

PERSONAL NOTE FROM JUDY CROMPTON

“New Zealand is one of the fore-runners in the understanding of the long term effects that psychological trauma has on birthing women; Trauma both from events during the woman’s life and from a birth experience that is perceived as traumatic. Good support and, where necessary, trauma counselling, are essential to ameliorate the impact of this. In particular, access to a group who are able to advise, educate and de-pathologise the intense emotions which the women may be feeling is of primary importance. Such a unique group of dedicated activists is TABS who invited me to address them when I was in NZ in March 2000. It was an experience which I will always remember with great warmth. Good luck to you all. Fondest wishes, Judy Crompton”

POST-TRAUMATIC STRESS DISORDER AND CHILDBIRTH

Written by Judy Crompton BA (hons), RM, Diploma in Counselling (Royal Society for Health). After having 5 children, all but the first born at home, I trained as a midwife. I became interested in women’s differing birthing styles and realised that, sometimes, I was witnessing the symptoms of Post-traumatic Stress Disorder. Having subsequently trained as a trauma therapist, I specialise in Cognitive Behaviour Therapy and Eye Movement Desensitization and Reprocessing. I also write, teach, research, enjoy my grandchildren and love to travel.

Litigation is an ever present fact of life for those working in the area of women’s obstetric and gynaecological health.

Since 1980, when the American Psychiatric Association first described Post-traumatic Stress disorder (PTSD), it has been a compensatable diagnosis in litigation. As midwives, we have a duty of care to our clients and, as the causes and symptoms of PTSD have been in the public domain for twenty years, it may be that ‘lack of knowledge’ will be considered an inadequate response in the face of potential litigation. The issue of ‘foreseeability of harm’ is now examined by the courts (Jenkins ,1995). Medico-legal considerations have demanded a new precision in thinking, assisted by the new biological dimensions of the disorder, which are currently being explored. This paper highlights some of the issues around trauma and childbirth and seeks to indicate experiences of both clients and midwives that can lead to psychopathology. It begins with the case history of Emma.

Case History:

Emma was a 28 year old married woman who had been sexually abused by her father in childhood. She now has no contact with her parents. A primigravida, she was admitted to hospital and had vaginismus throughout labour. She was in a lot of pain which worsened when given a syntocinon drip. She did not have an epidural. She shouted and screamed with pain and was told to be quiet. She felt that the doctor and midwife were hostile to her because she was shouting. She was told that if she shouted she would harm her baby. Eventually she had a forceps delivery. Her husband was excluded from the delivery room but several student doctors and midwives were present in the room. She shouted for them to leave but no notice was taken of her request. She was subsequently delivered of a live healthy son but developed post-natal depression and feared that she might harm her baby, She complained to the hospital and received a letter agreeing that there should not have been so many people in the room at her delivery. The letter did not

acknowledge that her request had been ignored. She feels angry about her treatment and mistrustful of health professionals. She scores positively for PTSD using the PTSD-1 questionnaire ? reference for the questionnaire(Watson, Juba, Manifold, Kucala, & Anderson 1991). She has decided that she is not going to have any more children because of her experience.

Emma's experience is not unique, nor was her response. Creedy, Shocket & Horsfall (2000), contacted 500 Australian women 4 – 6 weeks after giving birth, and found that 5.6% of women met the diagnostic criteria for PTSD, and one in three reported a stressful birthing event with three or more trauma symptoms. Whilst the researchers did not question their population about previous trauma, other research over the last twenty years has indicated that one in five women will have been subjected to some form of sexual assault during their lifetime and one in seventeen will have experienced forced sexual intercourse (Bill C-127. Canadian Dept. of Justice reference needed in the reference list). These figures are generally agreed to be under-reported and ignore the incidence of child sexual abuse. From these statistics it can be seen that many women approach childbirth with a pre-existing history of sexual trauma which may be exacerbated by the experience of genital pain and a sense of loss of control. As yet, there are few protocols which encourage health professionals to access and consider this type of experiential history.

PTSD: What is it?

Knowledge of the long term effects of trauma on psychological, physiological and social well-being is growing. PTSD is one of the most serious effects of trauma. It has a psychiatric diagnosis, yet can be **wholly environmentally** caused. Waites (1993) suggests that PTSD can happen to anyone at any time with no predisposing physical or psychological factors, and has been described as the outcome when stress responses, that have originally been adaptive, continue after the threat is no longer there). The events which trigger PTSD may be natural, or man-made disasters (hurricanes or wars) or as a result of torture, hostage taking, kidnap, child sexual abuse (CSA), assault, bullying, crime, rape, battering relationships, traffic accidents.....and childbirth. It may seem strange that the 'normal' event of childbirth should be bracketed with these other events, but all of them can generate fear or horror.

