

Running Head: POST-TRAUMATIC STRESS AFTER CHILDBIRTH

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Post-Traumatic Stress Disorder After Childbirth: The Aftermath

Abstract

Background: Childbirth qualifies as an extreme traumatic stressor that can result in post-traumatic stress disorder (PTSD). Reported prevalence of PTSD after childbirth ranges from 1.5% to 6%.

Objective: The aim of this phenomenological study was to describe the essence of mothers' experiences of PTSD after childbirth.

Method: The qualitative research design used was descriptive phenomenology. The main recruitment approach was over the Internet through the help of Trauma and Birth Stress (TABS), a charitable trust in New Zealand. Purposive sampling was used and resulted in 38 mothers participating from the countries of New Zealand, the U.S., Australia, and the U.K. Participants were asked to describe their experiences with PTSD after childbirth. Their stories were analyzed using Colaizzi's method of data analysis.

Results: Five themes emerged that described the essence of mothers' experiences living with PTSD due to a traumatic birth. These themes included (1) Going to the movies: Please don't make me go! (2) A shadow of myself: Too numb to try and change, (3) Seeking to have questions answered and wanting to talk, talk, talk, (4) The dangerous trio of anger, anxiety, and depression: Spiraling downward, and (5) Isolation from the world of motherhood: Dreams shattered.

Conclusion: This powerful glimpse into the devastating lives of mothers with PTSD due to childbirth provides a sobering impetus to increase research efforts in this neglected area.

Key Words: PTSD, Birth Trauma, Phenomenology

1 Post-Traumatic Stress Disorder After Childbirth: The Aftermath

2 In 1980 post-traumatic stress disorder (PTSD) was first listed in the Diagnostic
3 and Statistical Manual of Mental Disorders (DSM-III) (APA, 1980). Vietnam war
4 veterans were the initial individuals identified as suffering from PTSD. In the DSM-III
5 one of the criteria required for the diagnosis of PTSD was an event that was considered
6 beyond the range of usual human experience. The DSM-IV provided an expanded view
7 of what constituted an extreme traumatic stressor. It was broadened to include “direct
8 personal experience of an event that involves actual or threatened death or serious injury,
9 or a threat to the physical integrity of self or others” (APA, 1994, p. 424). The
10 individual’s response is one of extreme fear, helplessness, or horror. Though the DSM-
11 IV does not specifically identify childbirth as one of its examples of an extreme traumatic
12 stressor, childbirth certainly can qualify as a traumatic event (Beck, in press). Reported
13 prevalence of diagnosed PTSD after childbirth ranges from 1.5% (Ayers & Pickering,
14 2001) to 6% (Menage, 1993).

15 In the most recent review of the literature on PTSD after childbirth, Bailham and
16 Joseph (2003) identified possible features in the presentation of PTSD in mothers after
17 delivery, which included sexual avoidance, fear of childbirth, and mother-infant
18 attachment and parenting problems. Bailham and Joseph strongly cautioned that these
19 features are speculative at this stage and call for the need for further research into the
20 clinical presentation of PTSD in mothers due to traumatic births. The purpose of this
21 phenomenological study was to investigate the research question: what is the essence of
22 mothers’ experiences of PTSD following traumatic births?

23

1 *Literature Review*

2 In reviewing the literature five studies were located that investigated the
3 prevalence of diagnosed PTSD due to childbirth and another five studies were found that
4 examined PTSD symptomatology in women after delivery. Only two qualitative studies
5 have been conducted: one phenomenological study on birth trauma (Beck, in press) and
6 one grounded theory study on the process and impact of traumatic childbirth (Allen,
7 1998).

8 Wijma, Soderquist, and Wijma (1997) assessed the prevalence of PTSD after
9 childbirth in Sweden using the Traumatic Event Scale (TES). Twenty-eight out of 1,640
10 women (1.7%) met the criteria for PTSD. Compared with a group of women who were
11 not diagnosed with PTSD after childbirth, the PTSD group had significantly more
12 primiparous women ($p=.003$), a higher frequency of a psychiatric counseling history
13 ($p=.003$), and rated their contact with the delivery staff as significantly ($p=.01$) more
14 negative than the non-PTSD group.

