I. Introduction:

There exists a cluster of mood disorders pertaining to women after childbirth on a spectrum of what is known as Perinatal Mood Disorders. The spectrum of these types of mood disorders runs on a continuum from mild to severe with gradations in between. Perinatal Mood Disorders encompass such psychiatric illnesses such as (from minor to major), Baby Blues, Postpartum Depression, Postpartum Obsessive Compulsive Disorder, Postpartum Anxiety Disorder, Postpartum Bipolar Disorder, Postpartum Psychosis, and Postpartum Posttraumatic Stress Disorder (PTSD). Furthermore, with the exception of the Baby Blues and more recently Postpartum Depression, these other mood disorders are hardly acknowledged, recognized, diagnosed or treated for what they are. For the purposes of this paper I will focus on PTSD or Posttraumatic Stress disorder and the Postpartum woman.

Very little research exists on the subject of Postpartum Mood Disorders which can and frequently do have a serious impact on the family unit. Interestingly enough, the only works that I found when doing my research into the subject of PTSD and the Postpartum period came from foreign countries: most notably, New Zealand, England and the Netherlands. Nothing came out of America, which is very telling. One reason for this seems to be that in these other countries, midwives were identified as the primary healthcare providers who delivered the prenatal care. In addition, also because of their close relationship with these pregnant women and close follow up after a birth, midwives identified the syndrome of PTSD as impacting women during the Postpartum Period.

I. History of this issue

These Postpartum illnesses have existed since time immemorial, but relatively little attention was paid to them by healthcare professionals, government officials and the lay public until very recent times. Research on the topic is still very much in its infancy and most of these mental illnesses are not even on the radar screen of the majority of professionals and laymen alike. I hope that this paper will ameliorate this lack of knowledge to some degree..

III. **Key Definitions: Postpartum:** The time period after a woman gives birth

PTSD: (Posttraumatic Stress Disorder): A severe psychological reaction involving intense feelings of fear and helplessness to intensely traumatic events involving actual or threatened death or serious injury to oneself or others

IV. Literature Review

"Childbirth qualifies as an extreme traumatic stressor that can result in PTSD. Between 1.5-6% of women suffer from this disorder in the postpartum period" (Beck, 2004, pg.217). Posttraumatic Stress Disorder (for the duration of the paper this will be referred to as PTSD) is defined in the DSM IV is defined as;

"A severe psychological reaction, lasting at least one month and involving intense feelings of fear, helplessness or horror, to intensely traumatic event-events involving actual or threatened death or serious injury to oneself or others…the DSM IV TR distinguished two forms of PTSD. In the acute form, the disorder lasts just a month or so and then fades away. The more severe, chronic form may last for years and even decades…PTSD differs from other anxiety disorders in that the source of stress is an external event of an overwhelmingly painful nature, so the person's reaction, tough it may resemble other anxiety disorders…it extremely debilitating" (Alloy, Lauren B.; Riskind John H.; Manos, Maragaret, J, 2005, pg. 157).

The symptoms of PTSD can be grouped according to three clusters:

1)" re-experiencing nightmares about the delivery, and flashbacks of the events over and over again

2) Persistent avoidance of getting pregnant again, experiencing amnesia in regards to the birth

3) Increased arousal (ex. Irritability, inability to concentrate etc)" (Olde,Eelco, Van Der Hart, Onno, Van Son, Maaarten,2006, pg.2).

The limited literature available consistently reveals the same signs, symptoms and causes of PTSD in the postpartum period. Additionally, the existing literature discusses the treatment modalities which may help woman suffering from this disorder, as well as preventative steps that could be taken to minimize a woman's chance for developing this disorder.

" PTSD is an unrecognized complication of childbirth and can be caused by feelings of being out of control, experiencing invasive, painful medical procedures, and intervention as well as lack of support and negative attitudes from hospital staff, family members and friends. Additionally, a lack of knowledge about what to expect and what was happening around them and to them made women more vulnerable to having a traumatic birth experience. Some other factors to consider that increase the likelihood of a woman suffering from PTSD is the lack of knowledge about the options available to her, lack of true informed consent, feelings of being ignored or feelings of failure and being powerless" (Olde et. al; 1996, pg.6).

The aforementioned article also points out that when women have had psychologically traumatic birth experiences, they are often not able to have future pap smears, future intercourse is minimal or nonexistent, and another pregnancy is unlikely to occur. There is compelling evidence to support the argument that a previous traumatic event (such as a rape or sexual abuse) is a major factor that increases the likelihood of a woman suffering from PTSD after childbirth.

