Traumatic Birth: Impact on Mothers and Bonding

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Plan for today:
- Who are you?
- Who am I?

- Describe context for case presentations (WBH)
- Define traumatic delivery: Focus on live births
- Risk Factors for P-PTSD and related PMADS
- Impact on maternal mental health
- Impact on infant bonding and attachment
- Focus on complex assessment (not much definitive research on best practice Tx for P-PTSD specifically but will touch on that)
- Discussion / Q & A
• Why I wanted to give this talk:

• The value thoughtful, empathic assessment: embracing complexity

• Frequency of subsyndromal Sx

• Intervention can be far reaching: maternal mental health and bonding

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**Traumatic Delivery Definition for Today**

*It's subjective*

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“If a woman says her birth was traumatic, the health care professionals caring for her should believe her.

Jane Vesel, Bonnie Nickasch

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• Expectations

• Perception of events

• Meaning attached to events

• Examples of maternal complications both during L & D and immediately PP

• Examples of neonatal complications / events connected to delivery

Context for case examples
• Department of Women’s Behavioral Health, Women and Infants Hospital, Providence, RI

• Description:
  • Outpatient
  • Consultation Liaison
  • Day hospital program
Case example 1

- EMILY

Case example 2

- VERONICA

Birth Statistics

- 2014
- US: 3,988,076
- California: 502,879
- Rhode Island: 10,823
- Women and Infants: Around 8,400 (~77%)
Prevalence of Perinatal Loss

- Although Perinatal loss is not the focus of this talk, previous perinatal losses may impact a mother’s experience of current delivery

- United States 650,000 women/ year

- WIH 2011-2014
  - Under 20 weeks gestation 456/year
  - 20 + weeks gestation: 55/ year

What we assess for, in relation to trauma in the perinatal period:

- 1. Current Safety
- 2. PTSD
- 3. Subsyndromal PTSD
- 4. Acute Stress Reaction
- 5. Dynamic Issues related to trauma history, including attachment and parenting issues

- We often see trauma reactive symptoms return or surface for the first time, in the perinatal period

Prevalence of Birth Related Trauma reactive symptoms

- Three reports: N=89, N=264, and a meta-analysis of 31 studies (Western European and Israeli Demographic)

- 2-6 % of women suffer full blown PTSD Sx in all major clusters:
  - Intrusive Symptoms (flashbacks, int. memories, nightmare, flooding, dissociation)
  - Avoidance
  - Negative Alterations in Cognition / mood (Changes expectations, < trust, detachment from others, persistent fear, guilt, shame, ANGER)
  - Hypervigilance

Subsyndromal Symptoms

Two studies found 24-26% suffered sub-syndromal PTSD Symptoms


Risk Factors for Birth Related Trauma Reactive Sx

- Meta analysis of 50 studies: N=21429
- Subjective distress associated with delivery regardless of delivery mode
- Having an operative birth (C/S, AVD)
- Mismatch bt preferred and eventual delivery mode
- Depression in pregnancy
- Fear of childbirth
- Poor health / complications in pregnancy
- Hx PTSD
- Counseling for pregnancy or birth
- Lack of support
- Anticipation of pain and fear in childbirth


More associated risk factors for P-PTSD

- Avoidant attachment style
- Traumatic previous childbirth with subsequent depression and anxiety
- Medical and mental crises reported during pregnancy
- Gynecologic interventions ongoing c/c. higher numbers (explain only same occurrences) also performances b/c. data is misleading
- Discomfort with undressed state (Israeli study)
- Infant complications
- Low support during L & D
- Fast delivery
- Previous depression (especially early in pregnancy) and trait anxiety
- Re sexual abuse / assault—reaction to helplessness
- Feeling out of control during L & D

25.6% of the mothers of Extremely low birth weight babies (24-27 weeks preemies) had the potential to suffer from PTSD following birth of the child

Worse with developmental or health difficulties associated with early birth


C/S vs SVD

Expectations study (Norway) N=1700
- High levels of fear about L & D pain and preferred C/S but delivered vaginally developed more PTSD symptoms than other groups

