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CHILDBIRTH-RELATED PSYCHOLOGICAL TRAUMA

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ABSTRACT

Traumatic childbirth is an international public health problem because it is supposed that currently up to 45% of new mothers have reported such an experience. International rates of PTSD due to birth trauma range between 1.5 and 9 percent of all births.

Birth trauma is defined as an event occurring during the labour and delivery process that involves actual or threatened serious injury or death of the mother or her infant.

A traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed.

The aim of this article is to present a review of published data for childbirth trauma over various periods of time, as well as in different regions of the world. Studies were identified through a comprehensive search of PubMed, PsycInfo, ProQuest and PILOTS (Published International Literature of Traumatic Stress) over the last 20 years.

More than 8000 articles were found. In this article we present and discuss some important findings.

Keywords: posttraumatic stress disorder, traumatic stress, stress response and trauma with the terms postpartum, postnatal, childbirth, peripartum, perinatal and birth

INTRODUCTION

To give life to a baby is the most important and happiest event in a woman's life. It is a unique feminine privilege in all the living world. However, this event could be the trigger for traumatic experiences for the mother herself. These conditions have been ignored for a long time, but in contemporary medicine, they are increasingly coming into focus, especially in the field of obstetrics and public health.

In our previous related research, we found that postpartum depression in our country is minimally present in 68% of women after delivery and as mild form in 25%. This was evaluated with the Beck Depression Questionnaire. It was shown that the level of education was negatively correlated with depression scores, and younger women happened to be more susceptible to depressive reactions. It was pointed out that there is a need for early recognition, follow-up and treatment of postpartum depression. This not only mothers but also provides for better child development [1].

Traumatic childbirth is another issue during this period of a woman's life which has recently become an international public health problem because it is supposed that up to 45% of new mothers have reported such an experience. Generally, reported international rates of posttraumatic stress disorder due to birth trauma range as high as 5.9%. Trauma associated with perinatal events is often lacking in discussions of women's trauma [2].

Birth trauma is defined as "an event occurring during the labour and delivery process that involves actual or threatened serious injury or death of the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror" [3, 4].

Axioms related to birth trauma are presented by Beck [3, 4] and there are assumptions that are "held to be researchable, all things considered, and provided a context for the macro and micro analytic processes inherent in the theory". The main points in these axioms are cited as follows:

1.Traumatic birth can be considered as an extreme traumatic stressor that can lead to PTSD.

2. Posttraumatic stress symptoms are a result of traumatic childbirth and can vary in intensity and duration.

3. Traumatic childbirth can have long-term, chronic consequences.

4. Traumatic childbirth can have stinging tentacles that can lash out at obstetrical clinicians and significant others who were present at the birth.

5. Posttraumatic stress symptoms can interfere with mother–infant interaction.

6. Traumatic birth can negatively affect a mother's breastfeeding experience.

7. At the anniversary of a traumatic birth, posttraumatic stress symptoms can flair up.

8. Subsequent childbirth after a previous birth trauma is an anxiety-filled time for mothers.

9. Not all subsequent childbirths after a previous birth trauma are healing.

Both terms – birth trauma and traumatic childbirth are used as synonyms. However, most women who have experienced a traumatic birth do not develop PTSD. Published studies report rates of PTSD after childbirth as varying between 1.5 and 9 percent of all births [5–10]. The differences among study findings are partly explained by differences in study designs, assessment tools, study populations [11], usual maternity care practices and caregiver attitudes [12, 13].

We all use the word "trauma" in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person's ability to cope. There are no clear divisions between stress, trauma, and adaptation.

Psychological trauma is the unique individual experience of an event or enduring conditions, in which the individual's ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity.

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss. In other words, trauma is defined by the experience of the survivor [14].

Those who have a traumatic delivery but are not diagnosed with PTSD have fewer symptoms of the disorder or the duration of their symptoms is less than a month. These women are referred to variously as having Post-Traumatic Stress Symptoms (PTSS), Post-Traumatic Stress Effects, (PTSE), or Partial Post-Traumatic Stress Disorder (PPTSD) [15]. All these terms refer to a less severe manifestation of birth trauma, meaning they had some symptoms of PTSD, but not enough to qualify for the diagnosis.