The symptoms of PTSD have been written about for centuries and it has variously been described as 'Railway Spine', 'Irritable Heart', 'Shell Shock', and mistaken as cowardice (Healy, 1993). In 1980, with the emergence of large numbers of veterans of the Vietnam War, all showing similar symptoms and self-medicating on drugs and alcohol, the disorder was officially recognised as a separate diagnosis, named and described in DSM-111 (American Psychiatric Association) under the generalised heading of Anxiety Disorders. The definition in the American Psychiatric Association (1994) DSM-IV is,

The essential feature of Post-traumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic experience involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or serious injury experienced by a family member or other close associate.
(p.424)

Diagnosis

Characteristic features of PTSD are expressed in three groups of symptoms (Crompton, 1996). The first set relates to reliving an aspect of the trauma, with nightmares, sudden actions, or

feeling as if the event is taking place again. The second group comprises symptoms related to persistent avoidance of anything likely to remind the individual of the trauma. The third group includes symptoms indicative of heightened irritability, such as hyperarousal, sudden shock reactions, loss of libido and sleep disturbances, as well as sudden outbursts of anger.

PTSD can be **acute** (4 weeks to 3 months after the event), **chronic** (longer than 3 months) or of **delayed onset** (showing first symptoms 6 months after the event)

These are the present categories of DSM IV (American Psychiatric Association, 1994) used in diagnosing primary PTSD, and it can be seen how traumatic childbirth would fit the type of experience needed for a diagnosis; for the mother, father or even the midwife. Others have suggested that these criteria may need to be relaxed even further in the future. There is anecdotal evidence that PTSD can be acquired by non-direct (i.e. secondary, vicarious) means by, witnessing traumatic events on television (Mihill, 1994) or by listening to the accounts of traumatised others (Turnbull, 1994)(references for the clinical evidence). Children are known to have developed PTSD from bullying at school, even if there is no physical contact with the aggressors.

Above all, it needs to be born in mind that it is the **person's** perception of the event which traumatises them, not another person's perceptions of whether an event should or should not be traumatic. This is a particularly important consideration for midwives. The working environment in which they are familiar and comfortable is alien territory for many women. Procedures which are regularly carried out as part of the ordinary working day (such as vaginal examination, suturing) may cause speechless terror to the client whose biography is unknown to us. Lying down with her clothes off when others are standing and clothed may contribute to a feeling of powerlessness (Crompton, 1996).

The two conditions most likely to predict the onset of PTSD are states of helplessness and hopelessness. This has been measured by the appearance of abnormally high levels of catecholamines in blood and urine samples under laboratory conditions (Yehuda et al., 1995)

What happens during a traumatic event?

When confronted with danger, humans have a similar repertoire of choices to that of animals; that is 'fight, flight or freeze'. The first two are mediated by hormonal events and the last has been postulated as a reversion to a primitive coping tactic of self-hypnosis. Stutman and Bliss (1985), suggest that self-hypnosis can generate a host of symptoms including depersonalisation, derealisation, hallucinations and amnesia which can, in turn, instigate and perpetuate the disabling post-traumatic syndrome.

Others, (Henry et al, 1992;Zeitlin, McNally & Cassidy,1993; Williams, Weir & Waldmann,1994) suggest that the trauma of a critical life threat, in which the victim fails to regain safety or control, causes the central nervous system to thrust all of its resources into the left cerebral hemisphere which dissociates to some extent from the right hemisphere. This is a condition called alexithymia and permits the sufferer to believe that he/she is still in control (despite evidence to the contrary).

There is now evidence that traumatic events not only alter brain chemistry (Coleman, 1992) but the actual structure of the brain (Bremner et al, 1995) and that, from a biological viewpoint, people who have suffered intense, prolonged trauma may never be the same again

The cycle of events, which is not completely understood, is believed to be such that the

emotionally intense shock of extreme trauma causes the release of abnormally high levels of adrenalin and noradrenalin into the bloodstream which appear to inhibit the normal processing of memories (Turnbull, 1994). These toxic levels cause changes to occur in the locus coeruleus; an area of the brain which co-ordinates the secretion of these two hormones. 90% of the cells for the brain's noradrenalin controlling system are located in the locus coeruleus. In the face of extreme stress, it is as if it is unlocked and the key thrown away. The sufferer is left with altered brain metabolism, which is vulnerable to surges of noradrenalin; thus prompting alarm states.

