'Wild card' dynamics – emotional work in pregnancy

By Rhea Dempsey

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If you are a card player, follow tennis or even politics you will be familiar with idea of 'wild cards'. A 'wild card' suggests high potency, high effect or high skill combined with unpredictability. You don't know when it will be played, but when it is you know it will have a significant impact. This article applies the idea of wild cards to birthing.

I first began to think about wild cards many years ago at the birth of a little girl, Janey. She was the second child of a couple whose toddler boy had died of a childhood cancer eighteen months previously. The mother carried unrelieved 'causal guilt' (guilt characterised by a feeling of responsibility) because she believed that a chemical insect eradication treatment used on their house before their son became sick was the cause of his illness. Whether or not this was the case, it was the anguished reality of this mother's belief. She had therefore taken great care during this pregnancy to minimise any possibility of carcinogenic or synthetic compounds affecting this baby's early formation and development. She was highly motivated to have a normal physiological birth, as she didn't want her baby subjected to any drugs or synthetic hormones during the labour itself. Although she had an epidural in her first labour, she did not want one this time. She also felt that her husband's emotional distress might prevent him from providing the support she needed, so she invited me to attend the birth to ensure that she didn't succumb to an epidural.

This will be straightforward, I thought – a highly motivated mother, clear about what she wants. I had little awareness then of such things as grief attacks, resistance, regression, triggering, cathartic release, of the potential for unconscious processes to sabotage conscious intentions, or of the importance of bearing witness. Over the hours of this labour I received a crash course.

In late first stage, after getting through some fear- and resistance-fueled crises, the triggering of this mother's grief for her son culminated in the explosion of a cathartic rage. I had been breathing with her through the contractions, assisting her to stay on track with her original intention. But now she was in (I now realise) a full-blown grief-fueled cathartic release. She pounded against my chest, pleading for an epidural, roaring at me repeatedly, over and over that: *You are so cruel. Get me the epidural! How can you be so cruel?* I was quite shaken: it took me (and her, I found later) completely by surprise. Knowing the likelihood of her later mental anguish if she *did* have an epidural, I tried to hold to her previously expressed intention for her longer term well being. But she was overwhelmed by the distressing present moment. Gradually I caught on. She was pouring out her grief, raging at me as a stand in, as a proxy for god, death, her son (for abandoning her), and the whole damn universe. She raged at the cruelty of her loss with the hallmarks of 'grief work' at its most raw.

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Thus my idea of wild cards was formed: particular life circumstances, issues and patterns carry a potent, unpredictable dynamic. We cannot know when they will play out in the birth or postnatal period, or exactly what their effect will be. We just know that they will arise in some way, coming out of left field and often blind-siding birth intentions or hijacking postnatal bliss.

With this realisation (and after checking with the midwife that the mother's and baby's vital signs were stable), I steadied inwardly. This woman had had to live through the death of her son: the least I could do was hold firm and 'bear witness' to her pain, grief and rage, whilst honouring her original request of me. And so we went on together, breathing, stomping, rocking, until finally the rage was spent, the tears of grief were shed and she came to a quiet place of readiness for her new baby. The wonder of her birthing body took over and, just as she had intended, her baby girl was born into her welcoming arms – not caught in her past grief or her future fears – as she became fully present to this baby and the life to be lived.

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Some years ago I presented a seminar on pregnancy and birth art to a group of art therapists, none of whom had a medical understanding of birth and only some of whom had personal experience of the birth process. We explored artwork from pregnant women who attended my pregnancy group, to which I added some information about their life circumstances. The art therapists were able to predict with a great deal of accuracy the eventual birth pathways of these women – whether they would go overdue, have long or short labours, straightforward or complex births, whether or where in the labour they might become 'stuck', and whether they would need medical interventions to complete the birth.

What psychological underpinnings did these art therapists base their predictions on? Firstly, they were trained in 'psychological thinking', which posits that everything has meaning. Secondly, they believed that unstructured art expression can tap into unconscious processes and were curious about the ways in which previous life experiences live on in our present. Many of our thoughts, behaviours and life patterns are reflective of unconscious processes and deeper impulses, which flow, in the first place, as instincts, but also, more individually, are shaped by the life we've lived. When you add the holistic notion of mind-body connection to these art therapists' curiosity and fortify it further by including insights from recent brain science research, then their capacity to predict birth outcomes becomes understandable.

When I make similar presentations to midwives, they too, if they are experienced and especially if they are working in 'known midwife' settings, can predict the pathway of a woman's labour based not only on medico-obstetric factors, but also by viewing birth through a bio-psycho-social lens. The current obstetric view of birth, which reduces it down to bio-medical risk factors, can leave us believing that it is dangerously unpredictable; that women's bodies are faulty; that surveillance and strict 'one size fits all worst case scenario' protocols are necessary; or maybe that only good or bad luck makes a difference. However, when we view birth through a holistic, women-centered, humanistic lens – a bio-psycho-social lens – we can marvel at the wisdom and responsiveness of the birthing woman's body to her internal and external circumstance; sometimes in line with her birth intentions, but sometimes not.

