

the

birth trauma association

helping women traumatised by childbirth

Post Natal

Post Traumatic Stress Disorder



Post Natal Post Traumatic Stress Disorder

What is Post Traumatic Stress Disorder ?

Post Traumatic Stress Disorder and 'birth trauma'

The term Post Traumatic Stress Disorder (PTSD) refers to a disorder that can occur following the experience or witnessing of life-threatening events. We usually recognise events like terrorist incidents, serious accidents, or violent personal assaults as being capable of causing such trauma, so, it has proved difficult for people to understand that a 'natural' process like childbirth can also be traumatising.

The fact is that a traumatic event can actually be any experience which involves the threat of death or serious injury to an individual or another person close to them (e.g. their baby). A person must then respond with intense fear, helplessness or horror for a diagnosis of PTSD to be made. Hence, it is now generally accepted that PTSD can be a consequence of a traumatic birth experience and, although this was only medically acknowledged in 1994,¹ previous studies, going back many years, had already demonstrated that women did in fact suffer this type of traumatic stress after birth. We call this type of PTSD, Post Natal PTSD (PN PTSD) or 'birth trauma'.

What are the symptoms?

A person who has been diagnosed with PTSD will find their normal life interrupted in many ways by a strong and powerful set of emotions and feelings over which they have no control. General symptoms typically include:

- The persistent re-experiencing of the event by way of recurrent intrusive memories, flashbacks and nightmares. A person will usually feel distressed, anxious or panicky when exposed to things which remind them of the event
- Avoidance of anything that reminds them of the trauma (this may include talking about it). This can lead to emotional detachment or numbing.
- Bad memories and the need to avoid any reminders of the trauma will often result in difficulties with sleeping and concentrating. Sufferers may also feel angry, irritable and be hyper vigilant (feel jumpy or on their guard all the time). These are called 'hyperarousal' symptoms

It is important to understand that, following a traumatic event, sufferers of PTSD are left with a world view which has been altered profoundly and which often leaves them deeply afraid and anxious. The world is no longer considered to be a safe place and it can be difficult to trust the very individuals (health care professionals) who are

¹ PTSD was recognised as a disorder by the 1980 Diagnostic and Statistical Manual of the American Psychiatric Association guidelines. In 1994 revised guidelines (DSM-IV) changed the definition of the disorder to include subjective perceptions, with the result that childbirth could be recognised as causing PTSD

supposed to be there to help. For those who develop PTSD, the future may look bleak as they struggle to liberate themselves from the images of the trauma they have endured. This can be particularly hard for women with 'birth trauma' because they often suffer these problems at a time when everyone expects them to be happy and positive. As a result, they often end up feeling guilty and this lowers self-esteem. Unfortunately, this situation is exacerbated by the fact that women are frequently struggling to articulate these damaging emotions in an environment which cares predominantly only for the physical outcomes of the birth experience and not the emotional ones.

When Post Natal PTSD develops, its symptoms may start soon after childbirth or they could be delayed for months. The symptoms may persist for a long time and can result in other problems such as depression but the two disorders have clinically different origins.

This is why the Birth Trauma Association believes that PTSD has a profound significance in the post natal setting and that it requires specialised attention and treatment.

What causes Post Natal PTSD?

Currently, research into this field is limited and, to date, it has largely focused on the importance of the type of delivery a woman has undergone. However, recent studies have begun to look at the significance of women's perceptions of their birth experience. For example, it has been noted that psychiatric outcome actually depends as much on a woman's subjective perception of the event as the objective experience itself.² Others have suggested that the degree of distress is often less associated with the events themselves but rather with the perception of control, the attitudes of people around them, relationship with the maternity care provider, feelings of not being heard, level of information provided and ability to consent. Consequently, it is not always the sensational or dramatic events that trigger childbirth trauma.³

The Birth Trauma Association believes that there is an urgent need for extensive and properly funded research into the scale and nature of this problem which, in reality, represents a complex interplay of objective and subjective factors. We have set out some of the most significant causes of Post Natal PTSD below, but we have punctuated our explanations with the words of women who have contacted us to tell their story.⁴ This is because we believe that is only through the eyes of women who have suffered trauma that we can see the truth of the problem.

