Psychological birth trauma

A guide for health professionals

While the concept of physical birth trauma (or birth injury) is well-accepted, there has been less research into psychological birth trauma. With the potential for both birthing and non-birthing parents to experience significant levels of post-traumatic stress following birth, key considerations include that:

- **post-traumatic symptoms occur on a continuum, ranging from acute distress, to post-traumatic stress symptoms or post-traumatic stress disorder (PTSD)**
- **birth trauma can occur with or without PTSD and still cause associated distress and may also be associated with anxiety or depressive symptoms or disorder**
- **births may be experienced as traumatic even when they are perceived as obstetrically straightforward**
- **an event that is traumatic for one person may not be for another**
- **many parents don't seek help after their first birth which may have been traumatic or distressing, but may seek help once they are planning to have a second child**

Prevalence

1 in 3 women in an Australian cohort study reported the presence of at least three trauma symptoms at 4-6 weeks postpartum following physical birth injury. Physical birth injury, in turn, affects mental health. Of the eight in ten women who experienced birth injury and reported that their mental health was affected, almost half experienced depression or anxiety and a third reported post-traumatic stress symptoms. Another study suggested that PTSD can result from a traumatic birth experience, though this is not the normative experience.

Causes

Factors that contribute to birth being experienced as traumatic include:

- previous experience of trauma, including childhood abuse, domestic violence, rape and migrant trauma
- unplanned intervention (including emergency caesarean section or instrumental birth)
- giving birth to an unwell (e.g. preterm) or stillborn baby
- child removal
- birth, social and cultural expectations
- fear of birth or a pregnancy requiring increased monitoring
- a history of vaginismus
- physical injury and subsequent poor postpartum pain management
- having a strong desire to adhere to a birth plan
- co-occurring or history of a mental health condition.

Other predisposing factors to experiencing birth as traumatic include: lack of social support; poor coping strategies; feelings of powerlessness; extreme pain; perception of hostile or uncaring staff; loss of control; medical interventions; lack of information and past traumatic birth.

Some of the risk factors for experiencing psychological birth trauma are covered in the Postnatal Risk Questionnaire (PNRQ) and could be used to identify risk of experiencing birth as traumatic.

Use routine psychosocial screening (e.g. PNRQ) to gain knowledge about a woman's risk of experiencing birth as traumatic.

Symptoms

Following a psychologically traumatic birth, women may experience symptoms of distress (acute stress) or adjustment disorder. This is a normal response and will likely resolve without treatment. However, standard care should include ongoing monitoring, support and the provision of information to support help-seeking. Providing parent-centred, trauma-informed opportunities for review of what happened during the birth shortly afterwards and again at 6 weeks is an important aspect of postnatal care. Symptoms extending beyond 3 months may be indicative of more serious disorder.

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Symptoms occur across a continuum and include:

- appearing dazed, agitated, overactive and/or withdrawn, disorientated, emotionally numb, increased psychological arousal
- autonomic anxiety symptoms - increased heart rate, palpitations, sweating, jelly legs, "butterflies in stomach" and dry mouth
- depression and/or anxiety
- some amnesia-blocked memories, intrusive memories or flashbacks
- depersonalisation, hypervigilance, nightmares
- bonding difficulties, fear of sexual intimacy
- avoidance of normal vaginal birth or future pregnancy
- avoidance of infant.

Screening and assessment

Diagnostic scales are available to assess PTSD symptoms and clinical disorder in women or their partners who have experienced trauma in childbirth (e.g. the City Birth Trauma Scale; BiTS). The BiTS has recently been validated as a reliable measure of childbirth-related post-traumatic stress symptoms in Australian women.

If post-traumatic symptoms persist beyond 3 months, consider referral to appropriate mental health professionals for further assessment and/or care.

Treatment and management

Psychosocial and psychological interventions

Trauma-focused cognitive behaviour therapy should be the first-line psychological treatment for birth-related post-traumatic stress disorder. While there is less evidence on eye movement desensitisation and reprocessing (EMDR), it has also shown benefit when delivered between 1 and 3 months after trauma. Single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma do not appear to be of benefit and could cause further psychological distress. Peer support may also be of benefit.

Offer women who have post-traumatic stress disorder resulting from a traumatic birth a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing).

Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who experience a traumatic birth.

Medications

Post-traumatic stress disorder is a severe anxiety disorder and treatment may include antidepressants. A combination of trauma-informed cognitive behavioural therapy and pharmacotherapy outperforms either alone; depending upon the woman's symptoms, a stepped approach including pharmacological therapies may be needed.

Depending upon the woman's post-traumatic stress symptoms, consider the use of adjunctive pharmacological treatments.

Tips for providing support

Listen and reassure

- encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that psychological birth trauma can be treated and managed.

Provide information

- Refer all women to Ready to COPE – to receive ongoing information and support strategies throughout her pregnancy and/or the postnatal period.
- Provide the woman with quality information about psychological birth trauma - see COPE consumer fact sheet.
- Provide details of helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner/others.

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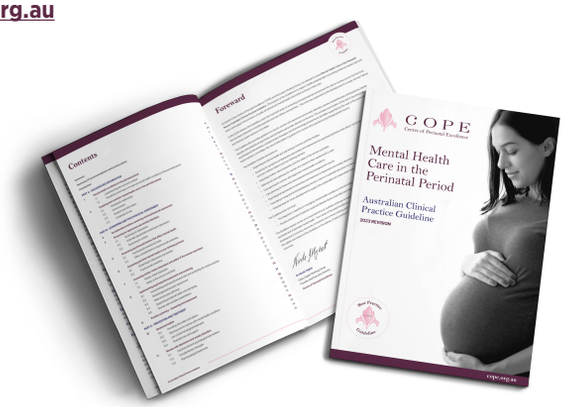
Direct to care and support

- Encourage the woman to consult with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to identify and draw on possible supports and services that may be available to her for practical and/or emotional support.
- Provide details of helplines if she is feeling distressed and needs support.
- Remind the woman that she can go to her doctor or local hospital if she is at risk of harming herself or others.

This resource was developed from the *Mental Health in the Perinatal Period: Australian Clinical Practice Guideline* (2023).

The Guideline can be downloaded from the COPE website at cope.org.au



Information for women and their families:

Ready to COPE Guide:

Women and their partners can receive free weekly information about emotional and mental health throughout the perinatal period, including preparing for, and recovering from a traumatic birth, via the **Ready to COPE** Guide. Visit **readytocope.org.au** for more information.

Information:

Provide women with consumer fact sheets on psychological birth trauma in the **perinatal** period.

Telephone support:

To access a specialist counsellor, call the **PANDA helpline** on 1300 726 306
(Monday to Saturday 9.00am – 7.30pm AEST/AEDT)

Further mental health information:

To find out about other perinatal mental health treatment and support services, visit the **eCOPE Directory**

Further information for health professionals:

- Postnatal Risk Questionnaire (PNRQ)
- Perinatal Anxiety: A Guide for Health Professionals

COPE
Centre of Perinatal Excellence

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