The aim of this article is to present a review of published data for childbirth trauma over various periods of time, as well as in different regions of the world. Studies were identified through a comprehensive search of PubMed, PsycInfo, ProQuest and PILOTS (Published International Literature of Traumatic Stress) over the last 20 years. The following search terms were used: posttraumatic stress disorder, traumatic stress, stress response and trauma with the terms postpartum, postnatal, childbirth, peripartum, perinatal and birth.

More than 8000 articles are found. In the following some important findings will be discussed.

DEFINITION OF TRAUMA

The concept of trauma is generally understood as a severely disruptive experience that profoundly impacts the self's emotional organization and perception of the external world. Trauma studies first appeared in the 1990s and are based on the Freudian model of trauma, where an extreme experience challenges the limits of language and even ruptures meaning altogether. In Freud's early work, *Studies in Hysteria* (1895), he argues that traumatic hysteria develops from a repressed, earlier experience of sexual assault. The process of remembering inflicts psychological pain but also ascribes value to a previously repressed experience in the unconscious. This traumatic remembering is termed "pathogenic reminiscences" meaning the pathologic symptoms caused by the memory [16, 17].

The medicalization of trauma was first crystallized by the American Psychiatric Association's classification of Posttraumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III) published in 1980. The DSM-III classified the external stressor for PTSD as "a psychologically distressing event outside the range of usual human experience" that is accompanied by "intense fear, terror, and helplessness" and causes "significant distress in most people" DSM-III: 236–8, 248) [18].

In the DSM-5, PTSD is defined as "a trauma or stressor related disorder initiated by exposure (direct / indirect) to a traumatic event that results in intrusive thoughts, avoidance, altered cognition or mood, and hyperarousal or reactive behaviour that lasts more than a month, causes significant distress, and is not the result of substance abuse or a medical condition". Shortly, in the DSM-5, the chapter 'Trauma-and Stressor Related Disorders' cites different conditions related to stress, even birth trauma [19]. The diagnosis is based on precise criteria: at least all nine symptoms, from the aforementioned categories, lasting for at least one month:

Intrusive recollections, such as: Nightmares, flashbacks, feeling the traumatic event is recurring, intense psychological or physiological reactions when reminded of the event

Avoidance/numbing reactions, such as: Avoiding the thoughts, feelings, location, or people associated with the trauma; Avoiding situations in which it can recur, amnesia of parts of the event, diminished interest in significant activities, detachment from others, inability to feel loving feelings, sense of foreshortened future.

Hyperarousal, for example: difficulty sleeping, irritability or angry outbursts, difficulty concentrating, hyper-vigilance, an exaggerated startle response, panic attacks or symptoms

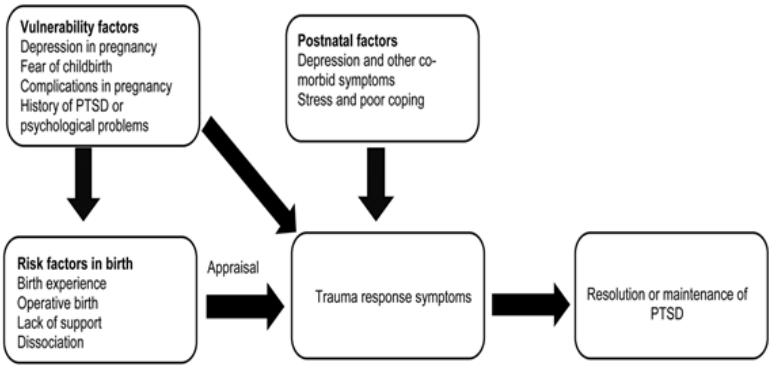
Functional impairment, such as: Significant distress in social, occupational or other areas of functioning.

The modern pluralistic model of trauma shifts the focus to the external, cultural factors that influence the meaning of a traumatic event because the recollection process in the present moment is influenced by cultural and historical contexts that impact narrative recall and create knowledge of the past. Defining the trauma's effects on identity and memory as an interplay of external and internal forces as well as individual character traits and cultural factors creates a broader appreciation for the links between the singular and collective traumatic experience. Examining the cultural context of an individual or collective group's experience of trauma enables greater attention to representations of extreme experience such as rape, war, the Holocaust, the Gulag, American slavery, colonial oppression, and racism.

