

PTSD Following Childbirth, Can it be Prevented and Can it be treated? A Case Report

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Introduction

Around 15-20% of women who had childbirth experience childbirth as traumatic per DSM-IV criteria [1]. No wonder there have been increasing recognition of the importance of mother's PTSD following child birth. The prevalence of PTSD in women following childbirth has been estimated to happen in between 1.5 and 5.6% of these births [2-9]. Women may perceive their labour as traumatic because of many reasons. One of these is the mode of birth, as clearly first and more prolonged labour is more likely to be perceived as more traumatic. Also, medical and nursing interventions during labour or birth can also be of immense importance. And lastly, women's perceived manner of treatment by healthcare professions during and after childbirth [10]. The aetiology can further be classified traditionally in psychiatry in these 3 criteria [11].

- a) Predisposing factors: these are factors that are there before or during pregnancy, this includes previous traumatic experience in patient's psychiatric history [12].
- b) Precipitating factors (childbirth trauma): Women perceived trauma during complicated delivery. Caesarean section, forceps delivery, vaginal examination, being naked in the presence of others, perceived sever pain and the sense of lack of control during labour all were found to be significant factors in developing PTSD [13].
- c) Maintaining factors: Post natal factors that work as maintaining the problem. These are studied to involve the need after birth to attend hospital, words associated with labour or delivery. It also includes women avoiding of sexual contact for fear of further pregnancies and the fear of responsibility and the over protective behaviour towards the new-born [13].

The Case

This is a 30 Years Old married housewife who lives with her husband and daughter in the small city of Chelmsford in the borough of Essex, North East of London. Her problems started following

the birth of her daughter in September 2014 when she noticed a change in her mood and increasing anxiety. The maternity ward in Broomfield Hospital where she delivered her daughter initially induced labour that was tried and she felt that it was very painful.

The patient said that she was not informed that induced labour was more painful than natural labour and that the midwives told her that it is only 'uncomfortable' and they delayed giving her adequate pain relief. Thus, she felt that her delivery of daughter, which was subsequently via emergency caesarean section, was very painful, traumatic and not what she had planned or hoped for as a delivery. The PTSD symptoms started 6 weeks after labour and continue till she was seen by the psychiatric services. She continues to have thoughts about the treatment she received on the maternity ward which resulted in her finding it difficult to bond with her new-born daughter [14-16].

She said that she had no control over thoughts that she believes have ruined her life and caused her to engage in self harm behaviour e.g. punching her face and head, standing in the cold inappropriately dressed and having cold showers to distract her mind away from these thoughts. She has also reported having suicidal thoughts but no suicidal intent. She said that she just wants her thoughts to stop. She reported being low in mood having poor sleep and appetite and not being able to enjoy things as she used to. These thoughts have strained her relationship with her partner of 5 years.

She understood her PTSD to be the result of flashbacks of the memories she had of the pain she experienced during her labour. She spoke of fears of being out of control, and a thought 'my suffering will never end'. She further described beliefs she had been deceived, disrespected and that her cries for help during delivery were ignored and trivialised. She reported wanting maternity services to ensure her experience would never happened to anyone else and wanting justice for the pain she now suffers. With this she had been ringing the maternity ward where she had daughter multiple times at day, even in the early hours. She noticed that the perceived

lack of adequate information/reassurance she received during the calls increased her distress further, whereby she reported feeling suicidal, anxious and angry and as such was admitted to the Mother and Baby Psychiatric admission ward.

After admission to the Mother and Baby Unit, there were problems with her caring for her child. She was completely preoccupied by her problem with the maternity ward and had been pestering the complaint department at the general hospital and that was interfering with her relationship with baby that she refused to care for her baby at times. The antipsychotic drug Risperidone was started and increased to 5mg which was added to the antidepressant Sertraline 150mg OD she was already on. Patient was offered psychotherapy with CBT and she started having successful leave and started bonding better with baby. Her PTSD symptoms continued to be severe and the psychotherapist who saw her for CBT suggested the use of EMDR that was available at the community recover team then. She was discharged from hospital to be followed up by the community recover team.

