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TRAUMATIC CHILDBIRTH

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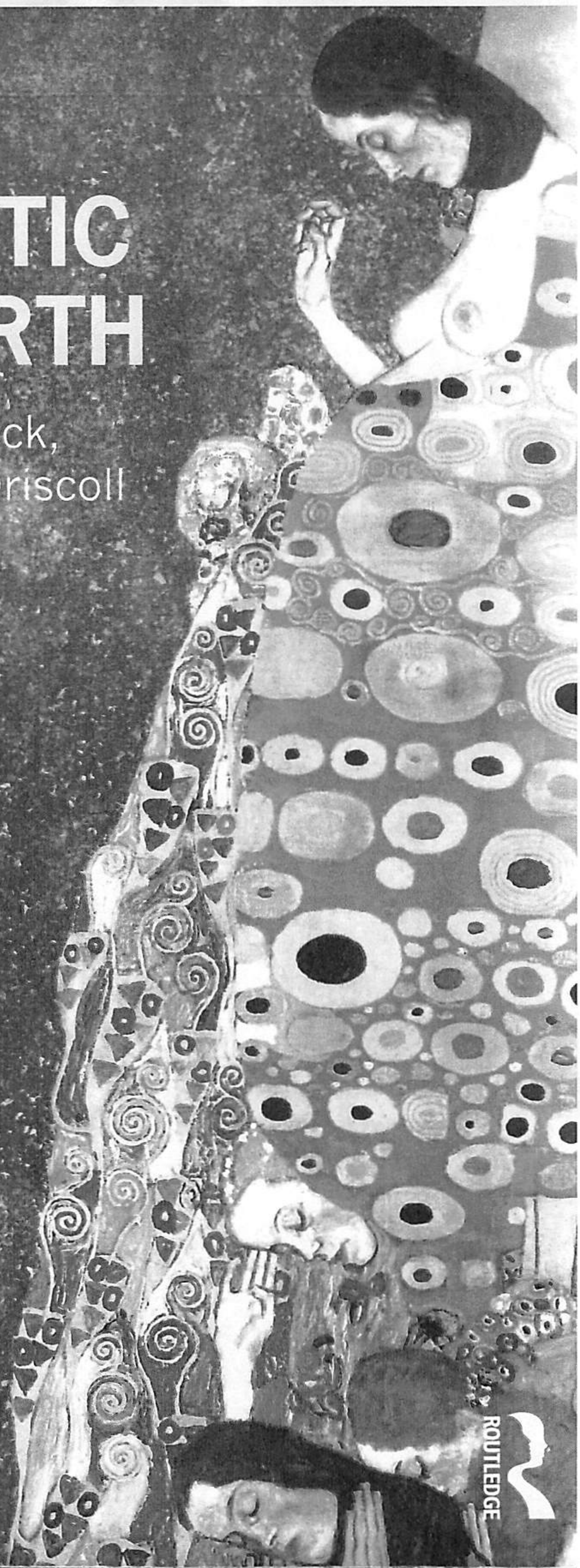

during these emergency cesarean births. These women also reported a lack of postpartum follow-up, fatigue after childbirth, and inadequate support from their husbands as influencing factors for their posttraumatic stress symptoms.

In the Netherlands, Stramrood, Paarlberg et al. (2011) examined the prevalence of PTSD following childbirth in homelike versus hospital settings. Within 2 to 6 months after birth, 428 women completed the Traumatic Event Scale-B (Wijma et al., 1997). In this sample of Dutch women, 1.2% was determined to have PTSD due to childbirth and 9.1% experienced their childbirth as traumatic. No differences in PTSD were reported after controlling for complications and interventions. Unplanned cesarean births, poor coping skills, and severe labor pain were associated with higher levels of posttraumatic stress symptoms.

Preeclampsia/HELLP

Van Pampus et al. (2004) brought attention to women who can develop PTSD after pregnancies complicated by either severe preeclampsia or HELLP syndrome. Preeclampsia is a syndrome women can experience after the 20th week of pregnancy. It consists of increased blood pressure and protein in their urine. HELLP syndrome is a type of preeclampsia. H stands for hemolysis (breakdown of red blood cells). EL stands for elevated liver enzyme and LP for low platelet count. In the Netherlands Stramrood, Wessel et al. (2011) reported a prevalence rate for PTSD of 11% in women who had preeclampsia.

