

# ***Tabs - Childbirth and Emotional Trauma: Why it's Important to Talk Talk Talk***

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## **INTRODUCTION**

Although there is now heightened awareness of postnatal depression, symptoms of trauma tend to be missed in women who have recently given birth. It is important for professionals and lay persons to have some understanding of the differences between depression and post traumatic distress disorder because the treatment can be quite different for the two disorders. The literature in this emerging field is still quite limited; nonetheless, there are some identified risk factors and treatment considerations that will be discussed below.

## **DEPRESSION OR PTSD?**

### ***A. Major Depression***

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV Text Revision, American Psychiatric Association, 1995) in order to meet the diagnostic criteria for a diagnosis of Major Depressive Episode, a person must exhibit five or more of the following symptoms over the previous two weeks; one or both of the first two symptoms must be present:

1. Depressed mood most of the day nearly every day,
2. Markedly diminished interest or pleasure in activities,
3. Significant change in weight or appetite,
4. Significant change in sleep,
5. Significant speeding up or slowing down of psychomotor activity,
6. Significant fatigue or loss of energy,
7. Feelings of worthlessness or guilt,
8. Decreased ability to think clearly,
9. Thoughts of death or suicide.

For a diagnosis of postnatal depression, the DSM suggests that these symptoms must have commenced within four weeks of the childbirth. In practice, PND might be diagnosed up to six months after birth, or even longer in some cases.

### ***B. Post Traumatic Stress Disorder (PTSD)***

The old DSM definition of PTSD suggested that it had to be in response to events outside of normal human experience. However, since 1995, triggering events are more broadly defined and include those that involve actual or threatened death or serious injury. The person's response involves intense fear, helplessness, or horror. The symptoms are generally in three categories as follows: intrusion, avoidance, and hyper-arousal. For example, intrusion would include the persistent re-experiencing of the trauma through distressing recollections, dreams, or feeling like one is reliving the whole traumatic

experience. A person might respond in a very distressed manner at internal or external cues that resemble some aspect of the traumatic event. Their response might include a heightened physiological reactivity to cues. There might be avoidance of thoughts, feelings, or conversations associated with the trauma. The person might avoid any kind of activities or places that arouse recollections of the trauma. Hyperarousal symptoms might include difficulty falling or staying asleep, irritability, poor concentration, hyper-vigilance and exaggerated startle response. In general, the duration has to be more than one month. The onset can occur months after the stressor.

Yehuda (2002) has demonstrated the neurochemical responses to stress in the hypothalamic-pituitary-adrenal (HPA) axis. There are clear differences between the responses of a normal subject v. One with Major Depression v. one with PTSD. “The sensitivity of the negative-feedback system of the hypothalamic-pituitary-adrenal axis is increased in patients with PTSD rather than decreased, as often occurs in patients with major depression” (p 4).

In the context of childbirth, the prevalence of post traumatic stress disorder has been estimated at between 1.5% (Ayers & Pickering, 2001; Wijma et al, 1997) and 5.6% of mothers (Creedy et al, 2000). A case example might help to make the disorder more meaningful.

### *C. Case Example*

Mandi came to see me 9 months after the birth of her second child. Her GP had placed her on anti-depressants which hadn't really helped a lot. She admitted to me that she felt embarrassed and guilty that she believed the delivery of her second child was a terrible experience and his crying made her feel horribly distressed. Mandi has recurrent thoughts about the delivery, and she has dreams every week or two that involve distress associated with childbirth.

She described a fairly typical history of emotional trauma from childbirth rekindling feelings associated with childhood trauma. She describes the delivery as follows: she was vomiting when she awaited the caesarean section, the anaesthetist bruised her hand and pricked his own hand, he put a drape over her head which then fell right on top of her face when the baby was delivered. She had allegedly told the nurse and anaesthetist that she “needs TLC”, but this was not acknowledged: nobody was wiping up her vomit. She states that she was offered a two second view of the baby: he had appeared blue in the face and appeared to be foaming at the mouth. The baby was then taken away without explanation. She did not get a chance to hold the baby until she was wheeled down to the nursery shortly afterward (before regaining feeling in her legs). However, she indicated that seeing her baby “smile” at her in the nursery was wonderful.

Mandi reports that one year after the birth, she still reacts negatively to his cries when he's sick or upset. She noted that coming back to the hospital to see me caused her to feel sick in the stomach and distressed. After our initial appointment during which I diagnosed PTSD, she has tended to avoid coming back. She has rung my office on occasion to have a friendly chat on the telephone.

Some of her symptoms of hyperarousal her doctor no doubt felt were due to depression: these included difficulties sleeping, occasional irritable mood, and difficulty concentrating. Her GP noted in addition that she tended to be somewhat withdrawn socially and/or agoraphobic. She demonstrated some emotional numbing or detachment from others: she stated that she would often just say “no, I don't care”.

How do we know who might become the next Mandi? A variety of risk factors of have been proposed and will be discussed next.

