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perspective

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Dealing with post-traumatic stress disorder following childbirth

The emotional and psychological trauma that some women may feel after childbirth can seriously affect their ability to bond with and care for their baby. Psychologists Kirstie McKenzie-McHarg and Aimee Poote outline the impact of post-traumatic stress disorder following childbirth and how this can be approached by health professionals and practitioners.

'I just can't stop thinking about the birth. Every time I look at my baby, I jump in my head to the doctor's face, telling me that my baby might die. And I'm just so furious about it, all the time. Why did that happen to me? Why can't anyone understand that I can't be a good mother when all I think about is how I nearly lost him? I know I didn't, but it doesn't feel that way, it feels like somehow I lost him anyway.'

What is PTSD in relation to the perinatal period?

Post-traumatic stress disorder (PTSD) is a mental health issue following direct or indirect exposure to, or witnessing of, actual or threatened death, serious injury or sexual violence[1] characterised by intrusive memories, avoidance of triggers, negative or anxious mood and alterations in physiological arousal.

PTSD following childbirth (PTSD FC) is qualitatively different from PTSD after other types of trauma in that birth is predictable, typically voluntary and culturally positive.[2] It may follow an objective (e.g. postpartum haemorrhage) or subjective (e.g. feelings of abandonment) trauma.[3] Only 1% of births in the UK result in infant death or 'life threatening near-miss episodes'[2] indicating that subjective understanding of the event is crucial.[4] Prevalence in partners is estimated at between 0 and 5%[5,6] and health professionals are at risk of developing Secondary Traumatic Stress.[7]

Causes and statistics

The prevalence of PTSD FC is estimated at 3.1%, rising to 15.7% in high-risk groups[8] equating to 7,000–21,000 postnatal women in the UK annually. One third of women present with sub-clinical trauma[9] and it is helpful to conceptualise trauma responses on a continuum.[2]

'My clinician told me that I used to have PTSD, but now I only have some trauma symptoms left. I found this really helpful because I like thinking that I got partly better on my own.'

Two literature reviews have found a range of risk factors for PTSD FC.[4,10] These have been categorised into four themes: perceived lack of care, poor communication, perceived unsafe care and perceived focus on outcome over experience of the mother.[4]

How can practitioners recognise PTSD?

Women with PTSD may present with anger, low mood, self-blame, suicidal ideation, isolation and dissociation.[11] PTSD FC is highly comorbid with postnatal depression (PND);[12] intrusive and distressing flashbacks, thoughts or nightmares are unique to PTSD FC. While a small number have bonding difficulties[13] including overly intrusive parenting styles or disengagement,[14] the long-term impact of this is unclear.[15] Women may delay or avoid future pregnancies, request caesarean sections to avoid vaginal delivery[16] and may avoid intimate physical relationships.[17] While research is lacking, there are clinical indications too that some women find breastfeeding is impacted upon by their traumatic experiences, either rejecting breastfeeding altogether, or striving to succeed at breastfeeding in order to compensate for the birth at which they feel they 'failed'.

What are the needs of women going through PTSD?

Women experiencing PTSD FC need early identification and appropriate onward referral. Where comorbid with PTSD FC, clinical experience shows that PND is nearly always secondary[15] and thus treating PND alone will not resolve the PTSD symptoms. Women need sympathetic understanding from health professionals, as symptoms such as flashbacks can impact significantly on functioning. Recognising that women can develop PTSD due to subjective birth experiences (e.g. feeling unsupported in labour) is critical. These PTSD

symptoms and experiences are as valid, and as disabling, as those developed following more objective causes such as significant haemorrhage.

'After the birth I told my midwife that I couldn't stop thinking about the delivery and she just laughed and said "oh that's normal." It didn't feel normal, it was like a film going over and over in my head. And then I told my health visitor and she asked me about the birth. She said to me "but you had a really normal delivery, what are you worrying about?" I think she was trying to be kind and understand, but I felt useless and dismissed. I wanted her to understand that it didn't feel normal to me, it felt scary and I felt alone. I know nothing really dramatic happened, but that doesn't make any difference to the way I feel.'

How might these needs be met by services?

Antenatally, women should be provided with realistic depictions of labour and birth. This means being honest about the different ways deliveries can evolve, including induction, caesarean sections (both planned and in labour) and instrumental deliveries. It is important that accurate figures in terms of the likelihood of these occurring are presented, and that couples are supported to understand their choices. Professionals should aim to be clear and transparent about delivery, while balancing the needs of women who may be anxious about delivery already. If women are being given open and honest information, they are more likely to be positively prepared for the realities of birth, even if their reality turns out to be not as they had hoped.

Trusting relationships in labour are crucial[3] as poor relationships can result in a lack of trust in all health professionals. Women and their partners should be supported in informed and shared decision-making processes.[18] Where birth is not proceeding as planned, professionals can support couples to understand what is happening, and why. Time can be made for this even in the midst of an emergency situation, simply by slowing down speech slightly and ensuring the woman and her partner are listening to what is being said.

Postnatally, counselling and/or debriefing should not be offered but a 'postnatal discussion' where women have the chance to ask questions[19] or birth listening services which allow women to share their experiences can be valuable[20] as is the opportunity to repeatedly describe traumatic events[21] in a supportive environment without intervention.

Health professionals are well placed to identify women with PTSD FC,[4] facilitate social support[22] and identify vulnerabilities which may be predictive of PTSD FC (previous trauma[23] and tokophobia (fear of childbirth)) providing early referral on to and liaison with perinatal mental health services. Training should be accessed if professionals lack confidence regarding onward pathways[24] as lack of training has been identified as a cause of anxiety for professionals.[25] Referral on to specialist services should be provided as appropriate in addition to information about local services for information and support.

Professionals also have a strong responsibility to ensure that they are aware of local services and are informed on relevant policies within associated services.

Signposting to specialist services – where to go for help and support

Specialist services can provide intensive and high level therapeutic input for PTSD[26] and liaise with obstetric/midwifery teams to develop birth plans.[21] The use of birth flow charts may also help reduce PTSD.[27] Referrals can be made through perinatal mental health services; where these are unavailable, referrals should be made using local systems to generic mental health services. For women who have bonding difficulties, referral to infant mental health, or Child and Adolescent Mental Health Services (CAMHS) may be appropriate. In addition, third sector services such as the Birth Trauma Association or the Association for Postnatal Illness (APNI) may be able to provide support.

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Further reading and resources

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Birth Trauma Association: **www.birthtraumaassociation.org.uk**