In time, the sensation of an adrenalin surge (for whatever reason) acts as a memory and as a cognitive cue for the sufferer to relive the original trauma in intrusive recollections (known as 'flashbacks'). These are frequently so intensely distressing that the person will do anything to avoid a repetition of their trauma. There is, therefore, an avoidance of stimuli associated with the event or which may symbolise some aspect of the traumatic occurrence. This may take the shape of psychogenic amnesia or memory loss from psychological rather than physiological reasons (Crompton, 1996). It may also cause the woman to avoid all memory of her childbirth experience by non attendance for her postnatal check-up, or future smear tests (Menage, 1992), reluctance to resume sexual activity with her partner or even to have more children.

Childbirth and sexual trauma.

When talking about traumatic childbirth, women often use the language of sexual assault. "I came away hurting and feeling violated", "My opinions were dismissed as irrelevant, although it was my body which was being invaded", "I felt assaulted and then abandoned". (Menage, 1993 p223 & p226). In the absence of other relevant descriptions of the effects of childbirth trauma, that of sexual trauma is considered below.

'Sexual assault is a life crisis in which the ego is overwhelmed and the balance between internalised concepts of self and the environment is broken' (Moscarello, 1990 p25). Sexual assault is the violation of one human being by another of a fiercely protected, private aspect of oneself which breaches body boundaries and severely disrupts personal beliefs of invulnerability and belief in the world as a benign place.

No one passes through life without experiencing some degree of distress, devastation or contact with a world that can suddenly be seen as cruel, grotesque and alien to their expectations. Psychic trauma results when an individual experiences an adverse event which causes undue stress which is perceived to be beyond their control. When the event is unforeseen and happens quickly, such as obstetric emergency, it can be overwhelming.

Coping Strategies

Each person has a limit to the quantity and quality of stressful events they can experience before their capacity to cope begins to break down. The setting of this limit is not yet known but believed to have some genetic input but also to relate to early childhood experiences and the quality of social support experienced. Hans Selye (1956) called this limitation "the general adaptation syndrome" which established three stages of response to a noxious stimulus:-

Alarm

Resistance

Exhaustion

To understand the effects of psychic trauma one needs to understand the word 'self' which is as enigmatic as the concept that it represents, but can be described as a construct that develops over time and is the summation of a person's lifetime experiences.... which have been edited by their

personal beliefs and attributes. Trauma has a devastating effect upon a person's perception of the world and his/her self image and identity. During psychic trauma the internal library of experiences is found to be empty of any useful response, which places the individual in an anxious and threatening position (Horowitz, cited in Brett & Ostroff, 1985). The person has no guidelines for responding to this event and finds themselves in a state of suspended animation; emotionally numbed, unable to attend to stimuli and out of touch with their environment. To defend the self from being overwhelmed she moves into a phase of suppressed association (dissociation or 'stepping out'), in which the connection between the self and the event is broken (van der Kolk, McFarlane & Weisaeth, 1998). In the immediate aftermath of sexual assault, and also after traumatic birth, women have been observed to cope in two distinctly different styles (Karl, 1989) (in approximately equal halves of the population). These styles can best be described as '**expressed**' and '**controlled**'.

The expressed style is that of immediate distress, agitation, anger and disorganised behaviour, which is the expected and accepted reaction to trauma.

However terror, helplessness and a sense of loss of control lead **half the population** to respond with a regressive reaction, which results in automaton-like behaviour. This presents as a cool, calm, co-operative, organised and controlled style. In reality, the victim is emotionally numbed, dissociating themselves from their situation and denying its validity. This is a protective mode in which an oscillating process begins which alternates between the state of numb shock and the emotional arousal which occurs as realisation begins to overpower the self and over-ride the attempts to deny the terror experienced and to make sense of their predicament. This is the unconscious coping mechanism of this group of people and may result in healing so long as symmetry and balance in the oscillations can be maintained. However, it is frequently the case that, after days or weeks, the emotional arousal eventually breaks through the detached state and the distressed and agitated behaviour of the 'expressed' group can be observed some time after the event (Karl, 1989). This may be why birth questionnaires completed in the immediate aftermath of the event may be of little validity, particularly those enquiring about the quality of care or the birth experience itself.

Long Term Effects.

If untreated, PTSD is associated with increased physical morbidity, subsequent psychiatric illness, accidental and non-accidental death (DSM IV, APA 1994). It is generally accepted that chronic stress is related to physical problems such as ischaemic heart disease, asthma, arthritis, cancer and susceptibility to infection. Depression is common in sufferers and there is an increased incidence of alcohol and other substance abuse. The impact on social and occupational functioning may be considerable; as may the breakdown of family and marital relationships.