Recent research suggests that childbirth may be a significant cause of PTSD in women [20, 21]. Studies have reported that prevalence rates range from 1% to 30% of postpartum women [22]. Important risk factors in community samples included current depression, labour experiences (such as interactions with medical staff), as well as a history of psychopathology. In at-risk samples, impactful risk factors included current depression and infant complications.

In 2007 Ayers [23] proposed a schema for birth related PTSD (Table 1):

Table 1. *Factors related to post-partum PTSD*



According to Ayers, the vulnerability factor of prior PTSD is likely to interact with birth events to determine appraisal of birth as traumatic and the development therefore of traumatic stress responses. Thus, prepartum PTSD symptoms may continue into the postpartum period and trigger PP-PTSD. By contrast, PP-PTSD may signify the occurrence of the onset of first-time posttraumatic stress syndrome. Having a difficult childbirth experience for some women might be extreme enough to result in PP-PTSD, even without having prior PTSD symptoms. The childbirth event would then be regarded as the index event of traumatic exposure, although other vulnerability factors are possible.

Generally, findings suggest that, by nature, women are resilient and cope well with the childbirth experience. Childbirth is not inevitably appraised as traumatic. However, the birthing parent's partner may also experience birth trauma.

There are several types of experiences that can constitute birth trauma. A physical medical emergency during or shortly before or after the birth is one possible experience as a birth trauma. Those emergencies can include induction, emergency Caesarean-section, haemorrhaging after birth, eclampsia, placental abruption, or the immediate need of a large medical team in a way that was unknown prior to labour or delivery. Birth trauma can also take the form of a lack of pain management during a Caesarean-section, the feeling that the birthing environment is not emotionally safe, or the feeling of being continually unseen or unheard in the birthing process.

The second category of birth trauma is when the baby is at medical risk, when there is a stillbirth, or when the baby passes shortly after birth. Birth trauma relating to the baby's health may also arise with preterm labour, as well as a discovery post-birth that requires intense medical intervention, the diagnosis of an unanticipated medical condition, an extended stay in the neonatal intensive care unit, or when there is an injury to the baby during labour and delivery. Additionally, a type of birth trauma could be related to remembering past traumatic events, such as sexual abuse, domestic violence, or emotional or physical distress.

In research focusing on PTSD in the postpartum period, two groups have emerged in regards to the stressor criterion. The first group includes women who identify childbirth as traumatic and subsequently develop PTSD symptoms due to this experience. Within this group, women often had unexpected interventions during labour and delivery such as emergency Caesarean sections or vacuum assisted vaginal deliveries. In other cases, women may have felt a loss of control, felt that they were not fully informed about the process of childbirth or may have experienced extreme pain and subsequently label childbirth as traumatic. Consequently, women may develop PTSD symptoms that are specifically related to childbirth.

The second group consists of postpartum women who identify previous traumatic events that are not related to the perinatal period as the cause of PTSD symptoms, events like childhood sexual abuse, rape or physical assault. Among these women, it is likely that PTSD symptoms were present before childbirth and simply continued into the postpartum period. Such a failure to consider both of these groups of the postpartum PTSD leads to imprecise estimates of PTSD prevalence and to misidentification of important

risk factors for PTSD in community and "at-risk" samples of pregnant/postpartum women.

Studies [24, 25, 26] have shown that women's subjective experiences during labour and delivery are strongly associated with the development of PTSD due to childbirth. Some complications such as hospitalization and hyperemesis during pregnancy often predict postpartum PTSD [27, 28]. Additionally, significant associations with PTSD due to childbirth include a history of psychiatric disorders both during and before pregnancy as well as an existing history of trauma [29, 30, 31]. The strongest associated factors included subjective distress in labour and obstetrical emergencies. Demographic variables, however, have been inconsistently associated with postpartum PTSD. Single relationship status [32, 33] appeared significant, but age [34, 35] appear as non-significant.

MANIFESTATIONS

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are quite normal and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Some common reactions across domains (emotional, physical, cognitive, behavioural, social, and developmental) associated with singular, multiple, and enduring traumatic events are presented in Table 2.