## **RISK FACTORS**

1. Poor support from partner, family and/or staff (Czarnocka & Slade, 2000; Lyons, 1998). In the case of Mandi, she complained that she had asked for TLC, but was left to vomit and couldn't wipe herself.
2. Unplanned pregnancy (Czarnocka & Slade, 2000).
3. Previous stillbirth may lead to an increased risk for PTSD. One group of researchers suggest about 21% of women with a history of stillbirth experienced PTSD during the 3<sup>rd</sup> trimester of the next pregnancy (Turton et al, 2001).
4. Previous trauma: we see women who have experienced childhood sexual abuse in the PTSD group. Some aspects of labour and birth might remind her of previous sexual assault (e.g., loss of control, exposure of her body, having legs open, pressure in the vagina. Reynolds, 1997; Roussillon, 1998).
5. High trait anxiety (Czarnocka & Slade, 2000): some women are simply more prone to anxiety of all kinds.
6. Perceptions of not being in control during labour and/or not knowing what's going on (Gonda, 1998; Lyons, 1998; Menage, 1993; Reynolds, 1997; Ryding, Wijma & Wijma, 2000). The classic portrayal of a mother not being in control is portrayed humorously in the Monty Python classic movie, "Meaning of Life Part I: The Miracle of Birth." The woman is clearly of less interest to the staff members than the machine that "goes ping".
7. Poor pain relief can be extremely traumatic (Reynolds, 1997; Sonne et al, 1996). Receiving an epidural can also be quite distressing in and of itself. For a woman with a history of childhood sexual abuse, the loss of feeling in her pelvis may be particularly worrisome. Thus she may need to discuss issues surrounding the epidural prior to childbirth so that she can take some control over this decision during labour.
8. Fear for the well-being of the baby or oneself (Czarnocka & Slade, 2000; Lyons, 1998) can be traumatic. For example, Mandi recalled seeing a blue baby who was then rushed out of the delivery suite. She was desperate to see that the baby was okay in the nursery. This fear can continue after the birth if the baby is unwell. The mother may be extremely distressed every time she visits the nursery, and may start to avoid visiting. When she does visit, she might not "hear" what's being said because she's too anxious. She may appear to overreact to what attending staff view as fairly trivial incidents.

Other risk factors are less carefully studied and include:

1. Tendency to blame staff or self for things that went wrong (Czarnocka & Slade, 2000; Ryding, Wijma & Wijma, 2000). For example, a patient might contact the hospital Patient Advocate to raise a complaint. Things do go wrong; we need to improve the way we manage the emotional sequelae of negative events.
2. There are mixed research findings regarding a difficult or prolonged labour and PTSD symptoms (Czarnocka & Slade, 2000).
3. Secondary trauma symptoms may be present in partners and attending staff: bystanders might not be too helpful if they have been traumatised too.

## **TREATMENT**

### *Assessment*

As Czarnocka & Slade (2000) point out, we must firstly ensure that new mothers are assessed for trauma. We tend to look for symptoms of depression whilst overlooking symptoms of trauma. Sara

Weeks, at the Marce Conference (2002), suggests that we ask all women how the labour and delivery went.

When treating women with co-morbid problems such as depression and substance abuse, ensure that trauma is not the original problem. If it is, then it needs to be treated. In the case of Mandi, simply assessing and diagnosing trauma has helped to put her mind at rest.

### *Primary Prevention*

Some researchers have argued that we should not apply another medical label that puts the problem in the woman's mind; we should instead identify factors that are associated with PTSD in order to prevent it. For example, there needs to be a continual review of invasive obstetric procedures to decrease their use. We need to prepare women realistically for possible emergency procedures. We need to enhance perceptions of control and support in labour. Because thinking and talking about the experience promotes information processing, we should ensure adequate social and practical support as soon as possible after delivery (Reynolds, 1997; Watson, 2002).

### *Debriefing*

There is much controversy about debriefing both in the general PTSD literature and in midwife led debriefing. In fact, Cochrane reviewers recommend that "compulsory debriefing of victims of trauma should cease" (Rose, S, Bisson, J & Wessely, S: Cochrane Depression, Anxiety and Neurosis Group: Cochrane Database of Systematic Reviews. Issue 3, 2002). With regard to midwife debriefing, Small et al (2000) failed to show it to be clearly helpful. Nonetheless, Boyce and Condon (2000) recommend that midwife debriefing should be at least offered to all women who have had a potentially traumatic birth experience. They concede that it should not be done if the mother does not want it. Follow-up with a midwife at eight weeks should be offered to women at risk and these women should be referred on if symptoms of depression, anxiety or PTSD are apparent. They recommend that the husband should be included since he may have been traumatised by watching the birth. They point out that midwife led debriefing would be best rather than using trained debriefers who cannot answer relevant medical questions.

### *Support Group*

While the Trauma and Birth Stress group in New Zealand offer support to mums, I am unaware of any similar group in Australia or elsewhere.