15 In Australia Creedy, Shochet, and Horsfall (2000) reported a 5.6% prevalence of
16 PTSD due to childbirth (28 out of 499 women). Diagnosis was based on the Post
17 Traumatic Stress Symptoms Interview (PSS) (Foa, Riggs, Dancu et al., 1993) which was
18 conducted 4 to 6 weeks postpartum. A high level of obstetric intervention during
19 childbirth and the perception of inadequate labor and delivery care were significantly
20 associated with the development of acute trauma symptoms.

21 Ayers and Pickering (2001) also used the PSS (Foa et al., 1993) to measure the
22 prevalence of PTSD at 6 weeks and 6 months postpartum. Out of a sample of 218

1 mothers in the United Kingdom (U.K) 2.8% fulfilled criteria for PTSD at 6 weeks
2 postpartum and this number decreased to 1.5% at 6 months postpartum.

3 Menage (1993) reported a prevalence rate for PTSD after childbirth of 6% in the
4 U.K. The PTSD Interview (PTSD-I) of the Veterans Administration Medical Center in
5 Minnesota (Watson, Juba, Manifold, Kucala, & Anderson, 1991) was used to diagnose
6 PTSD. Thirty mothers out of 500 satisfied the DSM-III-R criteria for PTSD. The only
7 study to date conducted in the U.S. identified a prevalence rate of 1.9% (Soet, Brack, &
8 Dilorio, 2003). Out of a sample of 103, two women were diagnosed with PTSD due to
9 childbirth trauma at approximately 4 weeks postpartum.

10 In other studies post-traumatic stress symptoms were examined but a formal
11 diagnosis of PTSD was not included in the design. In Sweden, Ryding, Wijma, and
12 Wijma (1998) compared the psychological impact of emergency cesarean delivery
13 (N=71) with elective cesarean delivery (N=70), instrumental (N=89), and normal vaginal
14 delivery (N=96). Post-traumatic stress symptoms were measured using the Impact of
15 Events Scale (Horowitz, Wilner, & Alvarez, 1979) one month after delivery. Mothers
16 who had an emergency cesarean delivery reported significantly more post-traumatic
17 stress symptoms than the elective cesarean and normal spontaneous delivery mothers but
18 not when compared to the women who had instrumental vaginal deliveries.

19 Lyons (1998) also assessed post-traumatic stress symptoms one month following
20 delivery using the Impact of Events Scale (Horowitz et. al, 1979) with 42 primiparas in
21 the U.K. Higher post-traumatic stress symptoms were significantly related to the feeling
22 of not being in control during delivery, being induced, and having an epidural.

1 Post-traumatic stress symptoms have been reported at a significantly higher level
2 in mothers of high-risk infants (Callahan & Hynan, 2002; DeMier, Hynan, Harris, &
3 Manniello, 1996) than in mothers of healthy, full-term infants. Post-traumatic stress
4 symptoms in mothers of premature infants were examined by Holditch-Davis, Bartlett,
5 Blickman, and Miles (2003) using a semi-structured interview with 30 mothers at 6
6 months postpartum. The interviews were analyzed for three PTSD symptoms: re-
7 experiencing, avoidance, and increased arousal. Twenty-four of the 30 women reported
8 avoiding thinking about aspects of the birth/NICU and re-experiencing the preterm birth
9 of their infant through intrusive thoughts. Twenty-six mothers described increased
10 arousal that focused on overprotecting their infant as a type of hyper vigilance. Mothers
11 reported difficulty sleeping and generalized anxiety and also experienced persistent fears
12 that their children might die or become ill again.

13 In her grounded theory study Allen (1998) examined the processes that occurred
14 during traumatic childbirth, the mediating variables in the development of PTSD
15 symptoms and the impact on postpartum adaptation. Twenty women were interviewed
16 10 months after delivery. The Revised Impact of Event Scale (Horowitz et al., 1979) was
17 used to measure PTSD symptoms. Six mothers reported scores above the cut off point
18 indicating clinically significant levels of PTSD symptoms following childbirth. Their
19 distress included panic and tearfulness due to thoughts of the trauma, anger directed at
20 clinicians and their partners, decreased closeness in their relationships with their partners,
21 emotional detachment from the baby, less patience with their other children, and fear of
22 future pregnancy.

