowerment may be a tool to enhance quality of life (Aujoulat et al., 2007). Freire further viewed empowerment as both a process and an outcome (R. Anderson & Funnell, 2009). Empowerment as a process refers to an educational event, utilized to increase individual autonomy and critical thinking (R. Anderson & Funnell, 2009). Empowerment as an outcome refers to enhanced individual self-efficacy. In other words, a young mother may indeed believe she has the skill set to take care of a child with disability (e.g., feeding, diapering her baby, bringing the baby to medical

appointments), but an empowered mother experiences a deeply intentional commitment to her child, which goes beyond a simple skill set and includes self-knowledge of her willing capacity “to go the distance.” The rehabilitation counselor facilitates the empowerment process, providing psychoeducation and encouragement to the client mother, assisting her in discovering her many layers of parental love and devotion (Feste & Anderson, 1995).

Empowerment and Its Clinical Application

Feste and Anderson (1995) suggested empowerment achievement is executed by the individual, a process facilitated by the rehabilitation counseling or allied health professional. When assessing individuals for levels of empowerment, the rehabilitation counselor or other allied health professional may focus upon individual spiritual and psychosocial well-being (Feste & Anderson, 1995). Other factors could include an individual’s history of coping and coping efficacy, familial and other social support systems, the individual’s ability to self-advocate, and hopefulness (Feste & Anderson, 1995).

Feste and Anderson (1995) stated that individual empowerment could also come about through psychoeducation. Seven notable educational factors include: (a) the idea of well-being assists individuals in value, needs and goal identification; (b) the aspect of self-image is recognized as a dominant force that guides behaviors and influences an individual’s attitude; (c) an individual’s motivation is explored to identify forces that impact decision making concerning behavior and attitudes; (d) the concept of adaptability supports individual ability to adjust to inevitable changes that occur within an individual’s life; (e) stressors and corresponding coping mechanisms can be identified and implemented; (f) problem-solving skills can be taught; and (g) support is at the core of a healthy lifestyle. Much like the focus of rehabilitation counseling, Feste and Anderson described the four pillars of empowerment as awareness, freedom, choice, and responsibility. Awareness relates to an individual’s ability to make informed decisions. Second and thirdly, individuals have the freedom to choose the manner in which they live their lives. Lastly, individuals must take responsibility for their choices and actions (Feste & Anderson, 1995).

Health care professionals view empowerment as an important patient characteristic for successful management of both acute and chronic health care issues (Feste & Anderson, 1995). Health care professionals utilize questions/dialogue, behavioral language, and storytelling to empower individuals in their care. At the heart of questions/dialogue is the goal to provide encouragement and to instill hope; and according to Feste and Anderson (1995), obtaining “answers” can help individuals discontinue the process of searching or inquiry, particularly in those situations where there are no “acceptable answers.” Behavioral language consists of incorporating language such as “list, label, classify, explain and design” to encourage individuals to act and make informed decisions. The art of storytelling facilitates individual opportunity for self-discovery (Feste & Anderson, 1995). Internal strength is often identified when individuals make connections with stories that have similarities to their personal beliefs and values. Feste and Anderson utilized the biblical story of David and Goliath as an example of how an individual’s internal strength may be awakened after reading or

hearing the story. Additionally, individuals may feel empowered when given the opportunity to serve as authors of their personal life stories.

Maternal Empowerment

International and national health care provider policy makers recognize the importance of maternal positive adjustment to childbirth (Commission on the Family, 1998; World Health Organization, 2005). Indeed, and according to Leahy-Warren, McCarthy, and Corcoran (2011), procedures and guidelines to incorporate an operational definition of social support or empowerment to increase maternal perceived parental self-efficacy are important. Rehabilitation counseling professionals operationalize empowerment as a combination of individual behaviors, including control, participation, and choice (Fischer & Howell, 2010). Portela and Santarelli (2003) argued that service providers can create real opportunities for women to feel empowered through reciprocal efforts to provide meaningful information related to care. In other words, women feel empowered when they are (a) provided information related to their health care or the health care of their child and (b) encouraged to analyze information in order to make the best health care and other life decisions possible (Portela & Santarelli, 2003).

To better support maternal empowerment, health care and rehabilitation counseling professionals must ensure continuity of mother/child care: beginning at the initial stages of a women's pregnancy, continuing through pregnancy and delivery, and carrying forth during the postnatal stage (Portela & Santarelli, 2003). Mother/child care coordination should include a team of skilled health care professionals, collaboration with family, and proper assessment and maintenance of home environment. Care services must also include empowering mothers to engage in behaviors consistent with sustaining self-care behaviors over time (Portela & Santarelli, 2003). According to Holland et al. (2011), mothers with poor parenting self-efficacy are more likely to avoid pursuing appropriate care for themselves and for their children due to absence of confidence in the ability to make effective judgments regarding health care. As a result, any mother/child health care issue can potentially deteriorate or worsen (Holland et al., 2011). Of greatest concern is the reality that (a) providing care for an infant or child with a severe disability has been linked with maternal depression, and (b) maternal depression further influences poor maternal coping (Holland et al., 2011).