### *Cognitive Behavioural Therapy (CBT)*

Cognitive-behavioural therapists generally work from the assumption that our thinking affects our emotions and behaviours (Dobson, 1988). This general psychological approach can include methods such as relaxation and distraction techniques to cope with arousal symptoms. Women can be offered an explanation of how thoughts, behaviours and feelings work together. Typically a woman's sleep routine would be reviewed. Challenging women's irrational thoughts needs to be done with caution: women with PTSD need to have their feelings validated not challenged.

### *Exposure Therapy*

Exposure therapy generally is a part of the treatment for fears and phobias. It can be "live" (*in vivo*) or in imagination. Women planning another pregnancy may be taken back to the labour ward as part of exposure therapy. Women's tendency to talk at length about their trauma may be a naturally occurring form of exposure therapy.

## *Writing Therapy*

Writing may be one way of exposing the individual to traumatic feelings, but research suggests that it needs to go further: the individual must find meaning in her experiences. One theory suggests that writing may promote disclosure and emotional processing which in turn can positively affect some of the “neuroendocrine dysregulation seen in PTSD” (Lutgendorf & Ullrich, 2002, p 188). One patient has said that she is learning to cope with repeated pregnancy loss through writing; she says, “if the feelings are on paper they are not tearing you up inside”. However, not all people enjoy writing so it is not a panacea.

## *Medications*

The SSRI class of medications might be helpful. Other medications have not been sufficiently researched in this area yet.

## **Summary of Treatment Considerations**

Three critical steps in treatment include the following (Van der Kolk, 2002):

1. The improvement of a woman’s sense of safety, perhaps by bolstering her social support network,
2. Learning how to manage anxiety symptoms, and
3. Promotion of emotional processing of the events, perhaps through psychotherapy.

## **CONSEQUENCES OF FAILURE TO TREAT PTSD IN MOTHERS**

In an attempt to avoid reminders of the trauma, a woman may avoid her baby. Needless to say, this would result in poor bonding and attachment (Sonne et al, 1996). Moreover, she may avoid sexual intimacy or pregnancy. She may opt for sterilisation or have a termination of pregnancy (Sonny et al). Barbara Gonda (1998) says “professionals may well be causing their clients more harm by overlooking the trauma and compounding and prolonging the patient’s depression. This in turn may place further burdens on their psyches, their relationships, and their children”. (pp 40-41)

## **CONCLUSIONS**

Always ask women how the labour and birth were, validate their feelings, help them regain control as soon as possible during high stress times, and allow them to talk talk talk. In some cases, a should be referred on to a psychological service.

## **REFERENCES**

- Allen, S (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, 16, 107-131.
- Ayers, S & Pickering, AD (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth*, 28, 111-118.
- Boyce, P & Condon, J (2000). Traumatic childbirth and the role of debriefing. In B Raphael & JP Wilson (Ed.), *Psychological debriefing: Theory, practice and evidence* (pp. 272-280). New York: Cambridge University Press.

- Creedy, DK, Shochet, IM, & Horsfall, J (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth*, 27, 104-111.
- Czarnocka, J, & Slade, P (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, 39, 35-51.
- Dobson, K (1988). *Handbook of cognitive-behavioral therapies*. New York: Guilford.
- Gonda, B (1998). Postnatal depression or childbirth trauma? *Psychotherapy in Australia*, 4, 36-41
- Menage, J (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures: A consecutive series of 30 cases of PTSD. *Journal of Reproductive and Infant Psychology*, 11, 221-228.
- Reynolds, JL (1997). Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. *Canadian Medical Association Journal*, 156, 831-835.
- Rose, S, Bisson, J, & Wessely, S (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD): Review. *Cochrane Database of Systematic Reviews*, Issue 3.
- Roussillon, JA (1998). Adult survivors of childhood sexual abuse: Suggestions for perinatal caregivers. *Clinical Excellence for Nurse Practitioners*, 2, 329-337.
- Small, R, Lumley, J, Donohue, L, Potter, A., & Waldenstrom, U (2000). Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *British Medical Journal*, 321, 1043-1047.
- Sonne, S, Rubey, R, Brady K, Malcolm, R, & Morris, T (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disease*, 184, 195-196.
- Turton, P, Hughes, P, Evans, CDH, & Fainman D (2001). Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *British Journal of Psychiatry*, 178, 556-560.
- Watson, S (2002). PTSD after childbirth: The voice of the consumer. Talk presented at The Marce International Biennial Scientific Meeting, 25, 26, & 27 September; Sydney.
- Weeks, S (2002). PTSD after childbirth: A clinician's perspective. Talk presented at The Marce International Biennial Scientific Meeting, 25, 26, & 27 September; Sydney, Australia.
- Wijma, K, Soderquist, J, & Wijma, B (1997). Posttraumatic stress disorder after childbirth: A cross sectional study. *Journal of Anxiety Disorders*, 11, 587-597.
- Yehuda, R (2002). Current concepts: Post-traumatic stress disorder (Review article). *New England Journal of Medicine*, 346, 108-114.

Websites:

[www.traumacenter.org](http://www.traumacenter.org)