ARTICLES ABOUT POST PARTUM PTSD

This selection of relevant articles may help with your understanding of PP PTSD and also highlight the value of debriefing following childbirth.

Compiled by Dr N George

"Post-Traumatic Stress Disorder And Childbirth", Crompton, Judy, British Journal Of Midwifery, June 1996; vol 4, no 6, 290-294.

In this article, the author reviews previous literature on PTSD and childbirth and provides some of her own insights and advice for midwives caring for women with PTSD.

Childbirth can be a primary trigger of PTSD.

It can also re-traumatise survivors of previous trauma.

Issues of sexuality surrounding childbirth may trigger "flashbacks" of previous events.

Trauma of human origin has more psychologically severe effects than natural human disasters.

Trust, respect, and the locus of control being with the woman may protect her against PTSD.

Why does PTSD happen?
One theory is that a return to "normal" will only be achieved when the traumatic experience is integrated into the sufferer's personal theory of reality. Humans engage in endless reiteration whereby trauma is reviewed and analysed (intrusive recollective ideation) until "the puzzle of life" makes sense.

Symptoms:
The three main groups are:

Reliving the trauma - flashbacks, intrusive memories, nightmares.
Avoiding reminders of the trauma.
Hyperarousal - irritability, poor sleep etc.

Definition of Childbirth as a trauma:
In 1980, the American Psychiatric Association stated that to qualify for PTSD, the trauma had to have been outside the range of usual human experience (DSMIII). Since many women give birth, this discounted the possibility that birth could cause PTSD. The definition was altered in 1994, (DSMIV) to include any event that caused fear for the life or bodily integrity of the person or a loved one. Which means we can now be recognised as PTSD sufferers and so receive appropriate treatment.

Secondary wounding: For women who come to childbirth with a previous history of trauma, further pain, helplessness and perceptions of loss of control can be secondary agents in the etiology of PTSD. There is a cumulative effect as unresolved traumas are layered upon each other.

"Post Traumatic Stress Disorder And Childbirth: 2"; Crompton, Judy, British Journal Of Midwifery, July 1996, Vol 4, no.7: 354-373.

This article discusses women previously traumatised eg, by sexual abuse.

Symptoms of previous trauma: to look out for: Obvious signs of injury. Need for complete control. Very detailed birth plan or insistence on home birth. Failure to keep antenatal appointments. Needle phobia. Extreme agitation.

And during labour look for the following:
Extreme fear or lack of trust. Knowing that they cannot escape physically, some women escape psychologically be dissociating. Some repress memories of previous trauma and cannot understand their own responses to labour: other have flashbacks. Flashbacks cause some women to be extremely emotional, screaming and crying when the midwife can see no reason for this. Others may revert to absolute silence.

Some women exhibit an intense modesty)to the point of vaginissmus), others show no apparent concern for their loss of personal privacy. Some express mistrust of their body or speak of it as a separate entity.

Helping to empower women:
Give the client control - it is her body and her baby.
Value and treat her with the utmost respect.
Always ask permission to touch her.

If a vaginal examination is necessary and the woman gives permission, tell her that you will stop the moment she asks you to (or signals you, eg by squeezing your hand. During labour, if you feel she is dissociating, keep her focussed in the present with eye contact and gentle reassurance. Never forget what suffering she may have endured.

"Can Midwives Reduce Postpartum Psychological Morbidity? A Randomised Trial", **Lavender, Tina and Walkinshaw, Stephen, Birth, 25:4, Dec 1998: 215-219.**

Background: Women who are traumatised after childbirth, find that listening, support, counselling, understanding, and explanation are the most useful treatments. However, little evidence is available from randomised trials of the relative efficacy of these treatments as a positive postnatal intervention. The study purpose was to examine if postnatal "debriefing" by midwives can reduce psychological morbidity after childbirth.
Method: A randomised trial was conducted in a regional teaching hospital in north-west England. 120 postnatal primigravidas were allocated randomly so that half received the debriefing intervention and half did not. Only women whose births had been relatively normal were included in the study. Excluded were women with caesarean, third-degree perineal tear, manual removal of placenta, baby admitted to special care unit, and women requiring high dependency care.