Pregnancy Loss

Two studies were located in which the focus was PTSD in women following pregnancy loss. In the Netherlands, Engelhard, van den Hout, and Arntz (2001) conducted a study of PTSD after pregnancy loss. At 1 month and 4 months after their pregnancy loss women completed the Posttraumatic Symptom Scale-Self-Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). At one month after miscarriage 25% of the women met the criteria for PTSD diagnosis and at 4 months 4% of the sample. Women who met the criteria for PTSD had an increased risk of depression. An example of the intrusive recollections women had of their pregnancy loss is illustrated by the following quote from a mother who had a stillbirth in her 32nd week:

> At the moment of birth, I saw Sara's head come out of me. I held her, and she was red, her skin was torn. One of her eyes was open. I looked to see if it was a girl. Her belly was dark-red. She had beautiful ears. A very white nose. Blood was running from her nose. Her legs looked broken.
>
> (Engelhard et al., 2001, p. 65)

In Germany, the long-term posttraumatic stress response 2–7 years after termination of pregnancy due to fetal malformation was examined (Kerstin

et al., 2004). The Impact of Event Scale-Revised (IES-R) (Horowitz et al., 1979) was used to assess posttraumatic stress symptoms and compare levels among the 83 women who had terminated their pregnancy 2–7 years earlier, 60 women who had experienced a termination of pregnancy 14 days earlier, and 65 women who had a spontaneous birth of a healthy infant. Women at 14 days and 2–7 years post termination had similar levels of elevated posttraumatic stress symptoms. The mothers who had delivered healthy newborns reported a significantly lower level of posttraumatic stress symptoms than the two groups of women who had a termination of pregnancy.

Spontaneous abortion has been described as one of the worst traumatic events in a woman's lifetime (Hamama, Rauch, Sperlich, Defever, & Seng, 2010). Women exposed to uncaring clinicians during their miscarriage are at an even higher risk of developing PTSD. Often women experience miscarriage at home and often get little care from clinicians, depending on weeks of gestation, so this variable is a high risk factor that needs to be included in the history/assessment aspects of the initial interview.

Preterm Birth

Seven studies were located in which posttraumatic stress symptoms were investigated in mothers of infants in the NICU (Neonatal Intensive Care Unit). The majority of these studies focused on preterm infants. Findings from all these studies confirmed that mothers of infants in the NICU had significantly higher levels of posttraumatic symptoms than mothers whose infants were not in the NICU.

The first study examining PTSD in mothers of high risk infants was conducted by DeMier, Hynan, Harris, and Manniello (1996). The sample consisted of 142 mothers who were primarily white, middle-class women. The sample was divided into three categories: mothers of premature infants, mothers of full-term infants in the NICU, and mothers of healthy full-term infants. Women completed the Perinatal PTSD Questionnaire via a mailed questionnaire. Women whose infants were premature and those whose term infants were in the NICU reported significantly more posttraumatic stress symptoms than mothers of healthy, full-term infants. Data analysis revealed that the severity of postnatal infant complications, gestational age, and length of NICU stay explained 35% of the variability in posttraumatic stress symptom scores in the sample.

Parental posttraumatic stress reactions to a premature birth were investigated in Switzerland using two groups: 55 parents of a preterm infant and 25 parents of a full-term infant (Pierrehumbert, Nicole, Muller-Nix, Forcada-Guex, & Ansermet, 2003). When the children were 18 months old, parents completed the Perinatal PTSD Questionnaire (PPQ: Quinnell & Hynan, 1999). Parents of premature infants had significantly higher posttraumatic stress scores than parents of full-term infants. Parents of preterm infants were subdivided into low and high risk groups depending on the severity of the perinatal stress. Using the

cutoff of six or more positive responses on the PPQ, 4% of mothers in the low risk group compared to 26% of mothers in the high risk group met the DSM criteria for PTSD reactions.

Thirty mothers of preterm infants were interviewed when their infants were 6 months old (Holditch-Davis, Bartlett, Blickman, & Miles, 2003). The data from the interviews were analyzed for the three major symptom clusters of PTSD: re-experiencing, avoidance, and hyperarousal. All 30 mothers reported at least one posttraumatic stress symptom. Twelve mothers had two symptoms and 16 had all three symptoms. Avoidance and re-experiencing were each described by 24 women while 26 women reported hyperarousal symptoms.