"One qualitative study examined the labor experiences of women who had experienced a sexual assault-a known cause of PTSD. The women noted that their labor 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. Some women reported that intravenous lines or monitoring equipment made them feel tied down. Commands given by birth 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. As a result of this association, she was unable to push" (Reynolds, L.; 1997, pg. 4).

This inability to push during labor, which is characteristic of many women who have suffered a prior traumatic sexual event, can lead to a mechanical or surgical extraction of the baby. This amplifies the woman's trauma, and significantly increases her chances of suffering PTSD after the baby is born. Many women plan a cesarean section to avoid trauma during labor and delivery.

Posttraumatic Stress Disorder in Postpartum women has also been associated with such events such as stillbirth, pregnancy loss (abortions or miscarriages), premature birth and perinatal loss. For example, a study on the psychological consequences of a stillbirth reported that 29% of women who suffered a stillbirth developed PTSD at one point in their lives (Olde et.al; 2006).

A woman can suffer from PTSD even after a straightforward, vaginal, full term delivery and healthy baby if the woman experiences any of the following during the process: 1) "uncontrollable, unbearable pain due to withholding of pain medication or inadequate pain relief; 2) a hostile or uncaring staff and/ or birthing team in attendance; 3) experience of feelings that one is without support or being taken advantaged of; 4) a strained or abusive relationship with a husband or partner if present; 5) or a feeling that her life is threatened due to a lack of control over her birthing experience and fear of death" (Olde et. al; 2006,pg.4).

The list of birth traumas which increase the likelihood of a woman suffering from PTSD mentioned in this literature review are as follows;

1)"Feelings of abandonment and aloneness during the birth process;

2) Not being treated with dignity or respect by healthcare providers and the staff at the hospital;

3) Lack of interest shown by healthcare staff in the woman as a person with feelings and a mind attached to, not separate from a body;

4) Lack of support and reassurance from those around her (family, friends and or staff)

5) Emergency cesarean section/fetal distress;

6) Mechanically assisted birth (ex. Vacuum extraction or forceps);

7) Fear of epidural, fear of interventions, fear of the hospital and fear of giving birth;

8) Nonexistent or inadequate pain relief if so desired;

9) Congenital anomalies in the infant;

10) Postpartum complications in mom (ex. hemorrhage, retained placenta etc.);

11) Premature birth;

12) Prolonged separation from her infant after the birth for any reason (especially a baby in the NICU also known as the Neonatal Intensive Care Unit);

13) Prolonged, painful labor and pushing stage;

14) Rapid delivery;

15) Degrading experience;

16) Taking away of a woman's individuality, dignity and sense of control;

17) Lack of proper communication between the staff and the woman, the woman and her family or the staff and the patient's family;

18) Lack of feelings of trust and of not feeling cared for or supported through the experience;

19) Fear of death or disability due to childbirth" (Beck, 2004, pp.32-33).

As stated elsewhere in this literature review," childbirth can be a very painful and traumatic experience often associated with feelings of not having control" (Reynolds, 1997, pg.1). Additionally, "mothers who experienced PTSD were bombarded not only during the day with flashbacks in which they relived their traumatic births, but also during the night with terrifying nightmares. Flashbacks and nightmares of the traumatic births affected the mother's

relationships not only with their children but also with their own husbands" (Beck, 2004, pg.219).

The following ideas have been proposed in order to try and decrease the likelihood of PTSD occurring during the Postpartum Period;

1) "All women should take childbirth education classes;
2) Healthcare providers should take a careful psychosocial history during pregnancy with a special emphasis on gathering information regarding any previous traumas, as well as ascertaining what if any social supports a woman has in place during and after the pregnancy to help her and her expectations about the birth;
3) She should be provided with excellent pain relief if requested during labor and delivery and be provided with ongoing respectful communication between healthcare providers, nursing staff and patient as well as any family members present" (Soet, Brack, and Dilorio, 2003, pg.36-46).

In conclusion, PTSD after childbirth is poorly recognized and as such is frequently undiagnosed and goes largely untreated. Thus, the implications and impact on the mother, her newborn infant and the family are widespread, long term, negative and pervasive on the micro, meso, and macro system level. The next section of this paper will seek to explain how a diagnosis of Posttraumatic Stress Disorder during the Postpartum period impacts on the mother- infant (child) attachment, as well as the affect PTSD has on the woman and those in her surrounding environment on each of these levels.