² Beck (2004) 'Birth trauma is in the eye of the beholder'

³ Associate Professor Gillian White, Massey University, Wellington, New Zealand

⁴ All names have been changed for anonymity's sake.

- **Mode of delivery.** ⁵

“For me the hardest thing is that I blame myself for what happened. The care was dreadful, the doctors and midwives didn’t have any time and I didn’t question what they were doing. I was induced without properly understanding why or whether it was the best and safest thing to do. I was in pain for hours after having the prostin and didn’t tell anyone how bad it was because I wanted to be tough”.
(Natalie)

Women can be traumatised by labour regardless of the method of delivery. Indeed, some women have reported truly horrific home births to us. However, it is clear that invasive obstetric procedures such as emergency caesarean sections, inductions and instrumental deliveries are more likely to be perceived as traumatic.⁶ Women have frequently described feelings of ‘violation’ as a result of invasive medical procedures.

- **Fear for their own safety or that of their child**

“The midwife was listening for my baby’s heartbeat and asking me what was wrong then she panicked. ‘The heartbeats too low we have to get this baby out now, your blood pressure is too high, we need to get a drip into you.....you are going to bleed too much.’ She was so unprofessional I completely freaked out and was screaming out for help. My mum and husband were panicking too although they were telling me that everything was okay and that it’d be alright but I could tell that something was wrong.At the same time I had a doctor trying to get a drip in my hand and the doctor and midwife arguing that they needed more help and the midwife saying that all the other midwives were busy. That’s when they pressed the alarm and suddenly there were loads of people in the room. I really thought at this point that my baby was dead, in fact I was telling myself you have 2 beautiful children already you are so lucky. It was the most awful feeling in the world and one I wouldn’t wish on my worst enemy.”(Lucy)

“I didn’t come round properly until the following morning and I remember lying in bed with the August sunlight streaming in the window and wondering who was going to break the news to me that my son was dead. I was so utterly convinced he would have died in the night and I couldn’t believe it when I was told he was doing well and given these rather crappy Polaroids of this strange baby all wired up....I thought he looked like a frog...” (Jane)

Fear for a child’s safety is a hugely powerful emotion and some women come face to face with the horrifying possibility of their child’s death during the birth process. It can take a long time to come to terms with these frightening perceptions and the potential risk for mother-baby bonding is obvious. This can be a particularly important concern with mothers of premature babies.⁷

⁵ MACLEAN et al (2000) Method of delivery and subjective distress: women’s emotional responses to childbirth practices. *Journal of Reproductive and Infant Psychology*, 18, 153 – 162. This indicated that those who have instrumental deliveries may see birth as more traumatic than caesarean section or a normal delivery.

⁶ Planned caesarean sections with consent and spontaneous deliveries are negatively associated with PTSD. See RYDING et al (1998). Psychological impact of emergency caesarean section in comparison with elective caesarean section instrumental normal vaginal delivery. *Journal of Psychosomatic Obstetrics & Gynecology*, 19, 135 – 144.

⁷ AFFLECK et al (1991). *Infants in crisis: how parents cope with newborn intensive care and its aftermath*. New York: Springer.

The BTA believe that the need for properly established consent to procedures carried out on women and for full information about a baby's well-being cannot be overstated. Women need to understand what is happening to be able to retain their feelings of control and safety.

- **Lack of control**

"Pretty much everything could have been avoided if there'd been enough staff with enough time. If I'd had the opportunity to ask questions. If I hadn't been left on my own endlessly not knowing what was going on. If I could only have had a bit of control over what was happening" (Natalie)

"In theatre I felt that if only one person could have taken the time to just explain things to us then it may not have been so terrifying."(Susan)

It is vital to realise that women can be traumatised by interventions they feel they should not have had.⁸ Hence, information and consent are key issues in ensuring control. It has also been shown that feeling in control during labour and delivery and knowing what to expect are important protective factors against the development of PTSD.⁹ The BTA strongly believes that by respecting women's choices, and their basic human rights, we can begin to allow them to maintain control over their baby's birth.