Kersting et al. (2004) were the first to conduct a longitudinal study of posttraumatic stress in mothers of very low birth weight (VLBW) infants who weigh less than 1500 grams. Fifty women of VLBW infants and 30 women of healthy term infants completed the Impact of Event Scale (IES-R; Horowitz et al., 1979) at four points in time: 1–3 days after birth, 14 days postpartum, 6 months and 14 months postpartum. At all four points in time, mothers of VLBW infants experienced significantly higher levels of posttraumatic stress symptoms than mothers of full-term, healthy infants.

In France, 21 mothers of preterm infants underwent a semistructured interview given by a psychologist at 2 months and again at 1 year after birth (Garel, Dardennes, & Blondel, 2006). Eight women (38%) reported the preterm birth had been a traumatic event. They experienced posttraumatic stress symptoms such as avoidance and re-experiencing the traumatic births.

Acute posttraumatic stress symptoms within the first week postpartum were compared in 59 mothers of infants in the NICU and 60 mothers of infants in the well baby nursery (Vanderbilt, Bushley, Young, & Frank, 2009). Women completed the Perinatal PTSD Questionnaire (PPQ) (Quinnell & Hynan, 1999). Women whose infants were in the NICU reported significantly more acute posttraumatic stress symptoms than mothers of infants in the well baby nursery. Using the screening criteria on the PPQ for risk of PTSD, 24% of NICU infants' mothers compared to 3% of well baby nursery infants' mothers met the criteria. When statistically removing the effects for depressive symptoms and prior lifetime history of traumatic events, having an infant in the NICU was significantly associated with mothers' posttraumatic stress symptoms scores.

At 30 days or more post admission to the NICU, parents completed the PTSD Symptom Checklist (PCL; Weathers & Ford, 1996) (Lefkowitz, Baxt, & Evans, 2010). Nine mothers (15%) and two fathers (8%) met criteria for a diagnosis of PTSD with an additional 11.7% (n = 7) of the mothers and 4% (n = 1) of the fathers with subsyndromal PTSD.

Most recently, posttraumatic stress symptoms in mothers of late preterm infants have been studied. Late preterm infants are infants born between 34 and 36 completed weeks of gestation. Using the PPQ (DeMier et al., 1996), Brandon et al. (2011) reported that mothers of late preterm infants had significantly higher levels of posttraumatic stress symptoms than mothers of full term infants.

Conclusion

As evidenced by the studies presented in this chapter, researchers have identified numerous risk factors of women perceiving their labor and delivery as traumatic. Research is needed, however, that investigates the diagnosis of PTSD and not just the severity of posttraumatic stress symptoms. Research is also needed into the etiology of why some women, and not others, develop PTSD secondary to traumatic childbirth. Treatment methodologies also need to be researched to determine the most effective strategies for new mothers suffering with PTSD due to birth trauma.

In order to add mothers' voices to the risk factors for PTSD discussed in this chapter, Chapter 5 highlights mothers' narratives of the following risk factors: increased medical intervention, pain, helplessness, postpartum hemorrhage, preeclampsia, perinatal loss, preterm birth, and childhood sexual abuse.

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Clinician's Reaction

The "silver lining" was PTSD versus HELLP? Again, we are hearing the story from the woman's perspective but again the health care providers are the enemy. They were not emotionally responsive, in this woman's mind and in fact she felt judged by them as she sang country songs during the closing of the cesarean incision as they discussed the bleeding situation secondary to the magnesium sulfate. Again I am struck with the individuality of experiences and how we each see things through our own eyes, perceptions, and embedded realities. We know that health care professionals suffer from compassion fatigue, burnout, as well as vicarious traumatization (see Chapter 17), but what do we do for them? Perhaps if more attention was paid to the mental health of the care providers, we would find less of this rupture in the caring relationship. I don't know but as the trends of increased diagnosis of PTSD secondary to birth trauma increase, we need to look at strategies to change the dynamic.

Mother's Reaction

Simple acts of compassion and listening to her would have made all the difference to this complication in Anne's pregnancy and birth. Careful compassionate listening and acceptance of what she says would help her. Childbirth often takes turns that obstetric staff do not expect, but they must still pay attention to what mothers tell them. Mothers know themselves, even in the midst of trauma. Any effort to preserve the mothering relationship between Anne and her newborn would have turned this situation around. Proceed gently with counseling; you are strong.

