

Traumatic Birth: Impact on Mothers and Bonding

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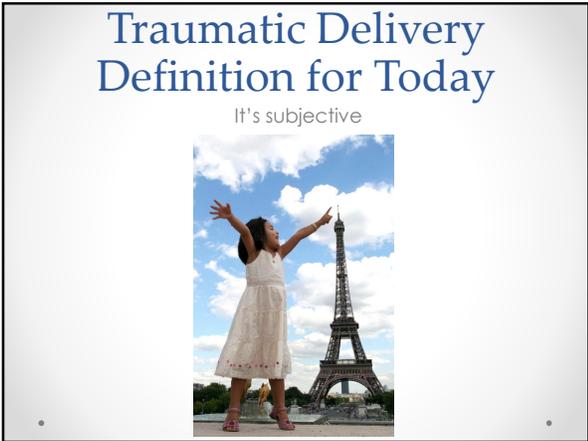
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- Who are you?
- Who am I?

Plan for today:

- 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 discuss strategies)
- Discussion / Q & A

- Why I wanted to give this talk:
- The value thoughtful, empathic assessment : **embracing complexity**
- Frequency of subsyndromal Sx
- What is pathology, really? The importance of understanding and validation in assessment.
- Intervention can be far reaching: maternal mental health and bonding



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

Jane Vesel, Bonnie Nickasch

Vesel and Nickasch (2016). An evidence Review and Model for Prevention and Treatment of Postpartum Stress Disorder. Nursing for Women's Health . 19 (6). 506-525.

- Expectations
- Perception of events
- **Meaning** attached to events:
 - Case example: *Emily*

Emily

- Presents with mild depressive and anxious Sx
- No PTSD Sx
- 5 day induction at 37 weeks d/t HTN
- Resulted in unplanned and unwanted C/S
- "The hospital was awesome. The doctors let me make all the decisions but I needed a C/S anyway."

- Complications can arise both during L & D and immediately PP
- Examples...

Context for case examples

- Department of Women's Behavioral Health, Women and Infants Hospital, Providence, RI
- Description:
 - Outpatient
 - Consultation Liason
 - Day hospital program

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
- Neonatal death (2007-2009) 65/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**
- Andersen, L.B., Melvaer, L.B., Videbeck, P., Lamont, R., Joergensen, J.S. Risk factors for developing post-traumatic stress disorder following childbirth: a systemic review.

Subsyndromal Symptoms

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

What are these?

How do we talk with mom's about these symptoms in relation to accessing appropriate treatment?

Czarnocka J, Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*.

Polachek, I.S., Harari, L.H., Baum, M., Strous, RD. Postpartum post-traumatic stress disorder symptoms: the uninvited birth companion. *Israeli Medical Association Journal*.

Assessment

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
- Counselling for pregnancy or birth
- Lack of support
- Anticipation of pain and fear in childbirth

Ayers, S., Bond, R., Bertullius, S., Wijma, K. (2014) The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. Psychological Medicine 44(6) 1121-1134.

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
- Obstetrical emergencies—emergency c/s higher numbers (explain only some occurrences)—also perceiving L & D care as inadequate
- Discomfort with undressed state (Israel study)
- Infant complications
- Low support during L & D
- First delivery
- Previous depression (especially early in pregnancy) and trait anxiety
- Hx sexual abuse / assault—relation to helplessness
- Feeling out of control during L & D

Ayers, S., Jesso, D., Pike, A., Parfitt, Y., Ford, E. (2014) The role of adult attachment style, birth intervention and support in posttraumatic stress after childbirth: A prospective study. Journal of Affective Disorders; 155: 295-298

Mothers of premature babies

- 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

• Zerach, G., Elsayag, A., Shefer, S., Gabis, L. (2015) Long-Term Maternal Stress and Post-traumatic Stress Symptoms Related to Developmental Outcome of Extremely Premature Infants. *Stress and Health, 31* (3) 204-213

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
- Use magical means: not talking about babies progress for fear of reversing progress or of own feelings (becoming cut off)

• Baum, N., Weidberg, Z., Osher, Y., Koheliet, D., (2012), No longer pregnant not yet a mother: Giving birth prematurely to a very-low-birth-weight baby. *Qualitative Health Research* 22(5) 595-606.

C/S vs SVD

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

Sexual abuse Hx as risk: #'s are high

- o 1995 National Telephone & Postal Surveys: 1 in 3 women report some type of sexual victimization in childhood
- o US department of Health and Human Services Childrens' Bureau reports 9.2% of children are sexually assaulted (2010)
- o Other studies suggest 1 in 5 girls and 1 in 20 boys are victims
- o Children are most vulnerable ages 7-13

Paula

- When the birth itself isn't traumatic but becoming a mother is
- We need to always consider the actual assessment as potentially retraumatizing
- How to do that?