Israeli Study (N=89) found instrumental or C/S deliveries were NOT independently associated with PTSD risk

Sexual abuse Hx as risk: #’s are high
- 1995 National Telephone & Postal Surveys: 1 in 3 women report some type of sexual victimization in childhood
- US department of Health and Human Services Children’s Bureau reports 9.2% of children are sexually assaulted (2010)
- Other studies suggest 1 in 5 girls and 1 in 20 boys are victims
- Children are most vulnerable ages 7-13
General Resiliency

- **Individual** (i.e., cognitive ability, self-efficacy, self-regulation, coping strategies, spirituality, internal locus of control)
  - Attend to psychological distress in pregnancy and prior
- **Family** (strong natural supports)
- **Community characteristics** (spiritual, community resources)
- ID and manage expectations about delivery early on

Embracing complexity in Assessment and Tx

Example

- ALMA
Impact on Maternal Mental Health-Comorbidity

- Depression is more common than birth related PTSD
- Depression and PTSD have a high overlap in general: one study says around 44.5% (one month post trauma) and 43.2% (3 months post trauma)
- (N=908) Trait anxiety and anxiety or depression in pregnancy as well as severe fear of childbirth predisposes to both birth related PTSD and PP depression
- We can catch these early


Complicated Tx

- PTSD Sx may complicate Tx of other PMAD symptoms
  - Ex) Nightmares may further disturb sleep
  - Afraid to sleep—aversive to meds
  - Fear of flooding may prevent women from seeking tx
  - Negative experience / lack of trust in medical system may as well
  - Interaction with expectations can contribute to / maintain depressive sx and interfere with attachment

- These complicating Sx can emerge due to complications immediately postpartum as well
- Depression can be trauma reactive
- Case Example CC-interaction with expectations
Very early delivery
- Feeling they did not participate in delivery
- Helpless and out of control
- Baby may have been removed, sometimes for a full day post-op
- Guilt and anger
- Hospital care may focus on the baby and not the mother
- Magical means: not talking about babies progress for fear of reversing progress or of own feelings (becoming cut off)


Birth related trauma and attachment
- Adult attachment style:
- Attachment style impacts both expectations of support and ability to regulate emotions
- Avoidant attachment may be a risk factor for developing P-PTSD, especially in operative births (study flawed-white, older, primiparous, middle class women only)


Birth related trauma and attachment
- Attachment is impacted by:
- Mother’s attachment style
- Mothers may be more prone to develop either avoidant or anxious attachment with baby

Avoidant response

- Mother’s mental health and dynamic issues:
  - A note on Dissociation
  - Fatigue due to decreased sleep (nightmares, physical pain)
  - Avoidance of baby or trouble connecting due to traumatic birth
  - Trouble connecting due to depression associated with traumatic birth
  - Case of Anya: avoiding the NICU “to make up time with older kids. Too hard to leave NICU”
  - Can also imagine it being hard to go to the hospital to see baby
  - Afraid of hurting baby
  - Lack of self-confidence as a mother “I failed at birth”

Anxious response

- Feelings of helplessness and vulnerability

- Case of Carrie:
  - Intrusive fear of harm coming to baby with O/C type response that is clearly impacted by traumatic preterm delivery
  - Filling entire freezer with pumped milk
  - Obsessing about baby’s sleep—setting alarm to check on baby
  - Not allowing baby to attach to others healthfully

Nursing

- Two studies:
  - Both PTSD and pp depression are associated with abandonment of breastfeeding in the 2nd month postpartum (N=117) and before the fourth month postpartum (N=542)

- Stress can inhibit let down

Notes on Treatment

• Very little research to date that is specific to P-PTSD
• Some support for:
  • Trauma-focused CBT (TFCBT) (Very little research)
  • EMDR (Very little research)
• Light therapy (mostly for depression, which so often accompanies P-PTSD)
• Alleviate insomnia to increase efficacy of all tx
• Give permission and encourage grieving of previous traumatic deliveries in subsequent pregnancies
• Partner involvement