1 In order to “return to the things themselves”, phenomenologists strive to
2 descriptively identify what each phenomenon under study is (Husserl, 1960). One
3 assumption of descriptive phenomenology is that for any human phenomenon there are
4 essential structures that make up the experience regardless of which specific person
5 experiences that phenomenon.

6 *Sample*

7 Thirty-eight mothers representing four countries comprised the purposive sample.
8 The majority of these mothers lived in New Zealand. Demographic and obstetric
9 characteristics of the sample are located in Table 1. Mean age of the women at the time of
10 participation in the study was 33 with a range from 25 to 44 years. Out of 17 women
11 who provided their educational level, 15 had at least a college degree. Thirty-two of the
12 mothers in this sample had also participated in another phenomenological study of the
13 experience of birth trauma (Beck, in press).

14 *Procedure*

15 Approval was first obtained from the University of Connecticut’s Institutional
16 Review Board. Data collection extended over a 24-month period and occurred via the
17 Internet mainly through the invaluable help of the Chairperson of the charitable trust in
18 New Zealand called Trauma and Birth Stress (TABS). Five mothers who had
19 experienced traumatic births founded TABS with the aims of supporting women who
20 have experienced birth trauma and educating health care professionals and the lay public
21 about PTSD after childbirth. Their website is www.tabs.org.nz and their e-mail address
22 is ptsdtabs@ihug.co.nz.

1 In order to meet the two criteria necessary for inclusion in the sample, first a
2 woman had to have experienced PTSD due to birth trauma and second she had to be
3 willing to articulate her experience. Members of TABS were informed of the study
4 through a letter written by the Chairperson of the self-help organization. An
5 announcement recruiting mothers was also printed in the TABS newsletter. Women
6 interested in participating in the study contacted the researcher using her e-mail address.
7 Directions for the study and an informed consent were sent by attachment to prospective
8 participants. Women electronically signed the informed consent and returned it by
9 attachment to the researcher. Each mother was asked to describe her experience of PTSD
10 following childbirth in as much detail as she wished and could remember. Thirty-six of
11 the 38 mothers in the sample sent their PTSD stories over the Internet to the researcher as
12 attachments. Two women hand wrote their stories and sent them to the researcher by
13 regular postal mail.

14 *Data Analysis*

15 The 38 mothers' stories of their PTSD after childbirth were analyzed using
16 Colaizzi's (1978) method of phenomenological analysis. Colaizzi's method begins with
17 reading and re-reading all the participants' descriptions of their PTSD following
18 traumatic births and ends with a final description of the essence of that phenomenon. The
19 middle steps of his thematic analysis focus on extracting significant statements that
20 pertain directly to the experience of PTSD and formulating their meanings. Next the
21 formulated meanings are categorized into theme clusters and referred back to the
22 mothers' original stories. At this point in the thematic analysis the theme clusters are
23 integrated into an exhaustive description of PTSD after childbirth. Colaizzi calls

1 participants in a phenomenological study co-researchers and based on this perception his
2 method includes asking some of these co-researchers to validate the exhaustive
3 description. Preliminary findings after 12 months of data collection were validated by
4 nine mothers who had participated in the study. The researcher met with these mothers
5 while she was speaking at a conference in New Zealand. The final results were reviewed
6 over the internet by four mothers and one father. All five persons agreed with the themes
7 that had emerged from the mothers' stories.

8 *Results*

9 Analysis of the 38 stories of PTSD following childbirth revealed five themes
10 which described the essence of this haunting experience for mothers (Table 2).

11 ***Theme 1. Going to the movies: Please don't make me go!***

12 Mothers suffering from PTSD were bombarded not only during the day with
13 flashbacks reliving their traumatic births but also during the night with terrifying
14 nightmares. Women repeatedly used the image of a video on automatic replay or loop
15 tracks imprinted in their brains to describe how uncontrollable the distressing memories
16 or "movies" of their traumatic childbirths were to them.