- **The attitudes of staff**

"Just before we arrived in theatre the ...midwife told me off as I was panicking, it made me feel like I was an enormous inconvenience and a burden...which contributed to my subsequent guilt and feelings of failure" (Jane)

"They kindly left me in stirrups with swabs hanging out of me while they scrubbed up and someone let the cleaners into the room, who complained bitterly about the 'bloodbath' they had to sort out. Stupid, but that memory is for me just so humiliating. Eventually one of the midwives put a sheet over me bless her but I felt by then that any dignity I had was gone." (Patricia)

"I think part of the degradation is the feeling that you are a 'nuisance' as things are going wrong. Can you believe that I actually said sorry to the registrar after he snapped at me for groaning in pain?!" (Patricia)

It is clear that the aggressive management of childbirth and a failure to understand the emotional process of giving birth can cause real problems.¹⁰ However, failing to respect dignity and privacy also create genuine suffering. Staff need training so that they are aware that the psychological outcome of the birth process is as important as the physical. A traumatised mother is not a 'healthy'

⁸ GREEN, COUPLAND and KITZINGER J, Great Expectations: a prospective study of women's expectations and experience of childbirth. 1998. Books for Midwives, Hale, Cheshire.

⁹ LYONS, S. (1998). A prospective study of posttraumatic stress symptoms 1 month following childbirth. Journal of Reproductive and Infant Psychology, 16, 91 – 105.

¹⁰ KITZINGER, When a bad birth haunts you
www.sheilakitinger.com/BadBirthHaunts.htm#When%20a%20bad%20birth%20haunts%20you

one. The BTA believes that the incidence of Post Natal PTSD should be a performance indicator for the obstetric services.

- **Inadequate pain relief**

“I hope this doesn't sound flippant but there was a poor bloke on television the other day who was writhing around in agony with kidney stones. The doctor told him he had the second most painful thing ever...second only to childbirth. I noted that she did not then produce a beanbag and suggest he leaned on it in different positions. Nor did she say 'come on mate, you must control the pain don't let it control you.' She instead gave him morphine and plenty of it (and rightly so). I try to laugh at these things but deep down I feel quite cross really. The whole pain thing was a big issue for me, but sometimes I still feel like a wimp for not having been able to stand it without crying out in pain.” (Patricia)

This is repeatedly cited by women as a traumatising factor. It is also linked to a feeling of control over the whole birth experience.¹¹ Women need to be free to view pain in their own way and make their own decisions about how to deal with it unburdened by social orthodoxy, personal judgment or any other pressures. Staff need training in the importance of respecting a woman's wishes regarding pain relief in labour. Women should not be made to feel 'weak' or 'unworthy' because they need help. Pain is a personal issue and we experience it in an obviously individual way. This needs to be understood and communicated to the woman, particularly at the antenatal level where women need to have full information about the pros and cons of pain relief options.

The BTA believes that any woman wanting to give birth in an obstetric unit with a 24 hour on call obstetric anaesthetist service should have the opportunity to do so. Currently, most women can but there are areas where this option is unavailable. This is important as it has been shown that choice of epidural pain relief is a leading requirement for women yet it is seldom highlighted as an important priority.¹²

- **Support**

“After the birth I was exhausted. It was the middle of the night and I'd been in hospital for several days so hadn't slept well before. But all the midwives wanted me to do was breast-feed. They just wouldn't let me sleep. After several hours I was allowed to, but then only for a couple of hours before they decided to give me a bed bath. Later on, my son was crying and I couldn't move. The midwife was busy. So he just got left. I felt so helpless. There weren't any beds in the post-natal ward so I was left on the post-op ward on my own for hours. Obviously the only beds available were in this ward, as women started coming in for ante-natal checks after being referred by AE. This was unbearable. I had to endure the sound of the baby heart-beat monitors echoing out. I panicked at remembering. Eventually I got

¹¹ REYNOLDS, J. L. (1997). Posttraumatic stress disorder after childbirth: the phenomenon of traumatic birth. Canadian Medical Association Journal, 156, 831 – 835; BALLARD, C. G., STANLEY, A. K. & BROCKINGTON, I. F. (1995). Posttraumatic stress disorder (PTSD) after childbirth. British Journal of Psychiatry, 166, 525 – 528.