V. Integration of Course Material

A) The impact of postpartum PTSD on mother-infant (child) attachment:

A diagnosis of PTSD in a woman during the postpartum period impacts significantly on the mother-child relationship. Mothers with this mental illness may respond to their babies in the following ways: 1): rejection of the infant; 2) the attempt to try and persuade a family member to take over permanent care of the baby; 3) that the baby be adopted; 4) mom may try to escape; 5) she may wish that the baby disappears, be kidnapped or die. Rejection of the child is frequently accompanied by pathological anger with shouting, cursing, and screaming together with impulses that are frequently acted upon to strike, shake, smother or otherwise harm or kill the child as well as neglect the needs of the infant" (Brockington, 2004, pg.2).

With proper diagnosis and treatment, these feelings can be resolved and a healthy mother-child relationship can potentially develop. Without proper treatment or diagnosis, the infant is at increased risk of child abuse and neglect, long term impairment of the mother child relationship, and psychiatric or learning or developmental disorders in these children. The goal of various therapeutic interventions would be to help the mother to enjoy her interactions with her baby.

The distress from the trauma experienced in childbirth affects a woman's ability to breastfeed and bond with her child, resume a normal sexual relationship, continue with household, childcare and job responsibilities, and have a subsequent pregnancy. Additionally, a woman who has experienced a traumatic birth for whatever reason and is diagnosed with PTSD in the postpartum period has a diminished sense of self worth, self esteem and a significant feeling of personal failure. This translates to perceived failure to be a good mother to her new baby and feelings of being an inadequate spouse or partner. These women can only remember the birth of their child with anger and sadness, or they remember nothing. Every birthday that this child has is spent in reliving the trauma and terror of the child's birth, year in and year out even with therapy. (Beck, 2006).

Most people look forward to birthdays. However, for the mother's who have or had PTSD as a diagnosis after childbirth, their children's birthdays are frequently a source of misery and pain instead of happiness. The birthday of this child with whom they suffered through PTSD, marks the anniversary of the traumatic birth experience, and frequently these moms relive their experiences all over again. Instead of being happy on their child's birthday, these women experience the following disturbing emotions year in and year out; dread, anxiety, stress, sadness, and grief instead of happiness. (Beck, 2006). Many women feel, and understandably so, that they are being denied or robbed of the experience of truly enjoying their child's birthday. Indeed, "the mother's birth trauma was glossed over again and pushed into the background as the celebration of the child's birthday took center stage and mom's true feelings took back stage so as not to ruin the party. Not only clinicians, but family and friends failed to rescue the woman during the period surrounding the birth trauma" (Beck, 2006, pg. 386).

The following anecdotes further illustrate how their children's birthdays adversely affect the mother. For example one woman states that

"each anniversary is a lottery. A real time bomb, really. One is at the mercy of one's emotions, one's memories and of course other people and daily life which of course are the identifiable triggers, the worst of all. Each year has its challenges and is different. None have ever been as intense as the first year. So PTSD can be like an octopus and its tentacles can take hold at any time. Its punishment is weird, wily and crippling. Your life is never the same again. It can take hold anytime" (Beck, 2006,pg.387).

Yet another woman relates the following: "I can't believe five years later that I feel such strong emotions and that my body responds physically. It is like the birthing trauma and the anxiety, loss and pain associated with it seems to reside in every cell of my being with a memory capacity that serves to never let me forget" (Beck, 2006, pg. 388).

"Traumatized by their birth experience, mothers experiencing PTSD considered themselves only a shadow of their former selves. This numbing of self and actual dissociation can begin immediately after delivery and even once home, the numbness and detachment continue" (Beck, 2004, pg. 220).

"The microsystem level is the most immediate to the developing individual. For children, microsystems are places they inhabit, the people who live there with them and the things they do together, involving interaction with one or two people at a time doing relatively simple activities such as feeding, bathing, and cuddling"(Gabarino, 1992, pg. 26). A woman who has a diagnosis of postpartum Posttraumatic Stress Disorder cannot engage in any of the above normal mother-child interactions due to her condition. Although many women realize they are being irrational, they frequently turn their anger towards their newborn infant and frequently blame their baby for the mental illness that she is suffering from. This leads to the mother feeling resentful towards her infant and thus attachment and bonding is at best impaired and at worst nonexistent. This makes the mother feel even more guilty and inadequate than she already feels, and these feelings of inadequacy exacerbate her condition. The mother tries hard, but feels no love towards this child and thus rejects or even abuses the child. The mother also is frequently either impaired in her ability to or unable to properly take care of the child's most basic needs which include feeding, bathing, cuddling and playing.