One must, however, be mindful of delicate sensitivities in any exploration of these wild cards, because understanding their dynamics requires delving into the birthing woman's life situation and psyche. Unless this is done with a respectful delicacy in the context of supportive care, we can appear to be blaming the birthing woman in the same way that a simplified view of birth culture can lead to blaming caregivers. The reality is more layered, nuanced and intricate than such uninformed blaming would suggest.

When I ask midwives whether they feel that most birthing women know that their life's journey can be as predictive of the pathway their birth will take as medical considerations, they say no. Most women do not realise that any of a myriad life experiences can act as wild cards, predicting complexity and difficulty in labour: a relationship with a parent or partner; guilt about a termination; the residue of a traumatic childhood; grief over a family death in childhood; the loss of previous babies through miscarriage, stillbirth or adoption; the distress of living far from the support of family. Why not?

Perhaps this lack of awareness arises because it is easier to discuss physical and medical matters than psychological ones, especially when, as is often the case, the birthing woman and the midwife are strangers. When trying to understand or explain why a labour has stalled, or the baby is not moving down into or through the mother's pelvis, or the mother's blood pressure is up, or the baby's heart rate is compromised, it is less intimate and confronting to offer explanations in purely physical and medical terms than to engage in more psychological explorations that, unless sensitively handled, may be confronting and experienced by the mother as judgments. It is easier to suggest that a mother is exhausted, than to try to talk about a tension and lack of support between the birthing woman and her partner. It is easier to suggest that a woman's pelvis is too small or her baby is too big, than to explore whether the rigidity in her body that is restricting her baby's ability to move through her pelvis and vagina is a result of 'triggered' pain from previous traumatic body experiences. Wild card dynamics are not discussed widely enough, yet for the 'willing women' – a birthing woman who wishes to work with her body towards a normal physiological birth –these understandings are essential.

> *Women who carry pregnancy losses, or other painful life wounds and circumstances, in their pregnancies and into their births, need courage and attuned, psychologically aware support for the work ahead. Ideally this will be done in care settings where they can access known experienced caregivers, one-on-one, throughout labour.*

The discussion that follows seeks to open up awareness of the life experiences and mind-body connections that can affect birthing potential. If we don't find a way to name and sensitively explore some of these 'wild card' issues, then many willing women, full of resolve and focused intention, may find themselves blind-sided during their labours. In our present medicalised birth culture we use screening tests, foetal and maternal surveillance, timing protocols and routine practices to watch over and control medical risk factors. Why not encourage the willing woman to reflect during her pregnancy on wild card dynamics and gain support for them to better maximize her birthing capacity?

It might be argued this is less necessary for a birthing woman who is not strongly motivated towards normal physiological birth – medical interventions can generally offer solutions to the disruptions that wild card dynamics may create during labour. Nonetheless, since wild cards can also play out in postnatal life, it remains useful to have a handle on them. In this article I focus on wild cards specifically associated with pregnancy loss.

Socially negated loss

Pregnancy loss is often socially negated loss – loss for which there is a lack of social recognition. Such silenced stories of grief can lead to social withdrawal and isolation and a lack of opportunities to process the grief, leaving the necessary 'tasks of mourning' incomplete. Buried feelings about terminations, unprocessed feelings about miscarriages or still-born babies and, particularly in contemporary IVF situations, loss of frozen embryos, can all present psychic pain that may become a resistant and unpredictable wild card dynamic in future births. Even when pregnancy losses are acknowledged, the grief may still be silenced due to well meaning comments along the lines of 'but you can get on and have another one'.

Tasks of mourning

Psychologist and bereavement researcher William Worden identifies four 'tasks of mourning': to accept the reality of the loss; to experience and process the pain of that loss; to adjust to the environment without the loved one including external 'day-to-day' adjustments, internal 'sense-of-self' adjustments and spiritual 'assumptive world' adjustments; then finally to relocate and memorialise the loved one. He calls this, as do other grief counsellors, 'grief work' – the active work of mourning, grieving and adapting to a loss. Completion of these mourning tasks enables mourners to reach a place where they can continue to have connection with the person who has died – a continuing yet transformed love for the deceased. However, if this grief work is incomplete, ongoing growth and development can be impaired.

Some of the dangers of uncompleted tasks of mourning with regard to subsequent pregnancy, birth and post-natal experiences are described in the following sections.