¹² See HUNDLEY's survey 'Women's preferences for maternity care' (Birth 28:4 December 2001)

moved down to post-natal at 4pm and the first thing they did was tell me off for not having fed my son since 9am. He'd been asleep - and how was I meant to do this on my own anyway? When I tried to get in a position to feed my son, my husband helped me to sit up and the midwife told him off. She needs to do it on her own. I'd had a major operation about 16 hours earlier! I was still catheterised, and they only cleaned or helped me when I rang the bell."(Natalie)

The availability of support may be an important protective factor.¹³ This goes further than immediate postnatal care, although this is vital. Social support networks are often lacking in modern society as women frequently live far away from families and sometimes friends. Health visitors have an important role to play and they should be trained to recognise the significance of 'birth trauma' and the differences between Post Natal PTSD and PND. However, the BTA also believe that Health Visitors should not stand isolated but feel part of a medical community which understands this phenomenon and treats it as a post natal health priority.

It has been suggested that 'debriefing' by hospital staff is an effective way of providing support and preventing PTSD but the research on this is inconclusive at present and needs further evaluation.¹⁴ The issue is complicated and further work needs to be done into the timing and validity of debriefing after traumatic birth. Until then, there is always the possibility that those organisations routinely offering this service may in reality be seeking damage limitation and reduction of the current high levels of obstetric litigation.

The BTA believes there should be thorough research into the timing and most effective method of 'debriefing' enabling standards of best practice to be established and followed by all hospitals.

- **Previous traumatic event**

There is also some evidence that a previous traumatic event may predispose women to a traumatic birth experience as there is a tendency for people with PTSD to relive the traumatic event if anything reminds them of it.¹⁵ The BTA has heard many stories from women who have been sexually abused or assaulted, or who have suffered other trauma and who find birth a terrifying ordeal if they are not dealt with sensitively.¹⁶

¹³ JOSEPH, S. (1999). Social support and mental health following trauma. In: W. YULE (Ed.), Post-traumatic stress disorders: Concepts therapy. Chichester: Wiley.

¹⁴ SMALL et al (2000) Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth BMJ 2000;321:1043-1047 (28 October) to show that midwives debriefing is clearly helpful but *Boyd and Condon* (2000) recommend that it should be offered with a follow up with midwife at 8 weeks to women at risk who should then be referred on if symptoms of depression/anxiety/PTSD apparent and that this should include the partner

¹⁵ CZARNOCKA, J. & SLADE, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, 39, 35 – 51; WIJMA, K., SODERQUIST, J. & WIJMA, B. (1997). Posttraumatic stress disorder after childbirth; A cross sectional study. *Journal of Anxiety Disorders*, 11, 587 – 597 recommends screening for previous traumatic events – people can relive original traumatic experience if encounter a similar one – particularly sexual abuse. However, AIMS believe this is a difficult issue and may lead to women being 'blamed' for their own traumatic experiences; ROBINSON, Post-traumatic stress disorder -- a consumer view, AIMS speech to RCOG 2003

¹⁶ See CROMPTON, PTSD and Childbirth <http://www.tabs.org.nz/pdfdocs/jrcrompton%20tabs.pdf>

From the above points, it is apparent that the delivery itself need not have been abnormal from the clinician's perspective for the disorder to occur. Indeed, evidence has shown that what is routine to an obstetrician may be extremely distressing for the mother, so that even an apparently 'normal' birth can be traumatic for some women. It is often this disparity in perception which leaves women feeling isolated and unable to cope. It is no surprise that feelings of guilt and shame in not being strong enough to move on are very common sentiments.

What problems are specific to Post Natal PTSD?

There are several important and distinct problems suffered by women with Post Natal PTSD and they have implications for the wider community too. For example:

1. Postnatal isolation

"I don't think the whole 'birth trauma' issue is taken seriously enough by some people...they assume that you should just be grateful for a healthy baby....pull yourself together and get over it. This is such an unhelpful attitude and just adds to the isolation that many of us feel."(Jane)

"I do get angry when people say 'at least the baby is ok' or when I read magazines or something that say 'just have a good birth plan and you will be fine.' Does that mean mums like us would have been okay if we'd only written a decent birth plan and we are somehow to blame? I blamed myself enough without helpful comments like that."(Patricia)

"I feel utterly robbed. Cheated. You can't turn the clock back now so I have to live with this feeling every day but it hurts me to my core. I look at pregnant women and other mothers and I feel resentment and anger at their happiness. It's almost like my baby died. She didn't, she's here, but I am grieving. People don't understand that, but to me it's easy. My daughter's birth should have been a joyous occasion, but I feel only intense pain at its memory. It was the worst day of my life. This was my start to motherhood and I'm expected just to get on with it" (Melissa)

From our own evidence, women who suffer PTSD symptoms after childbirth frequently find themselves very isolated by their experience and detached from other mothers. This can make them lonely and depressed. They may feel they are somehow 'weaker' than other women because they are unable to forget their birth experience, despite being told by others to 'put it behind them' and 'move on'. They may feel profoundly guilty as a result.