On assessment for EMDR therapy after referral to the recovery team she said that her sleep is still disturbed with nightmares and wakes at about 2 or 3 am and stays awake thinking about what happened during labour. Her appetite has increased but she was mainly comfort eating and has gained excessive weight and that is why she was keen to reduce the Risperidone. Her energy and motivation is low and sometimes she feels everything is an effort to do. She has fleeting self harm thoughts of banging her head on the wall, but she has no plans or intent to carry this out because she does not want to upset her partner. The Impact of Event Scale-Revised [16] on 15/08/2015 Total score 64 (cut off point 33) mean avoidance =2.75, Intrusion 3.5 and hyper arousal =2.33 (out of maxim in 4).

She managed to establish a safe place that she called "calming place". We assessed her memory of the trauma of induced labour, remembering the midwife rolling her eyes at her while she was in severe pain and asking for pain relief. The negative thoughts she had because of remembering this image was "I am insignificant". She also developed panic attacks when she remembered that image in the maternity ward and her distress rate was 10 out of 10. She had the feeling mostly in her stomach. She was found to be suitable for the EMDR therapy and started the week following assessment.

This memory was that of her when she was 13 years old witnessing her step father assaulting her mother and being angry towards her. She had the same thought of "I am insignificant" then. So we tried to go back to that memory and tried to process it. She remembers positive aspect of her responding to him in a more assertive way although she was only 13 then. There was no other concern expressed about childhood. She attended school in the small nearby town Braintree. She reported her school life as being normal. She left school and attended college where she studied childcare. She worked as a nursery nurse for 12 years. She denied any history of mental health problems before the birth of her daughter.

The Management of Childbirth PTSD

The National Institute of Clinical Excellence in the UK (NICE) suggests that psychological treatment should be the first line treatment of PTSD [14]. Two forms of psychological therapies were suggested by NICE; Trauma Focused Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). EMDR has been repeatedly and effectively used by British therapists to treat childbirth PTSD [15]. Our case had 12 sessions of EMDR, between August to October 2015, that helped to greatly reduce her symptoms and made her able to function and look after her daughter. The Impact of Event Scale - Revised [16] on 9/10/2015 Total score was down to 39 (cut off point 33) mean avoidance =1.25, Intrusion 1.88 and hyper arousal =2.33. This means that the patient symptoms were reducing the disorder from severe to mild PTSD and I would argue that if she would have received more EMDR sessions she would have had a much reduction of symptom that would have led to complete recovery.

However, although she is generally okay but can get worried at times and this seems to have increased in the last two weeks since she met two women in the park talking about childbirth. She was advised to use one EMDR self-help tool that includes using her nurturing, protective and wisdom figures that she remembers from the EMDR work we did and use these with the Butterfly Hug when Poppy is asleep so that she can have a quiet place. This seemed to have helped contain her anxiety.

Conclusion

It is very important for Obstetrics services to consider psychological and psychiatric history before and during child birth. The need for analgesia that have been reduced by advocacy for natural birth should not be applied as one size that fits all. Some patients and because of childhood trauma or psychological vulnerability might be susceptible to developing PTSD by exposure to the pain associated with child birth more than others. The giving of adequate information on the labour process and the pain and distress that can result which affect different women differently. This is particularly true for women delivering their first baby 'primigravida'. Special attention should be given to these women to reduce or prevent predisposing, precipitating, and maintaining factors for PTSD before during and after child delivery. We call upon all obstetric services to be trauma informed and take account in liaison with psychiatric service of the psychological and psychiatric history when making decision on the appropriateness of natural birth with no or less analgesia. EMDR is evidence based, useful and easy to use therapeutic tool to be used by psychiatric services to manage Birth trauma PTSD cases.

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