Impact on relationships

Different styles of mourning – active grief work styles, or passive 'time will heal' styles, externalising expressive styles or internalising 'stiff upper lip' styles – can place strain on relationships, leading to a lack of nurture, intimacy and support between a couple. Sexual difficulties may arise from misunderstanding the link between sexual connection and the longing for intimacy.

Loss can shake our 'assumptive world' – our fundamental view of the world, our values and philosophical beliefs – which may then reveal crucial differences between a couple. For some couples these strains may eventually lead to separation or divorce. While others may, too hastily, decide to have a 'rescue baby' before all their feelings are worked through, in an attempt to save their relationship.

Many other couples find that shared conscious grief work strengthens their couple bond and prepares them for any new possibility.

Fear of future pregnancy and birth

Some women fear being submerged in another grief and may choose not to trust another pregnancy. This can compound their grief: they grieve not only for this particular baby, but for the family they dreamed of. For other women, a subsequent pregnancy can raise rational fears about potential repeatable contributing factors to the previous loss. Clinical assessments and tests may be useful to minimise such fears. However, uncompleted grief tasks can lead to fears about grief being retriggered, leading to free-floating anxiety. Fear can cause a mother to consent to medical control mechanisms in the next birth in an attempt to control any perceived risk. Mothers may also be very psychologically controlled within themselves, and within their relationships with caregivers. Increased levels of fear, anxiety or psychological control affect the mother's hormonal balance, during both the pregnancy and birth.

Replacement baby

Mothers who have not completed the mourning task of relocating and memorialising their dead baby are in danger of seeking a replacement baby – one who is not psychologically differentiated from their previous child. Acknowledging, grieving and possibly naming the baby who has been terminated, miscarried or died becomes important in helping to find an appropriate place for the dead baby in their emotional lives, enabling a separate dream and separate identity for any subsequent baby.

Guilt

Unresolved grief can leave mothers, fathers or siblings with distressing feelings of guilt. Things done or not done; thoughts expressed or not expressed; feelings shared or not shared – sorting through these is the task of grief work. If this grief work is not undertaken an unnecessary burden of guilt can be carried into the next pregnancy or on throughout life.

This guilt can take many forms: recovery guilt (guilt at getting on with life with a new baby and a sense of dishonouring the memory of the lost baby), moral guilt (the feeling that some moral transgression in present or earlier life caused the loss), causal guilt (a feeling of responsibility for the death), or even sibling guilt (arising from the normal resentment of a new sibling). All of these can result in complex grief reactions and colour the relationship with any new baby.

Displaced anger and blame

When we experience the loss of any loved one, there can be a tendency to regress and to feel helpless, abandoned or rejected by the deceased. These feelings, unconsciously activated, not consciously formed, arise from our deepest survival needs for security. The death of a loved one shakes our belief in our world as a safe place, potentially triggering panic and anxiety, which can then turn to frustration and anger towards the deceased who caused our distress.

These feelings of frustration and anger at our helplessness need to be consciously identified and appropriately targeted towards the deceased for dying – for shaking our sense of a safe world and for leaving us bereft. Otherwise the anger may be displaced and directed towards ourselves or others at hand, leading to either acute self blame or the search to find someone else to blame.

The need to displace and deflect, to find a scapegoat to relieve our feelings of helplessness, frustration and anger, to find any other recipient but the deceased for this anger, is especially strong in the case of the loss of a baby or child. After all, how could we possibly be angry with the innocent child, angry that they didn't fulfil their part of our dream, that they have abandoned us and left us bereft – how could we blame them for dying? If this anger is not understood and resolved, and the grief and helplessness that generally lie beneath the anger expressed, they can all be brought into the next birth experience, which can lead to high anxiety, controlling behaviours and interpersonal tensions with partners and caregivers.

Reactivated grief

The experience of the death of an attachment figure (mother, father, grandparent, older sister, etc) in early life, known as a 'broken attachment', is understood to be an especial risk factor for postnatal depression and also can present as a wild card in labour. The grief of such broken attachments can also be reactivated in any current loss experience, so for a mother who has suffered an earlier broken attachment and also a pregnancy loss, the experience can reopen the old wounds.

Pain

Even if a woman has worked to heal or lessen the impact of any grief in her life, old grief can still reactivate with surprising potency during labour itself, adding a deeper layer of emotional pain, as in Janey's birth. If old grief has been avoided or not adequately worked through, then increased labour pain would also be expected. A woman carrying an unresolved guilt burden may experience labour pain as punishment, making it difficult to normalise the intensity of their body working.

Support

Women who carry pregnancy losses, or other painful life wounds and circumstances, in their pregnancies and into their births, need courage and attuned, psychologically aware support for the work ahead. Ideally this will be done in care settings where they can access known experienced caregivers, one-on-one, throughout labour.

Author Bio

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