In our experience, women are particularly sensitive to comments from health care professionals, including GPs and Health Visitors, who fail to understand the nature of trauma and who are dismissive of women's concerns. Comments such as "you expected too much", "you need to move on" or "you should think yourself lucky, you've got a healthy baby" are frequently reported to us and increase women's feelings of guilt and weakness.

Women often report that they feel robbed and cheated of an extremely special moment in their lives, their childbirth experience. They grieve for its loss. But,

often, when they express these feelings, they are not listened to or understood and some have described this as being made to feel like a 'non-person' as they are left alone with this pain. Acknowledgement of women's experience is vital. Failure to acknowledge may leave women without any visible source of support or even any method of expressing their distress. This can only exacerbate existing problems with recovery and bonding.

2. Fear of sex and childbirth

"Personally I will go for a natural birth again but only because I don't see the point of having my stomach cut open after also having cuts in all the other places! It would be like a double whammy. But in some ways the thought of a scheduled c-section is nice because I hope it would be calm and stress-free rather than my last experience which was a mess of fear, pain and chaos. Called natural birth...felt anything but natural!" (Patricia)

"I still wonder how my husband could ever bear to go near me again after half a hospital has had a feel" (Jane)

"I know that I want more children, but equally the thought of going through it all again terrifies me." (Natalie)

Women can develop a very real fear of childbirth as a result of a traumatic birth experience (secondary tokophobia). Often, women can end up feeling torn between their desire for more children and their determination to avoid another pregnancy. As a result, they may also lose interest in sex and these problems can obviously place a great strain on relationships.¹⁷ Further pregnancies may be more likely to result in elective caesarean sections as the women tries to remain in control¹⁸ which presents its own problems in terms of a woman's post natal psychological adjustment.¹⁹ Sadly, such pregnancies may even result in a termination even if the baby was wanted²⁰

The BTA believes it is vital that the effects of previous birth trauma are understood and discussed with women in future pregnancies. We must also desist from trying to force women to give birth in ways that are psychologically and emotionally damaging for them. Proper training must be given to all medical professionals who work with pregnant women on the importance of this issue.

3. Avoidance of other medical procedures or health care

It has been said that women may also try and avoid other types of medical care. Worryingly, this can include the investigation and treatment of abnormal cervical

¹⁷ FONES, C. (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disease*, 18, 195 – 196; O'DRISCOLL, M. (1994). Midwives, childbirth and sexuality. *British Journal of Midwifery*, 2, 39 – 41.

¹⁸ HOFBERG, K. & BROCKINGTON, I. (2000). Tokophobia: an unreasoning dread of childbirth. *British Journal of Psychiatry*, 176, 83 – 85. This study looked at 28 mums electing caesarean section operations and demonstrated that all had traumatic memories of previous childbirth experience.

¹⁹ SHEARER, E. (1991). Caesarean section: medical costs and benefits. *Social Science and Medicine*, 37, 1223 – 1231.

²⁰ GOLDBECK-WOOD, S. (1996). PTSD may follow childbirth. *British Medical Journal*, 313, 774.

smears.²¹ On a very basic level, women have also reported to us that they have found it difficult to use tampons or cope with the return of their periods.

4. Problems bonding with baby

"I first saw my son when he was 20 hours old and he really could have been anyone's baby, this is one of the real things that upsets me, I didn't 'instinctively' know which baby was mine."(Jane)

Many women find it difficult to breastfeed²² or bond generally with their baby as a result of the trauma they have experienced. A woman may feel detached and distant from her child whom she often describes as 'not feeling like hers'. This means that many women believe they are failures as mothers because they do not encounter an immediate rush of love for their baby as a result of their 'traumatisation'. Thus, insensitive or aggressive attempts by health care professionals, who may understand little of this issue, to ensure women breastfeed may actually inflict a great deal of damage and guilt.