17 A primipara who had a failed vacuum extraction followed by a forceps delivery
18 and a 4th degree tear provided an illustration of these loop tracks which left her feeling
19 like she was "*faking it*" and stuck in the past unable to enjoy the present with her infant:

20 *I lived in two worlds, the videotape of the birth and the 'real' world. The*
21 *videotape felt more real. I lived in my own bubble, not quite connecting with*
22 *anyone. I could hear and communicate, but experienced interaction with others*
23 *as a spectator. The 'videotape' ran constantly for 4 months.*

1

2 Another mother, who also had a failed vacuum extraction followed by a forceps
3 delivery, desperately want to get out of this nightmare she was starring in. As she
4 explained, *“I had nightmares of my delivery doctor as a rapist, coming knocking on my
5 door. I also believed when my son was born that the doctor had ripped his head off.
6 These two images were what affected my existence.”*

7 One woman who had been refused an epidural and had an *“agonizing forceps
8 delivery”* suffered from *“extraordinarily realistic nightmares.”* She shared that *“like
9 Lady MacBeth I became terrified of sleeping! I would go without sleep for about 72-96
10 hours .I always knew I’d have to fight the nightmares again. I was scared that this time I
11 wouldn’t have the strength to fight it, that it would succeed in destroying me.”*

12 Flashbacks and nightmares of the traumatic births not only affected mothers’
13 relationships with their children but also with their husbands. One multipara who had
14 experienced a high level of medical intervention during the delivery shared, *“after about
15 6 months my husband and I still hadn’t had sex since before the birth. When we began to
16 try I had flashbacks to the birth. At the moment of penetration I would have a flashback
17 to the instant when my body was pulled down the operating table during one of the failed
18 forceps attempts.”*

19 ***Theme 2: A shadow of myself: Too numb to try and change.***

20 Traumatized by their birth experience, mothers suffering from PTSD considered
21 themselves only a shadow of their former selves. This numbing of self, and for some
22 women actually dissociating, can began immediately after delivery. One woman who
23 had an emergency cesarean and postpartum hemorrhage vividly described that after

1 delivery she was “*put in a room with two other mothers. I had a drip, a catheter, and*
 2 *was silent. I felt completely numb. I did what was required and I felt my head was*
 3 *floating way above my body. I struggled to bring it back onto my shoulders. I still feel*
 4 *dissociated like this sometimes.*”

5 Another mother who had hemorrhaged on the delivery table recalled that she
 6 *was wheeled out to the recovery room. My parents were there as was my sister. I*
 7 *did not cry or smile. I watched them looking happy. I was completely numb and*
 8 *could not remember any emotional context to do with my delivery day. The*
 9 *midwife pointed my baby out to me in the nursery as I was wheeled by. He was so*
 10 *big. I felt no recognition. I felt nothing.*

11 Once home these feelings of numbness and detachment continued. One primipara
 12 who had a terrifying experience with an epidural shared, “*I’d wake up numb unable to*
 13 *feel a thing. I’d drag myself through the day. I am having the hardest time trying to*
 14 *overcome this feeling of being dead.*” Another woman poignantly described herself as
 15 feeling like her soul had left her and she was now only an empty shell. “*Mechanically I’d*
 16 *go through the motions of being a good mother. Inside I felt nothing. If the emotion did*
 17 *start to leak I quickly suppressed it. I’d smack myself on the hand and put my ‘robot suit’*
 18 *back on.*”

19 ***Theme 3: Seeking to have questions answered and wanting to talk, talk, talk.***

20 Mothers suffering from PTSD had an intense need to know the details of their
 21 traumatic births and to get answers to their questions. These women obsessed over trying
 22 to understand what had happened and why it had happened. This obsession took on
 23 many different forms. For some women it entailed making repeated appointments with

1 the physicians or midwives who had delivered their infants to have their questions
2 answered and to go over their hospital records. Reading obstetrical textbooks was the
3 way other women spent their free time when they were not caring for their infants

4 Revisiting the delivery room/OB theatre became necessary for some women even
5 as long as a year after birth. One multipara whose request for pain medications during
6 labor had been denied, shared *“at the first birthday of my little daughter, I had a horrible
7 recurrence of the PTSD. I insisted that the hospital let me visit the delivery room and
8 threatened them with a lawsuit if they didn’t grant my request.”*

9 Women experiencing PTSD revealed that they wanted to talk, talk, talk about
10 their traumatic births but they discovered quite quickly that health care providers and
11 family members became tired of listening. After her traumatic delivery a mother of
12 multiples revealed that *“I was so devastated at people’s lack of empathy. I told myself
13 what a bad person I was for needing to talk. I felt like the Ancient Mariner doomed to
14 forever be plucking at people’s sleeves and trying to tell them my story which they didn’t
15 want to hear.”*

16 Eventually some women stopped discussing their traumatic births which became
17 detrimental to their mental health. As one woman explained, *“I didn’t communicate with
18 anyone anymore. The room I was in became my cave. I was consumed by my birth
19 demon.”* Their unasked, unanswered questions *“gnawed away”* at them.