Debriefing was carried out by a research midwife (T Lavender) on the second postnatal day. The research midwife had no formal training in counselling. The women spent as much times as they felt they needed discussing their labour, asking questions, and exploring their feelings. The hospital notes were available throughout the interview. Women were encouraged to speak freely about their experience and to discuss its positive and negative aspects, knowing that their comments would remain anonymous.

The main outcome measure was the Hospital Anxiety and Depression (HAD) scale administered by postal questionnaire 3 weeks after delivery. The proportion of women in each group with scores significant for anxiety and depression were compared.

Results: The women chose to take between **30 and 120 mins to debrief.** Three weeks later, women who had not had the chance to debrief were **13.5 times as likely to be suffering from anxiety and 8.5 times as likely to be depressed**, as their counterparts who had debriefed. These results were highly statistically significant. **More than half** the women who had not debriefed were anxious or depressed, compared with 7% and 8% of those who had debriefed.

Conclusion: The support, counselling, understanding, and explanation given to women by midwives in the post natal period provided benefits to psychological well being. Maternity units have a responsibility to develop a service that offers all women the option of attending a session to discuss their labour.
To me this seems like an epidemic of postnatal anxiety and depression! It can be prevented so easily by the very low-tech approach of giving women the opportunity to talk. Also, it seems that those of us with full-blown PTSD are at the extreme end of a continuum of women with varying degrees of anxiety and depression due to a birth experience that they have not had the chance to come to terms with. -NG

"Born Under Stress", **Ralph, Karen and Alexander, Jo; Nursing Times, March 23, Vol 90, No12, 1994, 28-30.**

This is a review article: the two women authors argue for recognising that PTSD can occur due to birth. Writing in 1994, they were still working with the DSMIIIR definition of PTSD, which requires a traumatic event "outside the range of usual human experience, and one that would be markedly distressing to almost anyone. They are therefore in the position of having to argue that labour is not usual to women experience it, being a momentous event by any standards. They cite several anecdotal descriptions from other authors of a PTSD type reaction to birth in small numbers of women.

They suggest the use of a Critical Incident Stress Debriefing type of intervention for all women following birth. CISD has been devised by psychologists for use with small groups following a traumatic experience. CISD is used 24-48 hours after the trauma as an initial defusing of the situation. Clients who appear particularly quiet or stressed during the session are spoken to individually later and receive professional counselling if needed. They suggest that midwives be trained to use CISD in a one - two day workshop. They included a details of CISD.

"A Post Delivery Stress Clinic", **Allot, Helen, Changing Childbirth Update, Feb 1998, Issue 11, p14.**

The Royal Berkshire Hospital has a Post Delivery Stress Clinic, attended by 300 women in the 4 years it has been in operation by the time of writing. Women can self-refer.

There is no time limit and women presented whose stressful birth had occurred up to eleven years previously. Hospital notes were brought to the session. Stress was due to pain, delay, staff related problems, true obstetric emergencies, and post natal problems. 10% of the women attending had true PTSD and were referred on to psychologists. Many of the women were torn between the desire for another baby and the absolute conviction that they could not risk exposing themselves to further trauma. These women were offered management plans for further deliveries with a view to minimising trauma.

SUMMARY OF ARTICLES ON PP PTSD, FEBRUARY 2001

"Childbirth and the Development of Acute Trauma Symptoms: Incidence and contributing factors." Debra Creedy, Ian Shochet and Jan Horsfall. BIRTH 27; 2 June 2000; 104-111

These Australian researchers felt that they could improve on previous PTSD research. A Swedish study using a mailed questionnaire had revealed that 1.7% of all Swedish births resulted in PTSD; however, the Australian researchers felt many PTSD sufferers might not respond to a mailed questionnaire. They also wanted to work out exactly what it was about the birth that contributed to PTSD.