A sense of being robbed or cheated of their birth experience often provokes feelings of anger and injustice. Women report feelings of being engaged in a power struggle with their baby who constantly reminds them of the traumatising event. They may also be over-vigilant about their baby's health or find it very difficult to part from them or leave them with someone else. Unfortunately, there has been no research into the effect of Post Natal PTSD on a child's development, and there is an urgent need for further investigation and understanding in this area.

What is the scale of the problem?

One study in Sweden put the rate of Post Natal PTSD at 2% in first year after birth.²³

Another suggested that one third of those who go through traumatic obstetric or gynaecological procedures go onto suffer PTSD.²⁴

Dr Susan Ayers, of St George's Hospital Medical School, found 2.8% of women at a London hospital had PTSD at six weeks postpartum and 1.5% at six months (women who planned to have elective caesareans or whose babies died were excluded). She estimates that her findings could mean 10 000 chronic cases arising annually in the UK. This figure does not, of course, cover shorter-term problems of traumatised women, which may still have serious effects.

A report published by the Stephen Joseph, of Warwick University, and Dawn Bailham, of Northampton General Hospital, found that between 2 and 5 per cent may develop PTSD after a difficult and traumatic childbirth.

²¹ MENAGE, J. (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures. *Journal of Reproductive and Infant Psychology*, 11, 221 – 228.

²² See 11

²³ See 15, WIJMA (1997)

²⁴ MENAGE, J. (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures. *Journal of Reproductive and Infant Psychology*, 11, 221 – 228.

However, it is important to understand that although some women do not develop the complete disorder, many suffer some of the symptoms and as a result, they experience genuine and considerable distress. One study noted that 3% of women showed all the signs of PTSD but that a further 24.2% were partially symptomatic.²⁵

In reality, the number of women adversely psychologically affected by their birth experience could be very significant.

What are the problems with diagnosis?

Lack of awareness of this problem is a huge issue and it encompasses all health care professionals (GPs, health visitors, obstetricians and even non-specialist psychiatrists).²⁶ Many women report to us that they feel as if the issue is 'taboo' and that they are treated very dismissively when they raise it. One woman told us that she went to her GP about her concerns but when she raised the possibility that she might have PTSD "*he stared blankly at me and then upped my prescription for antidepressants*". Insensitive handling by health care professionals undoubtedly increases feelings of isolation.

There are also problems with:

- The absence of any effective screening method for Post Natal PTSD. This issue needs properly funded research and evaluation.
- Defensive medical practices. Many hospitals see women raising these issues as potential litigants and immediately adopt confrontational stances.
- Recognising the difference between PND and PTSD. Dr Helen Allott who runs the Post Natal PTSD unit at the Royal Berkshire Hospital has said "*the problem is that in many cases there is a misdiagnosis of depression and consequently inappropriate treatment with antidepressants which really do little to improve matters.*" There is a symptom overlap but the disorders must be treated as distinct and dealt with individually, particularly as a possible 25% of women with PTSD do not suffer PND at all and thus could remain entirely undetected.²⁷ The BTA firmly believes that, dismissing all women who present with problems after childbirth as having PND, may effectively deprive them of the opportunity to voice their concerns.²⁸
- The failure to understand the difference between a subjectively traumatic birth and one which is objectively recognised as traumatic
- The lack of support or referral services open to women which may assist in early identification of this disorder. Health visitors and other practitioners in the field report a complete lack of organised referral procedures and an absence of appropriate treatment options. This is significant because women with Post Natal PTSD need specialised care and treatment. This is certainly

²⁵ See 15, CZARNOCKA, J. & SLADE, P. (2000)

²⁶ ROBINSON (AIMS), Post-traumatic stress disorder -- a consumer view, AIMS speech to RCOG 2003

²⁷ See 15, Czarnocka and Slade (2000)

²⁸ It is possible that one group of drugs (Selective Serotonin Reuptake Inhibitors - SSRI's) are effective for both depression & PTSD, in as much as pharmacological treatment on its own can be effective (Susan Ayers).

an area where more research and, most importantly, more funding, must be made available.

