Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth

Education

Éducation

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Abstract

CHILDBIRTH CAN BE A VERY PAINFUL EXPERIENCE, often associated with feelings of being out of control. It should not, therefore, be surprising that childbirth may be traumatic for some women. Most women recover quickly post partum; others appear to have a more difficult time. The author asserts that post-traumatic stress disorder (PTSD) may occur after childbirth. He calls this variant of PTSD a "traumatic birth experience." There is very little literature on this topic. The evidence available is from case series, qualitative research and studies of women seeking elective cesarean section for psychologic reasons. Elective cesarean section exemplifies the avoidance behaviour typical of PTSD. There are many ways that health care professionals, including physicians, obstetric nurses, midwives, psychologists, psychiatrists and social workers, can address this phenomenon. These include taking a careful history to determine whether a woman has experienced trauma that could place her at risk for a traumatic birth experience; providing excellent pain control during childbirth and careful postpartum care that includes understanding the woman's birth experience; and ruling out postpartum depression. Much more research is needed in this area.

Résumé

L'ACCOUCHEMENT PEUT ÊTRE UNE EXPÉRIENCE TRÈS DOULOUREUSE, souvent liée à des sentiments de perte de contrôle. Il ne faudrait donc pas s'étonner que l'accouchement puisse être traumatisant pour certaines femmes. La plupart des femmes se rétablissent rapidement après l'accouchement, mais d'autres semblent avoir plus de difficulté. L'auteur affirme qu'un trouble de stress post-traumatique (TSPT) peut suivre l'accouchement. Il qualifie cette variante d'«expérience traumatique de la naissance». Il y a très peu d'écrits sur la question. Les données probantes disponibles proviennent de séries de cas, de recherches qualitatives et d'études de femmes qui choisissent la césarienne pour des raisons psychologiques. La césarienne élective illustre le comportement d'évitement typique du TSPT. Il y a de nombreuses façons pour les professionnels de la santé, y compris les médecins, les infirmières en obstétrique, les sages-femmes, les psychologues, les psychiatres et les travailleurs sociaux, de faire face à ces phénomènes. Ils peuvent notamment établir les antécédents médicaux avec soin pour déterminer si une femme a été victime d'un traumatisme qui pourrait entraîner un accouchement traumatisant, bien contrôler la douleur pendant l'accouchement et fournir, après l'accouchement, des soins attentifs qui incluent la compréhension de l'expérience vécue par la femme au moment de l'accouchement, et exclure la dépression postpartum. Des recherches beaucoup plus poussées s'imposent dans ce domaine.

I could see everything in the mirror: the forceps, the episiotomy, my whole body being laid open. Somehow I just wasn't there. I seemed to be floating around in the ceiling. It just really wasn't happening to me. — One woman's experience of childbirth

Most health care professionals tend to think of birth trauma in terms of physical injury. However, childbirth can be psychologically traumatic as well. This should not be entirely surprising. It is recognized that significant psychologic morbidity can arise from problems related to reproduction, such as infertility,[1,2] ectopic pregnancy,[3] miscarriage[4–7] and abortion.[8,9] There

is also some recognition that certain types of birth, such as emergency cesarean section,[10,11] can be psychologically difficult. But it appears that even an apparently normal birth can be traumatic for some women.[12]

There are 2 common features of childbirth that make it potentially traumatizing: extreme pain and a sense of loss of control. The deleterious long-term sequelae of these experiences is only beginning to be recognized. In England, a "post-delivery stress" clinic has recently opened to provide care for women who have suffered a psychologically traumatic delivery.[12]

There is some evidence that a small percentage of women have a traumatic birth experience. It appears that this is a little-recognized variant of post-traumatic stress disorder (PTSD). The objective of this article is to describe this phenomenon and consider its implications for health care professionals who care for pregnant women, including physicians, obstetric nurses, midwives, psychologists, psychiatrists and social workers.

To provide an understanding of the concept of traumatic birth experience, I will summarize what is known about PTSD to date, including its prevalence in women, and review the evidence that PTSD may occur after childbirth. Given that traumatic birth experience may be a rare and under-recognized phenomenon, some clinical implications for health care professionals will also be considered.