Five hundred women were recruited from hospital antenatal clinics, then phoned by a telephone interviewer 4-6 weeks after their birth, to explore the medical and midwifery management of the birth, perceptions of care during labour and birth, and the presence of trauma symptoms. (Women were not asked if they had a previous history of trauma). It has been shown that telephone interviews have a higher response rate and greater accuracy of information than mailed questionnaires. It was important to get as high a response rate as possible, due to the avoidance behaviour that typifies PTSD sufferers. The researcher was not part of the health care system and had not been present at the woman's birth. A proportion of the women's retrospective self-reports were compared with their medical records and a high degree of accuracy was found in the women's perceptions of what had taken place.

RESULTS:

Incidence of PTSD: 5.6% of women met the DSM-IV diagnostic criteria for acute PTSD. One in three (33%) of women reported a stressful birthing event and had three or more trauma symptoms (you need 6 to qualify for true PTSD).

Contributing factors: The level of obstetric intervention, and the perception of poor care during birth, were consistently associated with the development of acute trauma symptoms.

Obstetric intervention: Emergency cesarean section, forceps delivery (and to a lesser extent vacuum extraction), a medical complication for the baby ("I thought the baby was dead"; "I can still see the baby looking limp and blue"), and poor pain relief after delivery for those that needed it (cesarean, episiotomy, perineal pain), all strongly correlated with PTSD.

Perception of poor care: The perception that staff were lacking in some professional or technical skills was associated with trauma symptoms. The emotional dimension of care (in this study) was not statistically significant in relation to trauma symptoms.

Lack of partner support:: Women who perceived their partner (or support person) to be disappointed or not wanting to talk about the birth were more likely report acute trauma symptoms. (Secondary traumatic stress disorder can occur to partners seeing their spouse in distress. The authors were concerned about the effect of birth trauma on male partners.)

"Not Quite PTSD": The authors are concerned about women who are suffering from some trauma symptoms but insufficient for full-blown PTSD. Re-experiencing the birth, intrusive memories, continual avoidance and attempts to keep strong negative feelings at bay, impair a woman's ability to talk about and process the trauma, leading to social isolation and hampering access to appropriate health services and support.

Implications: Changes suggested: 1) A continued review to reduce the use of invasive obstetric procedures; 2) Realistic preparation of women for labour and birth, including information on the incidence of interventions and their risks and benefits; and 3) Ongoing postpartum emotional support for all women, because of the often delayed onset of PTSD.

"Maternity staff should provide opportunities for the new mother to discuss the birth experience. As the woman begins to understand the sequence of events during labour and birth and make sense of her feelings, the trauma symptoms may diminish and she may be better able to focus on caring for herself and her baby".

So, where is the funding and commitment coming from to make these changes when 1) Obstetricians love interventions and will use them on 100% of women in order to improve the outcome of 1% or less of births, partly to avoid litigation 2) First-time mothers at antenatal classes often either take the attitude "it won't happen to me" or become very anxious when told of possible nasties like prolonged labour, forceps etc., it is difficult for them to be realistic. And it is such a fine balance for childbirth educators to be realistic themselves, but at the same time instil confidence and an expectation that most births are quite normal and your body is designed to handle it. 3) Those responsible for allocating the health dollar will feel it is unrealistic to have to provide open-ended "emotional support for all women" for however long it takes to get over their birth. – A really good study, I thought, but they could have been a bit more specific in their recommendations. We need to come up with recommendations suitable for New Zealand..

“Reducing Maternal Depression in Women Following Operative Birth: A Randomised Controlled Trial of Midwife-led Debriefing.” Small, R etc.; (Editor only had access to Author’s summary.)

These authors (Australian) set out to test whether debriefing works. They took 1041 women who had had a cesarean, forceps or vacuum extraction. The women were given a debriefing session, run by a research midwife, during their hospital stay.

At 6 months postpartum the women were sent a postal questionnaire which included the Edinburgh PND scale, and a scale that measures physical, mental & social health status but nothing that specifically asked about trauma symptoms! The authors were pleased that they got an 88% response rate. Most of the women said that the debriefing had been helpful. There was no significant difference in emotional health between the debriefed & undebriefed mothers, although there was a trend toward depression in the mothers who HAD been debriefed, which did not reach statistical significance.