Maternal Engagement in Birth Planning

Informed maternal decision making as an intervention to positive health care will likely improve both preparation for birth-related emergencies and corresponding birth trauma (Portela & Santarelli, 2003). Furthermore, health care and rehabilitation counseling professionals may provide support throughout a woman's pregnancy with a birth and emergency obstetrical and neonatal plan (Portela & Santarelli, 2003). In developing these plans, health care and rehabilitation counseling providers encourage mothers to problem solve health-related scenarios.

Portela and Santarelli (2003) highlighted several key components that are beneficial to include in a mother's birth and emergency obstetrical and neonatal plan. Essential necessities for the birthing plan include: (1) the mother's identification of where the delivery will take place (e.g., home, hospital); (2) location of the closest health care facility in the event of an emergency; (3) identification of a skilled and competent health

care provider; (4) documentation of a spouse, family member, or next of kin for the delivery or in the event of an emergency; (5) support to oversee the home and children during stay at the hospital; (6) securing emergency funds for the new birth and/or complications associated with the delivery; (7) transportation; (8) obtaining appropriate necessities to best support the delivery in a hospital or home environment (e.g., if home delivery, secure blankets, access to water, appropriate delivery kit; if hospital delivery, secure clothing for mother and baby, bottles, soap); and (9) identifying a blood donor in the event of transfusion requirement (Portela & Santarelli, 2003). Due to the significance of the nature of delivery, it is imperative for health care professionals to understand that the decision-making process should be a shared responsibility between the mother and those providing care (Portela & Santarelli, 2003).

Adjustment to Motherhood

When a mother gives birth to a child, the process of delivery brings about a change or reorganization in both parents' lives (Boss, 2002). As a result, adjustment to and reassignment of parental and familial roles occur. Canavarro (2001) defined adjustment in relation to motherhood as the mother's ability to be successful in accomplishing a set of developmental tasks and utilizing the skill set to educate and further encourage positive child development (Moura-Ramos, 2006). According to Troutman, Moran, Arndt, Johnson, and Chmielewski (2012), there has been a rise in recent years regarding factors that influence a mother's perception of her ability to parent effectively. The concept of maternal parenting self-efficacy is an influential factor for interventions within the area of infant mental health (Troutman et al., 2012). As a result of the development of interventions and supports that cater to boosting mothers' level of self-efficacy, positive outcomes have been reported for families. According to Sanders and Wooley (2004), social learning models are effective in supporting parents to increase levels of self-efficacy.

Parental self-efficacy emerged from Albert Bandura's general model of self-efficacy. Bandura (1977) defined self-efficacy as an individual's perception or belief in his or her level of competence to accomplish a task. Bandura proposed five factors associated with increased self efficacy: (a) previous experiences; (b) vicarious experiences; (c) verbal persuasion; (d) physiological state; and (e) affective state. Previous experiences are similar to mothers' involvement with childcare prior to acquiring the title of mother, and these experiences may contribute to mothers' building a foundation of beliefs and sense of maternal self-efficacy (Leahy-Warren & McCarthy, 2010). Maternal self-efficacy may be enhanced through vicarious experiences. For example, mothers may interact with other mothers in comparable situations to boost maternal self-efficacy (Leahy-Warren & McCarthy, 2010).

Verbal persuasion could be utilized to reassure mothers that they most likely "have what it takes" to be a successful mother. According to Leahy-Warren (2005), positive feedback regarding mothers' parenting skills especially from an individual's own mother, partner or spouse and is linked with greater levels of maternal self-efficacy in infant care during the postpartum phase. Leahy-Warren and McCarthy (2010) went on to say that social supports have the capacity to strengthen maternal physical (and psychological) well-being. McVeigh (1998) proclaimed that mothers are more likely to experience difficulty adjusting to motherhood when supportive systems (e.g., childcare)

are absent. Mother's mood (affect) also contributes to maternal self-efficacy (Leahy-Warren & McCarthy, 2010). Positive maternal mood may give way to higher levels of self-efficacy, and negative mood, to lower levels (Leahy-Warren & McCarthy, 2010).