What is post-traumatic stress disorder?

PTSD was initially described among US men who served in the Vietnam war. For those at risk, such as combat veterans, the rates of PTSD ranged from 3.5% among uninjured veterans to 65% among veterans who had been prisoners of war.[13–16] Statistics on the prevalence of PTSD in Canada are unavailable. One US study found a prevalence rate of 1% in the general population,[17] although the prevalence may vary depending on the population studied.[18]

PTSD is characterized by 6 main features (Appendix 1).[19] First, the person has a history of a traumatic event during which he or she felt threatened by death or serious injury and responded to this threat with feelings of fear or helplessness. Childbirth can certainly qualify as such a traumatic event. For example, a careful study of women's assessment of pain during labour showed that 60% of primiparous women and 45% of multiparous women had severe or extremely severe pain during labour, and most reported that labour pain was the most intense pain they had ever experienced.[20] For the woman quoted at the beginning of this article, the event was so frightening that she experienced depersonalization, which often occurs during trauma.

The other criteria for PTSD involve the reaction to the traumatic event. There is the tendency to relive the experience, through flashbacks, for example. The person exhibits avoidance behaviour and may exhibit "hypervigilance" as well, as he or she tries to ensure that the traumatic event is not repeated, yet is always alert to the fact that it may happen again. Symptoms persist for more than 1 month and affect the person's ability to function.

Although much of the general research on PTSD has focused on trauma caused by war and exposure to natural disasters,[14] 3 studies have looked at sex differences in the prevalence of PTSD in the general population. In the late 1980s, Helzer, Robins and McEvoy[17] found that in a general US population the prevalence rates of PTSD were 5 per 1000 among men and 13 per 1000 among women. Whereas combat exposure was the most common triggering event for men, physical attack (including rape) and threats were the most common events for women. One woman in the sample had PTSD after miscarriage. More recent studies by Kessler and associates[21] and Resnick and collaborators[22] also found that PTSD was more prevalent among women than among men. Rape, sexual molestation and aggravated assault were the most frequent precipitating events. Unfortunately, none of these studies contained any specific inquiry about women's experience of childbirth. However, one can be fairly certain that a small percentage of women of childbearing age have a history of PTSD.

Evidence for traumatic birth experience

To determine the available evidence for the concept of traumatic birth experience, an extensive search of the literature was undertaken. MEDLINE and Psycinfo databases were searched with the use of the terms or text words "PTSD," "post-traumatic stress disorder," "stress disorder" or "mental disorder" and specific MeSH terms associated with pregnancy, pregnancy complications, labour, childbirth or difficult birth. I also searched for MeSH terms or text words "puerperal disorders" in association with long-term follow-up studies. I looked for references to any articles found through these searches in the Science Citation Index. I also scanned the current medical literature and bibliographies of identified articles. From this search, a total of 5 studies and 1 personal account were found.

There is some evidence that a previous traumatic event may predispose women to a traumatic birth experience. The diagnostic criteria for PTSD offer some insights into why women with a history of PTSD may be at increased risk for a traumatic birth experience. There is tendency for people with PTSD to relive the traumatic event if anything reminds them of it.[19]

One qualitative study[23] examined the labour experiences of women who had experienced a sexual assault — a

known cause of PTSD. The women noted that their labour sensations reminded them of their sexual abuse, and this precipitated a reliving of the initial trauma. They felt pain, loss of control and exposure during both events. Other links were made as well. Some women reported that the intravenous lines or monitoring equipment made them feel tied down, as they had been during a rape. Commands given by attendants, such as "open your legs," "cooperate" and "be a good girl," were similar to those used by the perpetrator of a sexual assault. In a birth account given by a woman who had been sexually abused as a child, the woman found that the enormous pressure of the baby's head in the vagina felt similar to the sensation of the adult penis in her vagina when she was a young child.[24] As a result of this association, she was unable to push.