Finally, PTSD and depression after traumatic childbirth may have profound implications on a woman's ability to make meaningful relationships. Her impaired ability to make affectional bonds with her baby (Henry, 1993) may cause the long term effects of PTSD to continue to the next generation.

Conclusion:

Far from always being a benign and normal experience, for many women childbirth is a traumatic experience which, untreated, can profoundly and negatively affect her family and her psychological health for the rest of her life.

It is important for midwives to understand the events that lead to trauma and how it impacts on the physiology of their clients so that practice can be centred around giving the woman the locus of control, rather than the professional. Until such time that it becomes policy to take lifespan history of a woman, rather than just her obstetric or gynaecological history, we shall never know what she may have experienced or endured. It is my opinion that the only way to ensure that many fewer women are traumatized by childbirth is to treat each of them as gently as if they are all survivors of previous traumatic abuse. **One in five of them are!!!**

Finally, it is important for midwives and health professionals to understand and monitor their own responses to traumatic events in the workplace. Elevated stress levels are a common cause of 'burn-out' and high rates of 'sick leave' which may be alleviated by understanding, being able to talk the event through with a non-judgemental listener, followed by sympathetic debriefing.

REFERENCES

- American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, (4th ed). Washington, DC: Author.APA
- American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders, (3rd ed). Washington, DC:Author.APA
- Bill C-127. Communication and Public Affairs, (1983) Ottawa. Canada Canadian Dept. of Justice
- Bremner J., Randall P., Scott T., Bronen R., Seibyl J., Southwick S., Delaney R., McCarthy G., Charney D., & Innis R (1995) MRI based measures of hippocampal volume in patients with PTSD. American Journal of Psychiatry. 152, 973-981.
- Brett E., Ostroff R. (1985) Imagery and PTSD: An overview. American Journal of Psychiatry. 142(4). 417-424
- Coleman, D.(1992). Wounds that never heal. Psychology Today. Jan./Feb.62-67.
- Creedy D., Shochet I., & Horsfall J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. Birth 27 (2), 104-111.
- Crompton, J. (1996). Post-traumatic stress disorder and childbirth. British Journal of Midwifery.4, 6,290-293
- Healy D. (1993) Images of Trauma. Faber and Faber. London
- Henry, J., Haviland, M., Cummings, M., Anderson, D., Nelson, J., Macmurray, J., Mcghee, W., & Hubbard, R. (1992). Shared neuroendocrine patterns of post-traumatic stress disorder and alexithymia. Psychosomatic Medicine 54, 407-415.
- Henry J. (1993). Psychological and physiological responses to stress: The right hemisphere and the hypothalamo-pituitary-adrenal axis: An inquiry into problems of human bonding. Integrative Physiological and Behavioural Sciences, October-December,(28), 4, 369-387
- Horowitz, M. (1976). Stress response syndromes. Jason Aronson. New York. cited in Brett & Ostroff (1985) op cit.
- Jenkins R. (1995). The Law and The Midwife. Blackwell Science. Oxford
- Karl, G. (1989) Psychic trauma. Journal of Psychosocial Nursing and Mental Health Services.27 (4) 15-19

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

Mihill C. (1994, February 4th) TV ghost story left two boys with PTSD. The Guardian. Page 4

Moscarello R (1990) Psychological management of victims of assault. Canadian Journal of Psychiatry. Vol 35 (1),25-30

Selye H (1956) The stress of life. New York. McGraw-Hill

Stutman, R.& Bliss E. (1985). Post-traumatic stress disorder, hypnotizability and imagery. American Journal of Psychiatry 142, (6), 741-743.

Turnbull G. (1994) Post Traumatic Stress Disorder. Seminar given for Emergency Services. Ticehurst House Hospital. Ticehurst. East Sussex. England

van der Kolk, B., Mcfarlane A., & Weisaeth, L. (1998) Traumatic Stress. New York. Guildford Press

Watson C., Juba M., Manifold V., Kucala T. & Anderson P. (1991) The PTSD Interview: Rationale, Description, Reliability and concurrent Validity of a DSM-111-Based Technique. Journal of Clinical Psychology 47, (2). 179-188

Williams, S., Weir, L., & Waldmann, C. (1994). Post-traumatic stress disorder in the ICU setting. Care of the Critically Ill.10, (2), 77-79.

Yehuda, R., Kahana, B., Binder-byrnes, K., Southwick, S., Mason, J., & Giller E. (1995). Low urinary cortisol excretion in Holocaust survivors with PTSD. American Journal of Psychiatry, 152, 982-986.

Zeitlin, B., McNally, R., & Cassidy K. (1993). Alexithymia in victims of sexual assault: An effect of repeated traumatisation? American Journal of Psychiatry. 150,(4,)661-663.

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