20 One mother of multiples who had an emergency cesarean poignantly tried to
21 express in words what happened,

22 *not only does PTSD isolate me from the outside world, it isolates me even from
23 those I love. How do I explain the sort of blind terror that overtakes me without*

1 *warning and without obvious logical cause? And what of my family and friends?*
2 *They don't know how I feel. They don't know what to say and they cannot make it*
3 *better, so they end up feeling useless. That's the real problem with PTSD. It*
4 *separates people at the time when love and understanding are most needed. It's*
5 *like an invisible wall around the sufferer.*

6 After repeated unsuccessful attempts at trying to get satisfactory answers about
7 their traumatic births or at least an apology from their health care providers and the
8 hospital, some women took their quest to a higher level. Examples of this next step
9 included taking their cause to the Health and Disability Commissioner, filing an Accident
10 Compensation claim, and submitting a formal complaint to the State Medical Board.
11 When, for instance, the State Medical Board sided with the physicians, women stated
12 they were “*re-traumatized.*” As one woman who had experienced an emergency
13 cesarean delivery painfully shared “*the emotional pain of this secondary wounding was*
14 *worse than the actual physical pain of labor.*”

15 ***Theme 4: The dangerous trio of anger, anxiety, and depression: Spiraling downward.***

16 This trio of distressing emotions permeated the daily lives of mothers suffering
17 from PTSD. Women experienced these emotions on a heightened level. Anger was rage,
18 anxiety turned into panic attacks, and depression left many suicidal. Anger was directed
19 in multiple directions. Its stinging tentacles lashed out at health care providers, family
20 members, and the self. Marital relationships were at times strained to the limit. As one
21 mother whose firstborn infant had died explained, “*to live daily with the fact that you*
22 *were like a time bomb ready to go off was dreadful. As time went on, I knew I was*
23 *personally 'too hot to handle' and not nice to be with, as invariably you could not help*

1 *but have some of your inner state ooze or jump out at those who did come close.”*

2 Another woman revealed that *“powerful seething anger would overwhelm me without*
3 *warning. To manage it I would go still and quiet, then eventually ‘come to’ realizing that*
4 *one or all of the children were crying and I had no idea for how long.”*

5 Mothers experiencing PTSD also turned their anger inward at times toward
6 themselves. A mother who had given birth to twins shared that she was so full of anger
7 at herself. *“How could I have let this happen? Why did I trust the doctors? How could I*
8 *have been so stupid?”*

9 Women were angry at the labor and delivery staff who they perceived betrayed
10 their trust and let them down. This anger was not a fleeting emotion. A mother whose
11 infant sustained a skull fracture from a vacuum extraction 3 years earlier shared that she
12 still sometimes “relives” the traumatic birth and is still really angry and mistrustful of
13 doctors.

14 Anxiety also plagued women suffering from PTSD due to birth trauma. For some
15 mothers the anxiety began on the delivery table. As a woman who had experienced
16 *“excruciating”* pain once her membranes had been artificially ruptured shared, *“I had*
17 *intense pains in my chest from the first moment after the birth that have been extremely*
18 *difficult to get rid of. They turned into anxiety.”* After her traumatic birth one primipara
19 became extremely anxious regarding intercourse causing her to have a non-intimate
20 relationship for most of the next 9 years. One mother was so anxious that she *“made*
21 *sores in my scalp and face.”* Women who had never experienced panic attacks prior to
22 their birth trauma began to be plagued by them. One mother whose infant had received

1 cuts and bruises due to a forceps delivery experienced panic attacks whenever she went to
2 a hospital or doctor's office.