The strongest evidence to date of PTSD after delivery comes from 2 case series. In the first series, consulting psychiatrists in England described 4 cases of PTSD during the postpartum period.[25] They noted that long or complicated labour and feelings of lack of control were common features and were described as important aspects of the birth experience for each of these women. Three of the 4 women had severe, unrelieved pain. All of these cases fulfilled the diagnostic criteria for PTSD; the women reported that they relived the labour experience in dreams and flashbacks and that they experienced extreme distress triggered by reminders.

The other case series, from France, examined 10 cases of *la névrose traumatique post-obstétricale* (postobstetric traumatic neurosis) out of 4400 births during a 2-year period, which suggests a prevalence rate of 0.2%.[26] These women were identified during subsequent pregnancies as a result of continuing effects of trauma experienced during the previous birth. All of the women had had long, difficult childbirths. Five had forceps-assisted births and 3 had stillbirths or a damaged infant. Some of the outcomes among these women included the avoidance of childbearing and the return of symptoms, including nightmares so terrifying that they caused insomnia, during the last trimester of a subsequent pregnancy.

There is suggestive evidence from 2 important studies conducted in Sweden of elective cesarean section for psychologic reasons.[27,28] These studies examined women who demanded elective cesarean section for personal reasons, which accounted for 0.2% of all births at the hospital where the study was conducted. Planned cesarean section appeared to be a way for these women to avoid trauma during labour and delivery. As noted earlier, avoidance behaviour is one of the classic features of PTSD.

Among parous women, there were 2 major reasons for wanting elective cesarean section. The first was a frightening previous labour, complicated by fear of pain and difficulty in getting help. The second was fear of losing the baby; many of these women had given birth to a severely compromised baby or experienced a frightening emergency cesarean section in an earlier pregnancy. Fear of vaginal rupture was the reason nulliparous women requested elective cesarean section. Two of the 5 women in this group had been sexually abused. Despite having undergone short-term psychotherapy, 58% of the women who requested cesarean section for personal reasons still chose to have a cesarean section.[28]

Clinical implications

Given that a traumatic birth experience is possible, what is a practising clinician supposed to do? I have seen 6 women over the last several years whose continuing distress seemed to be rooted in the trauma they had experienced while they were in labour or giving birth. The distress has affected their subsequent ability to breastfeed, bond with their child and resume sexual activity; it has also profoundly affected their sense of self-worth. They can remember the birth of their child only with pain, anger, fear or sadness, or they remember nothing, which is suggestive of traumatic amnesia.

Table 1 outlines some practical suggestions that health care professionals can consider as they follow women through pregnancy, childbirth and the postpartum period. There is no evidence for these suggestions, but they follow logically from what we know. Initially, it is very important to take a careful history. Previous reproductive "failures," such as miscarriage, abortion, ectopic pregnancy and stillbirth, may leave a woman feeling that she is bound to "fail" at giving birth as well and may place her at risk for a traumatic birth experience. Sensitive questioning about previous rape or sexual abuse may also be useful in determining whether the woman has a history of PTSD. A history of PTSD may also be elicited by asking specifically about nightmares or flashbacks of traumatic events. Difficulty trusting authority figures, multiple questions and extremely detailed birth plans may indicate that a woman has a strong need for control and severe anxiety

Table 1: Proposed therapeutic approach to women at risk for a traumatic birth experience

During pregnancy
Take a careful history
During delivery
Ensure good communication
Ensure excellent pain control
After delivery
Encourage discussion of the birth experience
Rule out postpartum depression
During subsequent pregnancy
Take a careful history
Consider elective cesarean section

about childbirth.[29]

During delivery, 2 things become critical: good communication, which allows the woman to feel as much in control of the situation as possible, and excellent pain relief. Helping women feel in control means fostering trust and offering choices when at all possible.[29] Since pain is such a large factor in trauma, relieving pain, while respecting some women's wish to avoid taking medications, is a vital preventive strategy.