Mothers: Their Children With Disabilities, Families, and Communities

In order to assist with ameliorating the reality of unfavorable infant health results following birth trauma, Neely-Barnes and Dia (2008) recommended empowerment as an intervention that encourages parental coping. Dunst, Trivette, and Deal (1988) defined empowerment as (a) an individual's access and sense of control over required resources; (b) autonomy with decision making; and (c) interactions with others that create the ability to gain access to resources. The concept of maternal empowerment serves the purpose of supporting families in coping with the stressors of caring for a child with a disability.

The magnitude of caring for a child with a disability is a difficult task in the best of circumstances. Within the parenting domain, Gohari, Dehghani, Rajabi, and Mahmoudi-Gharaei (2012) proclaimed that self-efficacy encourages parental competence and adjustment to new situations. Family perceptions of the childhood disability significantly impact the family's mental health status (Hung, Wu, Chiang, Wu, & Yeh, 2010). Barlow, Powell, and Gilchrist (2006) affirmed that families of children with disabilities are at a higher risk for psychosocial disorders. The high risk is a result of the absence of confidence that quality care can be provided for the child by the parent (Barlow et al., 2006). Family reports highlighted by Leung and Li-Tsang (2003) described family's experiences of physical and psychological disorders that have impacted the quality of life of family members. Due to the decline in family quality of life and high levels of anxiety and stress, the rehabilitation goals for the child often include goals for the family as well (Akmese, Mutlu, & Gunel, 2007). It is the recommendation of Akmese et al. (2007) that the psychological and social issues that are experienced by families of children with disabilities be reviewed in order to identify best practices in mediating these familial self-efficacy concerns.

Social support systems significantly influence parental psychological functioning (Simons, Lorenz, Wu, & Conger, 1993). Within most marriages, the spouse or partner is considered the primary maternal support system. By contrast, and in the majority of single parent homes, mother's friends, family, and outside relatives play a major role in the upbringing of single-parent children (Belsky & Vondra, 1989). Generally speaking, it is considered best practice among rehabilitation counseling and other allied health care professionals to promote and facilitate access to health care interventions, and these practices have particular poignancy and meaning for mothers and children living in poverty (Portela & Santarelli, 2003).

Early intervention programs that focus upon positive parenting skills and competencies are more likely to yield short- and long-term satisfactory outcomes for mother/child health care and overall development (Guimond, Wilcox, & Lamorey, 2008). Indeed, such outcomes have a significant and positive effect upon the greater mother/child family system. Programs that utilize modeling and role-play, including methods for constructive criticism, are likely to support both positive mother/spouse/partner/family relationships, as well as interactions with children (Sanders & Wooley, 2005).

Conclusion

According to Benzies, Trute, and Worthington (2013), limited focus has been placed on parental self-efficacy and level of adjustment for families of children with disabilities. Measuring maternal empowerment is likely a useful strategy in identifying appropriate services for parents of children with disabilities (Benzies et al., 2013). Empowered mothers who parent a child(ren) diagnosed with a disability typically exhibit positive adjustment over time (Benzies et al., 2013).

Heightened parental stress is a common experience among parents whose children are diagnosed with a disability (Baker, Blacher, Crnic, & Edelbrock, 2002; Dumas, Wolf, Fisman, & Culligan, 1991). Parental competence and ability to adjust are common risk factors, as well as parental depression and anxiety (Fisman, Wolf & Noh, 1989; Guimond et al., 2008). Accessibility to services can also contribute to maternal stress while caring for a child with disabilities. Parents are faced with the presence of the child's disability, current parenting abilities, as well as challenges that may be present in attaining sufficient health care providers and identifying appropriate community resources (Benzies et al., 2013).

According to Moos and Tsu (1977), mothers and parents who demonstrate highest levels of adjustment to parenthood are able to maintain psychological and emotional balance between worry associated with their child's disability and intention and hopefulness associated with positive child development. Intuitively-speaking, mothers who feel empowered are more likely to adjust to the social, physical, emotional, and psychological challenges following childbirth. This is particularly true for mothers and their children who have experienced birth trauma.

The American Academy of Pediatrics and American College of Obstetricians and Gynecologists developed standards to ensure maternal readiness to complete hospital discharge such as physiological stability, maternal knowledge, maternal capabilities, confidence in aspects of self-care and newborn care; availability of social support to assist with the transition phase from hospital to home and the availability of continuous obstetric and infant care following the mother and infant's discharge from the hospital (Weiss & Lokken 2009). Positive negotiation of these elements is particularly important for mothers experiencing traumatic childbirth. Rehabilitation counselors are uniquely poised to help mothers of traumatic birth navigate the all-important developmental challenges toward empowerment—and across both her “maternal” lifespan and that of her child.

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