Table 2. *Immediate and Delayed Reactions to Trauma*
[borrow from Journal of Psychiatric Research. 2011; 45:678–686 (36)]

Immediate Emotional Reactions
Numbness and detachment
Anxiety or severe fear
Guilt (including survivor guilt)
Exhilaration as a result of surviving
Anger
Sadness
Helplessness
Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself)
Disorientation
Feeling out of control
Denial
Constriction of feelings
Feeling overwhelmed
Delayed Emotional Reactions
Irritability and/or hostility
Depression
Mood swings, instability
Anxiety (e.g., phobia, generalized anxiety)
Fear of trauma recurrence
Grief reactions
Shame
Feelings of fragility and/or vulnerability
Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions
Nausea and/or gastrointestinal distress
Sweating or shivering
Faintness
Muscle tremors or uncontrollable shaking
Elevated heartbeat, respiration, and blood pressure
Extreme fatigue or exhaustion
Greater startle responses
Depersonalization
Delayed Physical Reactions
Sleep disturbances, nightmares
Somatization (e.g., increased focus on and worry about body aches and pains)
Appetite and digestive changes
Lowered resistance to colds and infection
Persistent fatigue
Elevated cortisol levels
Hyperarousal
Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions
Difficulty concentrating
Rumination or racing thoughts (e.g., replaying the traumatic event over and over again)

Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes)
Memory problems (e.g., not being able to recall important aspects of the trauma)
Strong identification with victims

Delayed Cognitive Reactions
Intrusive memories or flashbacks
Reactivation of previous traumatic events
Self-blame
Preoccupation with event
Difficulty making decisions
Magical thinking: belief that certain behaviours, including avoidant behaviour, will protect against future trauma
Belief that feelings or memories are dangerous
Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day)
Suicidal thinking

Immediate Behavioural Reactions
Startled reaction
Restlessness
Sleep and appetite disturbances
Difficulty expressing oneself
Argumentative behaviour
Increased use of alcohol, drugs, and tobacco
Withdrawal and apathy
Avoidant behaviours

Delayed Behavioural Reactions
Avoidance of event reminders
Social relationship disturbances
Decreased activity level
Engagement in high-risk behaviours
Increased use of alcohol and drugs
Withdrawal

Immediate Existential Reactions
Intense use of prayer
Restoration of faith in the goodness of others (e.g., receiving help from others)
Loss of self-efficacy
Despair about humanity, particularly if the event was intentional
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)

Delayed Existential Reactions
Questioning (e.g., "Why me?")
Increased cynicism, disillusionment
Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Loss of purpose
Renewed faith
Hopelessness
Re-establishing priorities
Redefining meaning and importance of life
Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to re-establish a sense of safety)

However, there are some biological factors related to PTSD, including changes in limbic system functioning, changes in hypothalamic–pituitary–adrenal axis activity with variable cortisol levels and neurotransmitter-related dysregulation of arousal and endogenous opioid systems which are well-known from psychosomatic medicine.

The cognitive factors related to traumatic stress are especially important and are presented in Fig. 1

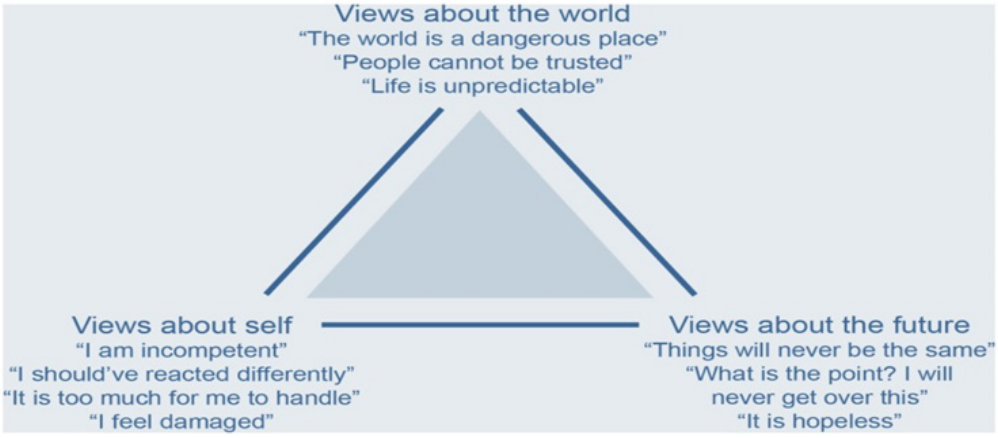


Figure 1. *Cognitive Triad of Traumatic Stress*
[Borrow from Treatment Improvement Protocol (TIP) Series, No. 57. Center for Substance Abuse Treatment (US). Rockville (MD): 2014] [37]

Birth trauma can be all-consuming and greatly affect the transition to parenthood, including making it harder to feel connected to one's own self, the baby, a partner, or the present moment.