Indeed, according to Bronfenbrenner, "the expanding capacity to do more is the very essence of development. Love is at the core-play figures prominently in this process from the early months of life. One of the most important aspects of a child's microsystem is the relationship of mom and dad with the child" (Gabarino, 1992, pg.25). In a family where mom is suffering from undiagnosed and untreated PTSD, the relationship between mom and dad is

frequently strained and they have difficulty communicating and getting along. Mom is incapable of playing with her baby and thus the child misses out on a crucial process in the early months of his/her life- the period that lays the foundation for the infant's development and social interactions with others over the course of the child's lifetime.

"Sociocultural risk refers to the impoverishing of the child's world so that the child lacks the basic social and psychosocial necessities of life. Children who grow up without proper nutrition, good medical care and affection, are "at risk for impaired development"(Gabarino, 1992, pg. 35-36). From this we can see the potential impact that having a mom with PTSD has on a child's mesosystem and thus future generations as well.

These children, as they grow up, will have difficulty in their own relationships both with other adults as well as with their own children (should they decide to have children). This difficulty is as a result of growing up in an environment that does not provide those needs that Maslow espouses in his hierarchy in order to be a well adjusted and productive member of society. A negative social and home environment makes the child vulnerable to being easily discouraged by everyday problems and turns the child away from fully participating in the world.

Thus, a child may grow up with intense feelings of rejection. Rohner (1975) examined rejection and found that across all cultures, "rejection causes an individual to have low or non existent self esteem, lack of feelings of social competence, and lack of hope. Parental rejection towards children leads to hostility, aggression, dependency, and emotional instability" (Gabarino, 1992, pp.33-34). These feelings that a child has about themselves, will naturally negatively impact upon them and their surrounding environment as they grow older and

venture out into the world unprepared to cope with life and the adversities that they will undoubtedly encounter.

The exosystem is the setting in which the child does not participate directly but nonetheless has an effect on the child. Thus, a parent's diminished ability to participate productively in the child's microsystem or people in institutional roles making decisions that adversely affect the child's microsystem will impact negatively on the child's exosystem (Gabarino, 1992).

For example, a child is being abused or neglected because mom has undiagnosed and untreated PTSD and thus cannot take proper care of her child. The child welfare system (an institution) gets involved and the people within this institution decide to remove the child from their home. This is an example of how the exosystem impacts upon the child's microsystem if a mother is suffering from PTSD. The child has nothing to say in the matter. The decision is made for him by those in institutional roles.

V

b) The impact of Postpartum PTSD on the Mother and the Family System:

The family system is also affected by mom suffering from PTSD during the postpartum period. Marsh and Johnson state that "Mental illness in a family can be a ravaging, devastating disease that disrupts a family and permits little opportunity for respite" (Goldenberg and Goldenberg, 2004, pg. 357).

When a new mother is suffering PTSD after giving birth and she is not receiving proper treatment, then the whole family suffers. Every family has to negotiate developmental transitions; at various life stages, it is necessary for the family members to master specific developmental tasks. An example of this would be when a couple has their first child. " "The arrival of children mark the family expansion phase." Additionally, "making this

transition, taking and sharing responsibility, practicing patience, setting limits-all these tasks must be mastered in the expanding family system…at the same time the former childless couple must find ways of maintaining and nurturing their relationship despite the substantial decrease in time and energy for private moments together" Goldenberg and Goldenberg (2004, pg. 37).

The birth of a child, either a first or subsequent children, is a nodal event in the lifecycle of the family. The homeostasis or equilibrium of the family undergoes a major upheaval and family roles frequently change and thus role strain is added into the equation in addition to everything else. When a child is born and the mom is emotionally ill, than these changes are more profoundly felt and difficult to negotiate. Under the best of circumstances, the mother would be fulfilling her traditional role as primary caretaker of the infant and other children. However, if she has PTSD, than she is not able to take care of, much less interact affectionately, playfully and appropriately with her baby.