3 Depression at times became severe enough to lead some mothers to contemplate
4 ending their own lives. A mother of multiples shared *that "I wanted to kill myself. My
5 life was a mess. Death seemed like a wonderful idea. I'd fight with myself while driving,
6 'put your foot on the brake, the light's red. No, don't put your foot on the brake,' and so
7 it went on."*

8 ***Theme 5: Isolation from the world of motherhood: Dreams shattered.***

9 The tightening grip of PTSD after childbirth choked off three lifelines to the
10 world of motherhood: (1) the woman's infant, (2) the supporting circle of other mothers,
11 and (3) hopes for any additional children. Concentrating first on the present, some
12 women shared that much to their dismay their PTSD distanced them from their infants.
13 As one mother who had an unplanned cesarean delivery painfully remembered, "*at night
14 I tried to connect/acknowledge in my heart that this was my son and I cried. I knew that
15 there were great layers of trauma around my heart. I wanted to feel motherhood. I
16 wanted to experience and embrace it. Why was I chained up in the vice-like grip of this
17 pain? This was my Gethsemane—my agony in the garden.*"

18 The walls that the birth trauma erected between mother and infant do not appear
19 to be temporary for some mothers. As a multipara who survived a severe postpartum
20 hemorrhage 3 years earlier painfully shared, her PTSD still holds a destructive grip on
21 her relationship with her son.

22 *My child turned 3 years old a few weeks ago. I suppose the pain was not so acute
23 this time. I actually made him a birthday cake and was grateful that I could go to*

1 *work and not think about the significance of the day. The pain was less but it was*
2 *replaced by a numbness that still worries me. I hope that as time passes I can*
3 *forge some kind of real closeness with this child. I am still unable to tell him I*
4 *love him but I can now hold him and have times when I am proud of him. I have*
5 *come a long, long way.*

6 PTSD also resulted in women isolating themselves from other mothers and
7 babies. Mothers with PTSD could not tolerate or cope being with other women who had
8 not experienced traumatic births. One mother would ask the nurse to schedule her baby's
9 well child checkups 15 minutes before the clinic opened so that she would not have to see
10 or meet other mothers.

11 To have more children or not? What a heart wrenching decision this was for
12 mothers suffering from PTSD. For some women the only choice for them was to have a
13 tubal ligation or for their husbands to have a vasectomy. The following passage
14 poignantly illustrates this: *"I couldn't envision EVER having another baby. There was*
15 *no way I could expose myself again to that degree of vulnerability and abandonment. My*
16 *little girl was the most precious thing in my life but events that occurred at her birth*
17 *mean that I will not be having anymore children. I had a tubal ligation and I grieved for*
18 *the babies I thought I wouldn't have."*

19 For other women even though they were terrified of going through another
20 childbirth, they opted to have another child. Pro-active planning and an "iron clad" birth
21 plan helped prepare the PTSD mothers for a second childbirth. Throughout her second
22 pregnancy one mother kept a diary as she struggled with her PTSD. One entry from her
23 diary vividly illustrates how vulnerable and fragile these women are as the bravely face

1 another childbirth. *“While I am trying to put my PTSD behind me, I am having to*
2 *prepare for the birth of my second child. My reality is that I am scared, heart and womb.*
3 *I need special care. My heart is fragile and I am trying to protect it.”* In her diary this
4 mother who had an emergency cesarean with her first delivery kept a list of questions she
5 was going to ask different midwives to help her choose a midwife she felt she could trust.
6 A sampling of these questions from her diary includes:

7 *Why are you a midwife? How would you describe your approach to women in*
8 *labor? What is the difference between being delivered and giving birth? What do*
9 *you do when a woman in labor starts saying “I’m scared” as you commence a*
10 *procedure?*

11 *Discussion*

12 The themes that emerged from analysis of the mothers’ gripping stories vividly
13 illustrate the characteristic symptoms of PTSD within the context of new motherhood,
14 such as flashbacks and persistent avoidance of stimuli associated with the trauma. For
15 these women the extreme traumatic stressor that triggered their PTSD was childbirth. In a
16 phenomenological study Beck (in press) identified the essential components of a
17 traumatic birth, those being, mothers’ perceptions of a lack of communication and caring
18 by labor and delivery personnel, provision of unsafe care, and the outcome of the delivery
19 overshadowing the mother’s trauma. Obviously the best intervention is to prevent birth
20 trauma in the first place so that PTSD will not develop. In addition to providing safe care,
21 the basic skills that all health care professionals are taught need to come to the forefront
22 with each and every mother: to be caring and to communicate effectively.