Perinatal Loss/Uncaring Labor and Delivery Staff (Marie's Story)

Thirteen years ago Marie became the mother of triplets named Michael, Paul, and Ellen. Here is Marie's heart-wrenching story in her own words of her devastating multiple losses of her beloved children.

> At 21 plus weeks I had premature labor, and Michael was born and died. Only hours later, my CBC came back. I had gone into labor because I had maternal sepsis with a white count of 28, high bands and a bad shift to the left. I was told by the doctor that they would be delivering the remaining triplets and a hysterectomy was planned for me in the morning. I remember every detail in excruciating, agonizing, and astonishing clarity. I desperately needed a nurse. I was terrified, in shock, in severe emotional distress, had some physical pain and felt tremendous guilt. In that moment, I did not believe I would survive the deaths of all my babies. The grief of it would surely kill me and if the grief didn't, I would surely finish the job. I was oozing ache. The profound depth of my despair, I could never have

imagined. Not one nurse spoke to me, not one. They abandoned me to labor alone and left me without care of any kind, only coming in and tweaking up the pitocin and then literally running from the room. Twice, alone except for my husband, I delivered something or someone in the bed. I was terrified and screamed to my husband, "Is it a baby?" "It's red and bloody," my husband said. "Is it moving? Any arms or legs?" I asked. "I don't know," my husband said with panic, "I'll get the nurse." The nurse seemed irritated at having to come in the room at all. "It's only the placenta from the first abortion," she carelessly said. "I didn't have an abortion. I had a baby, his name was Michael." I told her. Michael had lived for over an hour gasping and blue but was alive all the same. She removed his placenta and literally ran from the room. Many things about this hospitalization were horrendous and traumatizing and a case study in how not to do things and I could have healed from everything else that happened and gone on and even the deaths of my beloved, wanted children. But what happened when I delivered my precious beloved Ellen has impacted my life in as profound a way I could not have imagined. I have re-run the trauma of it many thousands of times in astonishing detail and the memory of it is burned on my brain and it will stay with me forever.

When it was time to deliver Ellen, I had the tap water at the bedside to baptize her as no chaplain was available, after all, premature babies this age don't last long and I wanted to be prepared. Right after she was born, I calmly requested, "Please, give me my baby." There were three people with "RN" engraved on their nametag in the room but they did not move or speak or acknowledge my request. There was deafening silence in the room. I repeated it several more times in a calm, polite, controlled and rational manner. No one moved, no one spoke, no one even looked in my direction. Instead, the "nurse" put my sweet baby girl, Ellen, on a cold metal counter next to the sink to die like she was discarding a piece of garbage. Then, over the course of the next 11 minutes I repeatedly and with increased escalation screamed for her at the top of my lungs over and over and over again and no one handed Ellen to me. I sobbed and begged and reached out yet no one responded. They stood like deer in the headlights, immobile, like statues, doing nothing but standing there when they could be handing my baby to me. "She'll die!" I screamed, "Give her to me!!!" I could see her. I raised up on my elbows and rough, uncaring hands pushed me down into the bed saying "You're busy!" "I'm not too busy to hold my baby! She'll die! Ellen, Ellen, Ellen!!!!" My baby was dying unbaptized, gasping and blue and cold on a hard metal surface and I only had moments or minutes to be her mother to comfort and to hold her and to love her and talk to her while she died and the "nurses" absolutely refused to hand her to me. Was she in pain? Did it hurt to die? She needed her mother! I could not get up because I was delivering another baby, Paul, or I surely would have bolted from the bed. I was beyond desperate for her. There was nothing in this world I had ever wanted more or will ever want

more. I was spiraling into a hopeless, cold black hole so deep, I knew I would never climb out and I knew it was something that I would never be able to recover from. If I could have dissociated and jumped out of my body to go to her, I would have. After 11 agonizing minutes, the doctor said, "Give her the baby!" But it was already too late, Ellen was dead, cold and alone. She died on a cold hard metal counter top, in pain, and without the warmth and love of her mother. The other babies lived for over an hour but Ellen's death was expedited by the "nurses." Also, she was unbaptized, maybe regulated to limbo or hell according to my parents' religious beliefs. The doctor then handed Paul, who was still alive and kicking to me and I did baptize him in time. Michael and Paul, two babies in heaven, poor Ellen in hell/limbo.