They not ask about symptoms of PTSD and, the Creedy study above points out the problems with postal questionnaires with PTSD: the most traumatised women were almost certainly those who did not respond.–NG.

“Stress Debriefing After Childbirth: Maternal Outcomes.” Hagan,R et al. PSANZ, 23/3/1999. (Again Ed only had access to the abstract.)

ANOTHER Australian randomised controlled trial “to test if a single structured debriefing session reduces the prevalence of postnatal disorders during the first year following a term or near term delivery”. A trained research midwife conducted a structured stress debriefing interview with 1745 mothers within 96 hours of delivery. Again they only used questionnaires, but they posted them after delivery and at 2,6,and 12 months. Again they only used standard scales for depression, and a General Health Questionnaire, but did NOT ask about PTSD symptoms.
There was no effect of the stress debriefing interview on depression.

My criticisms are the same as for the R. Small study above – NG.

“Confusing Debriefing and Defusing Postnatally: The Need for Clarity of Terms, Purpose and Values.” Jo Alexander, Midwifery (1998) 14, 122-124.

Jo describes DEFUSING as unstructured talking by the mother with active sympathetic listening, giving newly postnatal women time and space to talk about their labour and birth.

She describes DEBRIEFING as a more structured intervention (as described by Dyregov, 1989) in which the mother is asked to describe not only what happened but how she felt about it and what impression it had on her senses. Discussing sensory impressions is thought to be important as these can become triggers for intrusive thoughts.

It has been observed that if the midwife is expected to just sit and talk with the new mother, the midwife tends to use the opportunity to accomplish clerical tasks, she has primary control of the topics discussed and when the interview ends, and at times she forcefully asserts the normality of what happened without acknowledging the client’s uncertainty or distress. *(Many of us have had this kind of interaction with health professionals while suffering from PTSD.)*

Jo describes a Randomised Controlled Trial that showed that a single debriefing after road traffic accidents was NOT helpful to the victims’ mental health 4 months later and a pilot study on debriefing women who had had a miscarriage, which also showed no difference in “emotional adaptation” at 16 weeks, though the women said it had been helpful and complained that the psychologist who debriefed them could not answer their questions about miscarriage. *This, I think, illustrates two requirements of debriefing: to talk about what happened and how you felt, and to get real facts that contribute to your understanding – to help you fit the event into “the puzzle of life” –NG.*

She describes another study of 199 mothers of babies in the Special Care Unit: half were given 6 sessions of Cognitive Behaviour Therapy, but this intervention did not reduce the prevalence of postnatal depression.

She also describes the 2 Australian studies I have summarised above which were in progress at the time she wrote. (*When published, both of those studies concluded that debriefing had not helped prevent depression.)*

Then she mentions 3 initiatives where midwives have publicised their availability to discuss women’s births. All said the women valued the service.

She concludes that the hard evidence for debriefing to prevent psychological morbidity is not reassuring and

that more work needs to be done, eg in hospital or at home, soon after birth or later, etc.

"Debriefing After Childbirth: A Tool for Effective risk Management." Julie Smith, Salli Mitchell. British J of Midwifery, Nov 1996, Vol 4 No 11: 581-6.

A Birth After-Thoughts type unit was set up at an Oxford maternity hospital. Not only did it serve as an avenue for women to consolidate their experiences of childbirth, but feedback from women created a quality assurance and "risk management" cycle. (It seems the risks they refer to is the risk to health professionals of litigation). Outcomes included the provision of new facilities eg an early labouring facility, in response to women's complaints and suggestions. Comments by the authors:

The changing culture of Care.

Care is becoming more woman-focused, maternity services are being made to be more accountable. The average 1990s woman gives birth only twice in a lifetime and expects to have some control in the process. Women are often distressed by a lack of autonomy. The function of the extended family in caring for women after childbirth has been passed to the maternity services. The whole construct of antenatal and postnatal care (as opposed to birth care) has remained unchanged through this period & is now being challenged.