A person who has experienced birth trauma may continually experience hypervigilance, panic, anxiety, or flooding of thoughts, re-experiencing the event in waking moments or dreams.

Living in the seismic region, association of birth trauma as "a psychologically seismic occurrence of a magnitude" is relatively suitable. The Fig.2 is borrowed from [38].

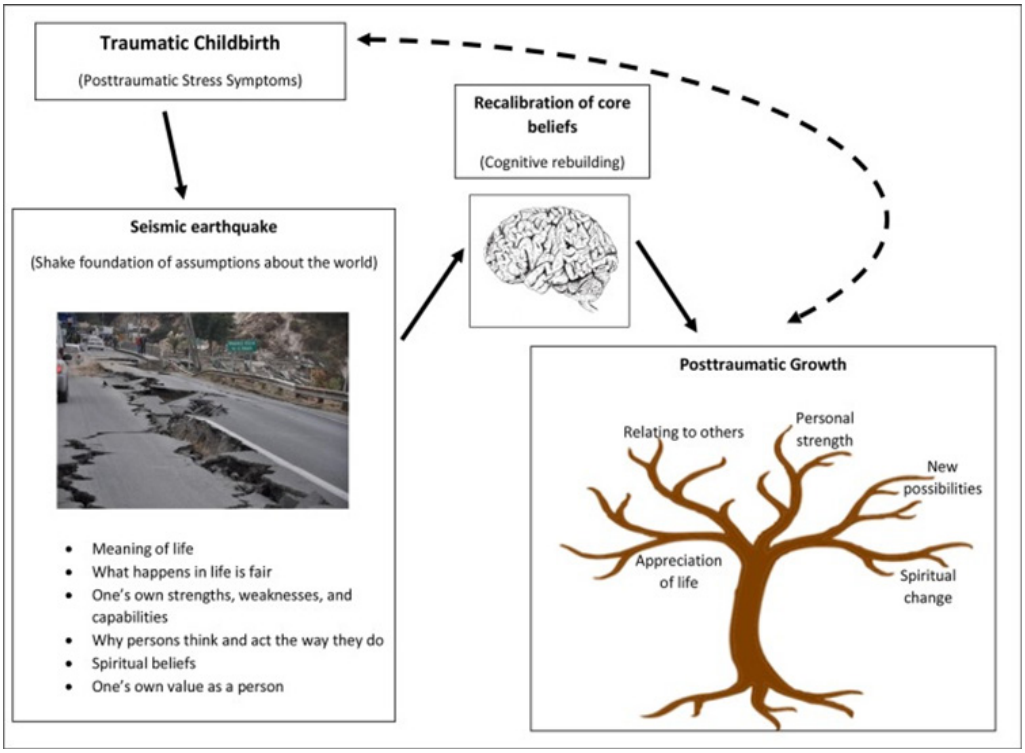


Figure 2. *Illustration of Tedeschi and Calhoun's posttraumatic growth model in traumatic childbirth*

Since trauma is a subjective experience, a traumatic birth occurs when a woman experiences an intense fear that she or her baby will die. This can include, but is not limited to:

• Births where the mother experienced significant blood loss

• Emergency caesarean, after the baby's heart rate suddenly drops

• Forceps birth

• Extreme or intense pain

• Stillbirth

• Escalated medical intervention to save the baby or mother

• Baby born with a disability as a result of traumatic birth

• Unexpected, or early, delivery of the baby

• Baby admitted into the special care baby unit or neonatal intensive care unit.

DISCUSSION

There are many different findings among studies concerned to birth trauma.