The consequences of failure to diagnose PTSD or misdiagnosis

If untreated, PTSD is associated with increased physical morbidity, subsequent psychiatric illness, accidental and non-accidental death²⁹). Suicide is the leading cause of maternal morbidity. AIMS state that *“the overwhelming majority of women who come to us in a suicidal state do not have postnatal depression alone, but have either severe post-traumatic stress reactions or PTSD. Every woman who tells us she has already attempted suicide has PTSD.”*

PTSD may also result in the following consequences:

- Depression
- An increased incidence of alcohol and other substance abuse.
- Profound problems for a woman’s relationship with her baby (Henry, 1993) e.g. problems with breast feeding and bonding. This may cause the long term effects of PTSD to continue to the next generation.
- Sexual avoidance
- Tokophobia (fear of childbirth)
- Requests for otherwise unnecessary elective caesarean sections in subsequent pregnancies
- Over-vigilance and anxiety about a child’s health (Creedy)
- Relationship breakdown. In other groups of PTSD sufferers (e.g. Vietnam Veterans), the disorder is associated with marital or relationship breakdown.
- The impact on a woman’s family. In addition to relationship breakdowns, it is clear from research undertaken in relation to PND that PND can be associated with developmental difficulties in children. Hence, it is likely that Post Natal PTSD will have an impact on the family unit and the child’s development.
- Avoidance of future medical care, including a number of cases of failure to have investigation and treatment in women known to have abnormal cervical smears.³⁰

What can be done?

The Birth Trauma Association has drawn up a list of basic demands to tackle Post Natal PTSD. We have called this the BTA Charter.

²⁹ DSM 1V, APA 1994

³⁰ See 26, ROBINSON and 24, MENAGE

The starting point must be primary prevention which means recognising the types of practices that cause trauma. These practices must then be stopped by means of continuous training and raising levels of awareness. Staff must be made aware of the types of situations and practices which might give rise to PTSD. Treating all women as potentially vulnerable to birth trauma may ensure that they are not traumatised by their birth event. In addition, social orthodoxy about the 'perfect birth' should not become a dogma and maternity services must operate in an inclusive and neutral fashion. Maternity services at all levels act most effectively when they enable women to make their own birth choices by supplying them with complete information and then actually respecting their wishes.

However, secondary prevention, (identifying women who are distressed after birth and taking steps to try and prevent the development of Post Natal PTSD) is also important as it could help dismantle the 'taboo' and reduce damaging feelings of isolation.

Finally, we need to look at tertiary intervention (what help do we give once women have Post Natal PTSD) e.g. the availability of support and psychotherapy. Psychotherapy may alleviate disabling feelings of self-blame and guilt and help validate a woman's experience. It may just help her regain her voice.

The BTA Charter

The BTA demands more funding for research to develop our understanding of the experience of childbirth. Fundamental to this understanding, is the paramount need to respect a woman's basic human rights throughout the birth process.

We believe that a traumatised mother is not a 'healthy' one and that maternity service providers should understand that childbirth has a psychological outcome as well as a physical one. Hence, the common sentiments expressed by women traumatised by their birth experiences should be acknowledged, although these experiences should not be generalised. These sentiments include the need for more complete information prior to birth, the need to maintain control over their birth process, the need to be free to view their pain as a personal issue and the desire for explanations after birth

The BTA demands that the Government address the following issues urgently:

Antenatal education

- Antenatal classes have an important role to play. Managing expectations properly does not prevent trauma but it may help prevent a culture of self-blame and guilt. Frank discussions about emergency procedures and medical interventions may enable women to be better prepared. Further, a more 'women-centred' approach should be adopted by antenatal educators with the recognition that the individuality and emotional well-being of women are important. This is an important message for women to receive from health care providers and it includes the supply of realistic information about pain and pain relief options, including the availability of different types of pain relief at local hospitals. Women frequently report that inadequate pain relief is an issue which contributed to, or created, their traumatic experience, so it is essential that women are free to make their own decisions about the way they view pain. Ultimately, antenatal education should empower women to pursue their own birth choices. However, the BTA is aware that maternity practices

need to be changed to ensure that women's wishes are, in practice, respected.