Decent human behavior? Not on the "nurses" radar. How would I explain to my own parents the gross lack of parenting I displayed when I was unable to baptize my own baby in time? Maybe the truth was that I had not fought hard enough, screamed loud enough, although I could not imagine what else I could have done. I had only 11 minutes to be a mother while Ellen was alive and those "nurses" cruelly and intentionally denied me that. I've forgiven them, but cannot forget and they continue to remain monsters to me.

Clinician's Reaction

Oh, how I hope that this story is never repeated. What a sad commentary on death and dying in the obstetrical arena. True, most of the time the experience of birthing is warm, happy, and exhausting but there are untoward events that occur during the "normal process" and as health care providers we need to be prepared and ready for those events when they do occur. Marie so clearly describes what the experience felt like for her, she can forgive but cannot forget. There is a basic reality, and it is the golden rule, "do unto others." What happened during Marie's experience? Where were the human care and concern from the staff as she was birthing her babies and watching them die, her hopes and dreams shattered? All the plans she had imagined during her pregnancy, her role as a mother, watching her children grow, all ended that day and she did not feel as though anyone helped her.

In so many ways we are a death-denying culture; we tend to isolate and ignore issues pertaining to unhappy endings. Is it because "there but for the grace of God go I"? What is wrong with speaking from the heart and caring for Marie and women like her as we would want someone to care for us? Again, much needs to be done to support the staff in the obstetrical divisions when it comes to untoward endings. How does the system provide emotional support to them? The purpose of this book is to increase awareness on the part of health care providers and health systems. These women's stories are real and powerful, take this opportunity to meditate upon what you as a health professional need to do for yourself to help you integrate the sad experiences that you encounter

in your clinical life and vow to take care of yourself: emotionally, physically, and spiritually. That self-care will allow you to be there for your patients in their hours of need.

Mother's Reaction

Marie's story is familiar in many ways, and she is not alone. Good support would be empathic, and let Marie lead the way. Support would not lead to judgment of or challenge to Marie's reaction. If she has not already done so, she would find a listening ear with one of the many baby loss support groups. She and her husband need to keep talking and to use every ounce of strength, resolve, and determination to regain their former selves, and perhaps "feed back" to the institution where this occurred. They must be strong.

Preterm Birth/NICU (Christine's Story)

The following is one mother's story of her traumatic experience of her preterm infant's birth and stay in the NICU. This mom had participated in Beck's (2004a; 2004b) earlier studies on birth trauma and its resulting PTSD.

Christine started her story with the telling fact that it had been eight years since her traumatic birth experience. It took her that length of time to be able to manage writing her story about her preterm birth. In Christine's own words:

> I was pregnant with my first baby and I planned to have a home birth. When I was seven months pregnant, I started to bleed and I was rushed to the hospital at around 7am. The first doctor said I would be having a cesarean that morning. Forms were given to me to sign. Drips and monitoring devices were set up. I insisted that they at least try to find out what was going on and as long as there was no fetal distress, we would wait and see. A thorough ultrasound showed nothing amiss. The blood loss had slowed but hospital staff insisted that I was in labor so I reluctantly signed forms which basically said they could do whatever they thought was necessary to my premature baby. If I didn't sign, they said they would not be able to care for him.
>
> When they were putting on a fetal scalp monitor clip, I passed a massive blood clot. I had three blood transfusions and I possibly had a near-death experience. I felt like I was floating above my body and I saw everyone running around me. Throughout the day there were staff changes, different people coming in to check on me and on the baby, etc. Luckily for me, other women came to the hospital who needed emergency cesareans so I just waited. The original doctor went off and I had a new doctor that evening who decided my baby should be born now. I was taken to a delivery room. I had an epidural and syntocinon (a variation of pitocin). I was fully dilated and the doctor said I had 20 minutes to deliver the baby myself then

he left. I had two great midwives helping me delivery. One of them said to me: "Push this baby out or he will come back" and she made a scissors sign with her fingers. My baby was delivered by the midwives. Then the doctor came back in and said, "Oh, it's out." I held my baby for about 2 seconds then he was taken away and my trauma began.