1 Clinicians need to play a proactive role in helping to prevent PTSD due to birth
2 trauma. Knowledge of predictors of PTSD after childbirth, such as high levels of
3 obstetric intervention, is crucial for health care providers so they can be alert to these
4 high risk women. Clinicians also need to be vigilant in symptomatic recognition during
5 the prenatal, intrapartum, and postpartum periods (Church & Scanlan, 2002). Symptoms
6 of PTSD or previous trauma that clinicians should look for during labor include: (a)
7 extreme fear and lack of trust of health care providers, (b) flashbacks which may cause
8 some women to cry or scream when a clinician can see no apparent reason for this
9 extreme emotional behavior, (c) dissociation as women psychologically escape from their
10 current labor, and (d) intense need to control their labor (Crompton, 1996; Kennedy &
11 MacDonald, 2002). The labor and delivery process can re-traumatize women who have
12 experienced previous trauma. Crompton (1996) urges clinicians to never forget what
13 suffering a woman may have already endured in her life. She believes that the only
14 approach that will ensure that fewer mothers are traumatized during childbirth is for
15 clinicians to treat all women gently as if they had all been survivors of previous trauma
16 (Crompton, 2003).

17 For women who perceive their delivery experiences have been traumatic,
18 debriefing sessions may be helpful in reducing trauma symptoms (Allen, 1998; Gamble,
19 Creedy, Webster & Moyle, 2002). Support and trauma counseling are essential for
20 diminishing the impact of traumatic childbirth. Crompton (2003) suggests that access to
21 a support group, such as TABS, composed of other women who have had birth trauma
22 and PTSD due to childbirth is of primary importance.

1 The theme of isolation from the world of motherhood powerfully alerts clinicians
2 to the specific effects of PTSD when the traumatic event is childbirth. Not only can
3 PTSD have devastating effects on the mother but also on her developing relationship with
4 her child. In only a handful of prior studies on PTSD after childbirth has mother-infant
5 attachment problems been addressed (Allen, 1998; Ballard, Stanley, & Brockington,
6 1995; Reynolds, 1997; Weaver, 1997). For some mothers their infants were reminders of
7 their traumatic births and in keeping with one of the characteristics of PTSD, the women
8 avoided any stimuli associated with the trauma. Further complicating these fragile
9 mother-infant dyads was numbness the women experienced. Functioning as only a
10 shadow of their former selves took a heavy toll on the attachment some mothers felt with
11 their infants.

12 Suggestions for future research can include, for example, a grounded theory study
13 to discover the basic problem women have to contend with in PTSD after childbirth and
14 the process they use to resolve or cope with this central problem. This powerful glimpse
15 rendered by the five themes into the devastating lives of mothers with PTSD due to birth
16 trauma provides a sobering impetus to increase research efforts in this neglected area.

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Table 1

Five Essential Themes of PTSD After Childbirth




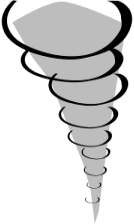

Theme #	Theme
1	Going to the movies: Please don't make me go!
	
2	A shadow of myself: Too numb to try and change
	
3	Seeking to have questions answered and wanting to talk, talk, talk
	
4	The dangerous trio of anger, anxiety, and depression: Spiraling downward
	
5	Isolation from the world of motherhood: Dreams shattered
	

Table 2

Demographic and Obstetric Characteristics of the Sample (N=38)

Characteristic	N	%
Country		
New Zealand	22	58
United States	7	18
Australia	6	16
United Kingdom	3	8
Marital Status		
Married	34	90
Single	2	5
Divorced	2	5
Education (N=17)		
Graduate	6	35
College	8	47
Partial college	2	12
High School	1	6
Parity		
Primipara	12	32
Multipara	26	68
Delivery		
Vaginal	21	55
C/S	17	45
Induction		
Yes	16	42
No	22	58