The research presented in (39) explores the experience of Chinese women with regards to psychological birth trauma. The findings provide deep insight into the women's feelings and mental needs during labour and birth. They suffer the mental torment of pain, the psychological burden of stereotypes, being neglected by family and medical staff, and fear of the unknown during birth. To reduce psychological

birth trauma and promote maternal and infant health, the researchers suggest taking measures towards pain management, thoughtful attention, adequate caring, and prenatal preparation.

The incidence of birth trauma in Taiwan was 41.16 per 1,000 vaginal deliveries. Induction of labour, premature rupture of membranes, academic degree of attendant physician at delivery, higher birth weight, and gestational age were associated with foetal injuries (40).

The evaluation of fathers who witnessed their partner's birth trauma is presented in (41).

Fathers reported that witnessing their partner's traumatic birth had a significant impact on them. They felt this affected their mental health and relationships long into the postnatal period. However, there is no nationally recognised support in place for fathers to use as a result of their experiences. The participants attributed this to being perceived as less important than women in the postnatal period, and maternity services' perceptions of the father more generally. Implications include ensuring support is available for both the mother and father following a traumatic birth, with additional staff training geared towards the father's role.

The findings from the study (42) indicated that more than half of women experienced a traumatic delivery. In addition, they found that post-partum PTSD was associated with low educational level, premature labour, inadequate prenatal care visits, having complications due to pregnancy, pregnancy intervals less than 2 years, labour duration, and emergency caesarean section.

Wen Q, Muraca et al, 2018 (43) show a temporal decline in fractures and other birth trauma among infants with spontaneous vaginal delivery over the past 10 years. Although the rates of forceps and vacuum delivery has declined over time, the rates of birth trauma following such delivery methods has remained unchanged, and they are higher when compared with all other types of delivery. The rate of severe perineal lacerations has declined over time in all types of vaginal delivery, suggesting improved obstetric care.

Women who experienced birth trauma often describe disconnection to their infants and lacking confidence in their parental decision making. Many perceived themselves as being "not good enough" as mothers. For some women, the trauma resulted either in memory gaps of the immediate post-partum period which they found distressing, or in a physical recovery which was so overwhelming that it impacted their capabilities to parent the way they had imagined they would. Some women developed health anxiety, resulting in an isolating experience of early parenthood (44).

Keeping such experiences in mind, it should be accentuated that birth-related PTSD must be recognised and treated as soon as possible. Therapy can include exposure therapies, where patients are encouraged to confront their fears; cognitive behavioural therapy. Talking therapy can help manage the issues by changing the way of thinking and behaviour. Finally, eye movement desensitization and reprocessing, which combines exposure therapy and a guided sense of eye movements is a very modern approach.

CONCLUSION

• Giving birth can be the most painful experience in a woman's life, yet the long-term effects that trauma can have on new mothers are still largely ignored.

• Regardless of the statistics, for the women who go through these experiences, there can be a long-lasting impact on their lives.

• Women who felt lack of control during labour or who have poor care and support are more at risk of developing PTSD.

• Birth trauma is not difficult to treat, but it is very difficult for women and partners to access appropriate support.

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Резиме

ПСИХОЛОШКА ТРАУМА ПОВРЗАНА СО ПОРОДУВАЊЕТО

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Травматичното породување претставува меѓународен јавноздравствен проблем, затоа што вакви искуства пријавуваат над 45 % од новите мајки. Интернационалните стапки за ПТСД како последица од породилни трауми се рангираат меѓу 1,5 и 9 проценти.

Како породилна траума се дефинира случка што настанува во текот на породилниот процес, која подразбира актуелно или заканувачко оштетување на мајката и на нејзиното дете.

Травматичниот настан или ситуација креира психолошка траума што ја надминува индивидуалната способност за справување и ја преплавува со страв од умирање, осакатување, уништување или дури предизвикува психоза.

Целта на овој напис е да се прикаже ревија публикувани податоци за породилната траума во текот на одреден временски период, како и во разни региони на светот. Студиите се најдени преку пребарување во PubMed, PsycInfo, ProQuest and PILOTS (Публицирана интернационална литература за травматичен стрес), објавени во последните 20 години.

Најдени се повеќе од 8000 трудови. Во овој напис ќе бидат прикажани и дискутирани битните наоди.

Клучни зборови: посттравматично стресно растројство, травматичен стрес, стресен одговор и траума во текот на породувањето, постнатален период, перипартум и перинатален период