Being alert to the possibility that a woman may be undergoing a traumatic experience during labour may lead to early diagnosis. Severe withdrawal, refusal to allow pelvic examinations or screaming out of control are crisis indicators. Getting women to articulate what they are experiencing and validating these women's feelings may be helpful.

The first indications that a women has had a traumatic birth experience may appear only during the postpartum period. There is obviously something wrong if, for example, a woman fails to interact with her baby, has persistent, vague pelvic pain, or has unexplained anger. However, the indications may be more subtle. Encouraging women to discuss their birth experience may help to identify problems. Health care professionals should ascertain whether the woman felt that her life or physical integrity had been threatened and whether this was associated with intense feelings of fear or helplessness. They should also ask about nightmares and flashbacks.

It is of the utmost importance in caring for any woman experiencing psychologic difficulty post partum to rule out postpartum depression.[30] Postpartum depression usually appears within 4 weeks after birth and includes all of the criteria of a major depressive episode (Appendix 2).[31] Although they are distinct entities, postpartum depression and PTSD are not mutually exclusive. A traumatic event may well precipitate depression. Any depression should be treated. Referral to psychiatric services may also be considered.

The treatment of PTSD in general has met with only modest success.[31] Studies of therapy with such drugs as monoamine oxidase inhibitors, tricyclic antidepressants and benzodiazepines suggest that these drugs have a small but clinically significant effect. Behavioural techniques involving therapeutic exposure also have been shown to have a beneficial effect, particularly in terms of intrusive symptoms such as flashbacks.[32]

Consideration of the effect of PTSD on the woman's family is also indicated. If a child is being neglected because he or she reminds the mother of a traumatic experience, then child-protection interventions may be necessary. Contraceptive counselling helps prevent a subsequent pregnancy, which could retraumatize the woman.

Some women get pregnant again after a traumatic birth experience. They may seek abortion as part of avoidance behaviour[12] or ask for a cesarean section.[27,28] It has been my experience, however, that, with counselling and the development of trust and courage, some women will go through labour and birth. This may be considered a type of behavioural therapy, and it should not be attempted in women who suffer from other psychologic disorders.[32] If the woman can have a positive birth experience after a traumatic one, it can have a marked therapeutic effect. This has been described as "a redemptive birth."

Conclusion

Pregnancy, labour and birth are powerful events in women's lives. The vast majority of women appear to recover quickly after the birth of a child. Yet, for a small percentage, childbirth leaves them with prolonged suffering that can have an enormously detrimental effect on their lives and on the lives of their family members. Previous traumatic events may increase the probability of a woman having a traumatic birth experience.

The evidence for the existence of a type of PTSD after birth is slim but compelling. Research in this area should be given a high priority. In the meantime, there are many things health care professionals can do to help prevent women from undergoing a traumatic birth experience and to address such an experience therapeutically if it occurs.

Without the courage of the women (C, S, W, J, T, S and M) who had had this experience and the wisdom of the women (C, L, J, L and S) who guided me in preparing this article, it would never have been written.

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Appendix 1: Diagnostic criteria for post-traumatic stress disorder[19]

The person has been exposed to a traumatic event in which both of the following were present

- The person experienced, witnessed or was confronted with an event or events that involved or threatened death or serious injury, or a threat to the physical integrity of self or others
- The person's response involved intense fear, helplessness or horror

The traumatic event is persistently re-experienced in 1 or more of the following ways

- Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions
- Recurrent distressing dreams of the event
- Actions or feelings as if the traumatic event were recurring (including a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
- Intense psychologic distress resulting from exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiologic reaction resulting from exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness, as indicated by 3 or more of the following

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., patient is unable to have loving feelings)
- Sense of a foreshortened future (e.g., patient does not expect to have a career, marriage, children or a normal life span)

Persistent symptoms of increased arousal, as indicated by 2 or more of the following

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

Duration of the disturbance is more than 1 month

Disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning

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Appendix 2: Criteria for major depressive episode[31]

Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., patient feels sad or empty) or observation made by others
- Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day
- Significant weight loss when not dieting; weight gain; or decrease or increase in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or of excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, suicide attempt or a specific plan for committing suicide