Consequently, the traditional mother responsibilities will fall upon dad, and the father will find himself trying to be both mom and dad thus adding role strain into the picture. Not only does dad have to continue to provide financially for his family, but he also has to take care of the child(ren's) personal needs and also contend with his wife's illness and all that it entails. Since by this time dad is probably experiencing considerable stress, the family may become even more dysfunctional, making homeostasis all the much more difficult to restore. If this family is fortunate, they may have supportive, extended family nearby and available that could step in and help out for a while. In fact, in addition to the stigma and ostracism people with mental illness face, a family who has a member with a mental illness experiences a disorganized household. This may include financial difficulties (often due to missed work

days and lost pay), employment problems (keeping a job after taking too many days off), strained mental and family relationships (because mom is not able to function and carry out normal day to day activities), impaired physical health and social isolation. It is very difficult if not impossible to maintain relationships outside of the family when one is the caretaker of the whole family including the mentally ill member (Goldenberg and Goldenberg, 2004).

Additionally, the following factors may also impact upon the family that has a loved one with a mental illness: grief, ongoing sadness, loss of dreams and hopes for the affected person and the rest of the family and potentially harmful or self destructive behaviors (Goldenberg and Goldenberg, 2004).

VI. Implications for Social Work Practice

From my research, I have learned that there is much work to be done to raise public awareness that women in the postpartum period can and do suffer from PTSD, and that healthcare providers, as well as many Social Workers and others sadly are not aware of this problem. I have also learned that, not surprisingly, most of the research on this topic comes from other countries, most notably, New Zealand and England. I believe that the paucity of research in this country in the area of mental health is due to the fact that mental illness is so poorly managed in America.

This is especially true in the area of women's mental health which until recently wasn't even acknowledged as an issue to be dealt with. A prevailing attitude amongst many psychiatric and healthcare professionals is that women are just a bunch of hormones and full of hysteria. This attitude also persisted in large measure amongst the lay public as well until recent history. It should also be noted that not only does more research have to be done on

this subject here in America, but also Social Workers and other helping professionals have to be aware of the signs and symptoms of this disorder. They have to educate the public through research, writing and speaking to lay people and healthcare providers on the signs, symptoms and treatments available to help both the woman and her family who is suffering from this debilitating disease. Additionally, Social Workers and others who work with pregnant women and their families need to be aware of how this disorder impacts on the family unit during the postpartum period.

Another implication for practice is the necessity for a Social Worker or the Health Care Provider to prenatally screen for women who are most at risk for developing this disorder. If a woman has any of the risk factors associated with PTSD before she became pregnant (sexual or physical abuse, abortions, rape, infertility, miscarriages or any other traumatic experience in her past history) she should be encouraged to go for therapy. Group therapy seems to be very effective. Indeed,

> "Group participation has been found to reduce symptoms of PTSD and other stress reactions, esteem, reduce depression and isolation, promote more pro social behaviors…as applied to individuals with a history of trauma …when survivors discover they are not alone, their sense of isolation is decreased…as survivors develop a sense of connection to others, which enhances self esteem and self worth…members interactions with one another can begin to alter their distorted views of social relationships and restore their sense of trust in others and self" (Knight, 2006,pg.22).

Also, individuals who have survived a traumatic event have a need to tell and retell the story over and over again as part of the healing process. "Telling the story enhances the client's sense of self efficacy and helps her or him to develop self regulation and self management of emotions" (Knight,2006, pg.23).

It is vital that a Social Worker who works with trauma victims be particularly cognizant of negotiating and maintaining appropriate boundaries in the therapeutic relationship because

these clients have difficulty respecting and understanding the concept of personal space. Additionally, the practitioner needs to be acutely aware of issues of transference and counter transference. Reactions range from avoiding to over identifying with both the client and the material presented by the client. A therapist is also at risk for experiencing vicarious traumatization (Knight, 2006).

The implications of this disorder for Social Workers in treating woman and their families both during the prenatal period and after childbirth are vast.

VII. Conclusion:

While there is much work to be done in the area of PTSD and the postpartum period in order to get it recognized as a disorder that woman and families suffer from and thus need help with, I believe we will eventually get there. It may take a while, just as having Postpartum Depression pushed to the foreground of the public took time. Now Postpartum Depression is recognized as a very common and highly treatable disorder. One day, Posttraumatic Stress Disorder will become well known, well studied, and acknowledged as the devastating disorder it can be if left undiagnosed and untreated.

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