Risk management in a rapidly-changing service.

There have been "budget-holding"-type reforms in the British national health service (NHS) which mean that the health service has to pay for the legal & financial consequences of litigation by women. This means it is to the hospital's advantage to listen to women! The structure of the Birth Afterthoughts Service (BAS) was based on a document "Risk Management in the NHS" – so, it was set up to respond to and defuse complaints and protect the hospital from litigation. *(Funnily enough, I assumed it was set up to prevent & treat PTSD!)*

A group of senior staff (called a mentorial group) was set up. This consisted of a midwife supervisor, a counsellor, obstetrician, psychiatrist, midwife educationalist, and a student midwife. The midwives on the ground who were doing the actual listening to women, could report any areas of concern to the mentorial group, which could then change the system!
Every postnatal woman was given a bookmark with the service's phone number and told of the service. GP surgeries displayed posters etc.

Narrative as a mechanism for debriefing.

Why tell your birth story? Most women feel the need to. It can be cathartic. Individual concerns can be validated & legitimized by those listening, enabling a more positive attitude toward some experiences. Some women find it hard to make sense of their experiences and tell a coherent story that accounts for their obvious distress. The service can help them to :

- seek information
- validate experiences
- express anger (or other previously unexpressed emotions)
- understand the reason for unmet expectations
- plan for future pregnancies.

The fundamental activity of the "debrief" is listening.

Present framework for Postnatal care (in the UK)

The present framework for the NHS postnatal service only allows the midwife to tend to the woman for 10 days, or in exceptional cases 28 days, postnatal. This structure needs to be changed because most women who use the Birth Afterthoughts service do so after 28 days, and other possible listeners eg GP, health visitor (Plunket-type nurse) quickly become out-of-touch with current practices in maternity hospitals. Midwives have up-to-date knowledge and have access to the hospital records, so are ideal. Consumers (*that's us!)* will be the driving force in pushing for the changes necessary to have midwives available for this service in the UK. – *and we can push to have such a service here, of course.*

There is plenty of evidence that women do develop PTSD and lesser degrees of trauma reaction from obstetric and gynaecological procedures. There was a study in 1977 (Affonso) in which 85% of postnatal women reported dreams and flashbacks of their labours. Almost all mentioned frustration and anger that they were not being allowed information which would help them understand their experiences.

Evidence to support debriefing as a risk management tool.

Forty-six women used the Oxford service in the first year (like us, not huge numbers). Time from birth to use of service 4 weeks to 45 years! Themes: Need for information; unmet expectations; failure of communication channels; lack of continuity as perceived by the woman; failure of the service to meet the needs of the individual; anxieties about the baby; outstanding health issues; complaints about the quality of service. Some women were pregnant again and wanted information urgently to prevent a repeat of the distress caused by a previous birth.

Deliveries: 42% instrumental, 35% emergency C section, 7% elective C section, 16% “normal” deliveries. ie you can’t just offer the service to women who had emergency cesarean or forceps, it has to be available to everyone.

Only one woman filled the criteria for full PTSD. Two were referred to a counselor or psychiatrist. In general, one episode of care per woman, lasting 1-2 hours, seemed enough. The service will see women at home if they choose.

This bit is important for hospitals to hear: NONE of the women who used the service have subsequently made formal complaints although around 54% had grounds for a complaint. They were satisfied they had been “heard” and that the service had teeth and could initiate changes based on what the women said.

Maybe it’s fine that our support group only sees many women once: this may be all they need, or want, at this stage.

Conclusions, the way forward:

Women must be seen as the focus of care.

- This gives us a framework to analyse and appropriately change our obstetric service.
- We need to acknowledge the cultural shifts in the traditional family unit. *(In New Zealand we have many cultures and we need to know what kind of support each one currently offers its birthing women)*
- Debriefing (the kind outlined here – unstructured talking, weeks or months after the birth) frees the woman to move on, and also provides a “quality assurance” or “risk management” tool.
- There has to be feedback via senior staff in the “mentorial” group to facilitate improvements in obstetric services.