My trauma is not so much about the birth as it is about the next 25 days when my baby was in the neonatal intensive care unit. I cried for 25 days. The staff couldn't work out why I was so upset all the time. I had a tiny baby, stuck in an incubator. I couldn't hold him. I couldn't breastfeed him. And they wondered why I was so upset! I stayed in the maternity ward for two nights then I was sent home—with no baby.

At home, I felt so far away from my baby. I had lots of support. My husband was fantastic. My mother came to stay and do all the housework, meals, and everyday stuff. I saw a lactation consultant. The midwives were great and kept coming to see me. But I was so devastated that I couldn't have my baby. I felt so robbed and so useless and so helpless. I couldn't stop crying. The NICU staff sent me to see a chaplain who asked me—was my marriage OK? Did I have financial problems? How did I think all the other mothers of premature babies were coping? They weren't crying all the time. What was wrong with me? Did I believe in God? This barrage of questions was unhelpful and, in my opinion, unnecessary and even irrelevant. I was sent off for a blood test. They decided I must have been anemic. I wasn't. Even the person who did the blood test asked me a question and when I said "I don't know," she replied: "We don't know much, do we?" I was severely traumatized and medical staff were being rude to me.

All this time I was expressing breast milk to feed my baby by nasogastric tube. I bought my own breast pump attachments so I had them to use whenever I wanted to. The hospital ones were not always available. One day someone stole my attachments which was devastating to me. Little things like that, I just couldn't handle. Finally after 25 agonizing days, after several overnight stints, and after rooming in for the last few nights, I was able to take my baby home. At that time I didn't realize the effect that this experience had had on me. I thought I was OK. I thought once I got home, everything would be perfect. Looking back now I realize a lot of my coping mechanisms were shattered and my perspective was radically altered. This led to an extremely tumultuous year. I finally got referred to a mental health specialist and was diagnosed with PTSD. I cannot emphasize enough how important it is to have support from helpful people after a traumatic experience. I found out the hard way that not getting that support can have devastating consequences.

Clinician's Reaction

Christine's story is very common in that mothers who birth premature babies often experience postpartum depression in addition to some having PTSD. The

striking thing with Christine's story is again, how clear her memory was of an event that had occurred more than eight years before she wrote her narrative for Cheryl's study. The memories are clear and the feelings are like it had happened yesterday. What an impact the NICU experience had on Christine! Her crying was a symptom that had meaning but rather than try to find the meaning, her behavior was judged and devalued. She was told that none of the other NICU moms were crying all the time. I wonder how many of those mothers were crying but no one was really asking them how they felt either. Christine had just delivered a premature baby. She began her journey of becoming a mother in a NICU where she felt criticized, judged and was clearly not seen as a unique individual with an experience that had only happened to her. She was not like everyone else, nor should she be. Each person has their own way of dealing with stress, loss, and grief. She had to learn to parent in a sort of fish bowl, the NICU, where she probably felt she was being watched by others all the time. An additional event that caused even more grief was the loss of her pumping equipment in the NICU, a personal assault added to the loss of the experience of birthing and mothering that she had hoped and dreamed of. Again, this is her story but one hears the continual theme that is present in these women's narratives of feeling uncared for, of feeling judged, devalued, and in many ways "not seen." We need to consider how the system and the professions can take these stories and change policy and procedure. The sad part is that we cannot make people learn how to feel!

Mother's Reaction

The NICU experience can be turned to good or increase the trauma. Sadly, for Christine, it was the latter, with the focus being on the well-being of the baby, and the prolonged shock of 25 days of waiting, waiting to be that mother. Her tears were eloquent. Their message was missed. However, you say both your mother and husband were fantastic, what a close unit you are! As with many mothers, she keenly felt her trauma, but the staff did not appreciate it. The dynamics of NICU have changed, and the voices of parents need to be heeded. Good support will help resolve Christine's trauma, and help her continue as a mother.

Childhood Sexual Abuse (Kerry's Story)

One mother, who had participated in Beck and Watson's (2010) study of subsequent childbirth after a previous birth trauma, courageously shared her story of her childhood sexual abuse. In her own words:

> I suppose I need to begin by saying that as a victim of childhood sexual abuse (a constant thing perpetuated by my father), I came into motherhood already plagued, unbeknownst to me, by PTSD. Pregnancy and labor and delivery exacerbated an already present issue. My subsequent experiences