- Hospital education can help too. Specific tours could be set up, on an antenatal basis, to help those women having highly “medicalised” births
- There should be contact with doctors and midwives if a highly “medicalised” birth is anticipated with sufficient time to ask questions. This should entail appropriate education of doctors and midwives in strategies to prevent the development of PTSD. It is important that medical staff understand that mental and physical health are of equal importance. When discussing the risks of different procedures, it is vital that both physical and psychological risks are addressed.
- Information about the possibility of PTSD should be available to women on an antenatal basis in the same way that most ante natal groups talk of Post Natal Depression. This would decrease the risk of isolation felt by some women who cannot put a ‘label’ to the way they feel after their births

Labour and birth

- Information is the key. When women face obstetric complications, they need to be fully informed of the options, procedures and associated physical and psychological risks. The woman must be central to the decision making process. Good quality leaflets and sympathetic information produced by hospitals can help enormously
- Women need to be presented with their choices in plain English so they are allowed to make their own decisions. This is particularly important because a high level of intervention is often marked by a sense of fear, loss, and pain at a physical and emotional level.
- Women need to be given as much time as possible to talk through their decision with appropriately qualified staff. If emergency procedures are necessary, the woman and her partner should be given as much information as possible and should be treated sensitively. Their decisions should be supported appropriately and care should be individualised, this includes pain relief provision and complete information about the well-being of their baby because fear and lack of trust are commonly associated with later traumatic experiences
- All maternity staff need to be trained fully in this area, so that those practices which contribute to or cause traumatic experiences can be eradicated
- The BTA believes that properly trained midwives providing constant, sensitive and responsive care to women in labour, whether at home or in hospital, are vital in preventing trauma. Adequate resources must be made available for this purpose.

Postnatal hospital care

- There is no consistent relationship between mode of delivery and Post Natal PTSD and women who have not undergone classic ‘emergency’ birth experiences can still suffer trauma. Thus, maternity services should carefully

explore the best ways of sensitively raising this issue on the post natal ward, perhaps by giving women information about possible symptoms.

- Unfortunately, many women have negative experiences of post natal care in hospital which frequently compounds their trauma and although women who have caesarean sections may receive some support other mothers who have had difficult births do not. The BTA demands decent, sensitive and supportive post natal care in hospitals for all women.
- In particular, if research proves this to be helpful, the opportunity to 'de-brief' should be provided to women but only if staff are trained appropriately to listen and refer where necessary. An open culture would undoubtedly assist many women if debriefing takes place in a compassionate and frank environment. However, there are obvious issues of avoidance of the event by the woman and damage limitation by the hospital which must be considered. Therefore, the BTA demands urgent research into and consideration of the efficacy and most appropriate timing of de-briefing.
- As part of their professional development, it is important that medical staff constantly review their practices to ensure that cases of Post Natal PTSD are minimised. It is therefore essential that there is liaison between the Primary Care services, Health visitors, midwives and obstetricians. The BTA believes that the incidence of Post Natal PTSD should be a performance indicator for the obstetric services.

Postnatal support

- We believe that, as there is no consistent relationship between mode of delivery and Post Natal PTSD, it would be useful for midwives or health visitors to screen women for PTSD symptoms a few weeks after birth and identify those who might need help.
- Local support networks could tackle isolation. Many women feel unsupported and detached from those who have had 'easier' births and may as a result feel somehow inferior. Ultimately, this means that emotions which are genuinely held, and which should be freely expressed, are repressed. The BTA demands that health care professionals review the availability of support to women in their areas. There is an urgent need for communication between health care professionals about the nature and scale of available provision.
- Health visitors and GPs need to recognise the difference between PTSD and PND. The consequences of misdiagnosis and wrongly prescribed anti-depressants can be grave. The BTA demands specific training for all health care professionals dealing with women who have given birth.
- Psychotherapy helps validate a woman's experience and reduces the risk of long term trauma. Psychotherapy services available to tackle these issues should be brought to women's attention on discharge and by their Health Visitors. The BTA demands that the provision of appropriately trained psychologists and therapists be increased and adequate funding be made available.
- The BTA demands that there should be effective follow up provision after discharge from the midwife as well as screening (as for PND) at the 6 week and 6 month check-ups.

- The BTA demands that the reality of secondary tokophobia (fear of childbirth usually after a traumatic earlier birth) should be to be considered and understood and appropriate provision made for psychotherapy to prevent debilitating anxiety and depression. Women also need to be provided with sensitive support and advice about all of their options if they wish to go ahead with another pregnancy.

For further information, please contact

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