General Resiliency

- **Individual** (i.e., cognitive ability, self-efficacy, self-regulation, coping strategies, spirituality, internal locus of control)
 - o Attend to psychological distress in pregnancy and prior
- **Family** (strong natural supports or even minimal but strong natural supports)
- **Community characteristics** (spiritual, community resources)
- ID and manage **expectations** about delivery/PP early on
 - o Example: History of OCD with termination ...how to manage?

Embracing complexity in Assessment and Tx



IT'S
COMPLICATED

Case example 2

- VERONICA
- Cultural factors

Veronica

- Liberian immigrant, G3P3 with no psych history
- EPDS 26/30; GAD-7: 18/21
- Onset of Sx with delivery and worsening
- Primary complaint "it's all because of the delivery"
- Veronica's story....
 - Intrusive memories
 - Frequent waking; checking baby all night d/t fear of harm coming to baby
 - Post c/s baby had increased mucous-pervasive fear of choking
 - Low appetite and concentration
 - Fear of another delivery but wants two more children
 - Unrelenting rumination and self criticism: "I should have made them remove the pitocin instead of agreeing to the C/S."

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

Soderquist J., Wijma, B.,Thorbert, G.,Wijma, K. (2009) Risk factors in pregnancy for post-traumatic stress and depression after childbirth. BJOG. 116: 672-680.

Complicated Tx

- PTSD Sx may complicate Tx of other PMAD symptoms
 - Ex) Nightmare 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
 - HOW DO WE ADDRESS THESE?

- These complicating Sx can emerge due to events immediately postpartum as well
- Depression can be trauma reactive
- Case Example KC-interaction with expectations....also a good example of the potential impact of trait anxiety

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)

Ayers, S., Joseph, D., Pike, A., Porfirio, Y., Ford, E. (2014) The role of adult attachment style, birth intervention and support in posttraumatic stress after childbirth: A prospective study. *Journal of affective disorders*, 152, 292-298

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

Ayers, S., Eagle, A., Waring, H. (2006) The effects of child-birth related traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health and Medicine*, 11(4) 389-398.

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
 - avoiding the NICU-too triggering or to make up time with older kids. Too hard to leave NICU"
 - Afraid of hurting baby
 - Lack of self confidence as a mother "I failed at birth"

Anya

- 28 y/o partnered G7P3: 3 miscarriages, one 21 week loss followed by the death of that daughter's father 2 months later in a car accident
- Subsequent Depression/anxiety, responded to Lexapro 20 mg and no therapy
- Improved with meeting new partner (F/O 3 sons)

- Onset Sx with unplanned pregnancy of baby Charlie, wchi she discovered on the anniversary o her daughter's death
- Worsening with traumatic delivery at 28 weeks gestation.
- Bled out resulting in emergency hysterectomy and 6 week inpatient stay
- Baby in NICU ongoing

- Full range of neurovegetative Sx
- Ruminative worry
- Anxiety with panic Sx multiple times per day
- Nightmares and flashbacks "I wake up thinking I'm still in the hospital"
- "I space out all day", "I don't hear what people are saying"
- Avoids NICU "I need to make up time with the older kids after being in the hospital and it's too hard to leave the NICU"
- Intrusive fear of FOB dying in a car accident
- Can't do DHP....What did we do?

Anxious response

- Feelings of helplessness and vulnerability
- Case of KC:
 - -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

Kristen

- Depressive and OCD Sx are related to trauma...no classic PTSD Sx
- 34 y/o MWF, Nurse
- Baseline OC personality
- No psych Hx
- 32 week premature delivery, 11 day antenatal inpt stay and 18 day NICU stay with delayed discharge after choking event
- DENIES ALL TRAUMA REACTIVE SX AND THAT THE EVENT WAS TRAUMATIC TO HER IN ANY WAY

- Intrusive scary thoughts of dead babies
- Severe depression, passive SI
- Compulsive pumping
- No one else can care for or feed baby
- Setting alarm clock to check baby throughout the night
- Feels "weak" and "out of control" of her emotions

How do we address the complexity?

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
- Lindau et al. (2014) Determinants of exclusive breastfeeding cessation: identifying an "at risk population" for special support. *European Journal of Pediatrics*, 174: 533-540.
- Machado et al. (2014) Determinants of the exclusive breastfeeding abandonment: psychosocial factors. *Rev Saude Publica*, 48 (4) 985-994.

Notes on Treatment

- Very little research to date that is specific to P-PTSD
- Some support for:
- Trauma-focused CBT (TF-CBT) (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
- Vessel and Hirsch (2014). An evidence Review and Model for Prevention and Treatment of Postpartum Stress Disorder. *Nursing for Women's Health*, 18 (3), 50-55.

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