

# PTSD following childbirth – The roll of obstetrics

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# Topics

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- Are obstetrical interventions to blame?
- What can we do in obstetrical health care in order to prevent post-traumatic stress?
- What can we do in obstetrical care about symptoms of post-traumatic stress?



# Associations between obstetrical variables and traumatic childbirth experience

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- Emergency cesarean section
- Instrumental vaginal delivery
- More than two pregnancy complications
- Brief first stage
- Lengthy second stage
- Unbearable pain, high postdelivery pain
- Episiotomy, sphincter rupture
- Manual removal of placenta, great blood loss
- Baby low Apgar, baby to NICU
  - Ryding, Wijma 1998, Creedy 2000, Cohen 2004, Ayers 2004, Oolde 2006, Fairbrother 2007 and more

# How often is emergency cesarean a trauma (DSM IV Criterion A)?

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- 53 women interviewed about 3 days after emergency cesarean
- 26 (49%) had experienced intense fear of death of the baby
- 14 (26%) had experienced intense fear of themselves dying or being seriously harmed
- 7 (13%) had dissociated
- Altogether 29 women (55%) met criterion A
  - Ryding, Wijma 1998

# Associations between obstetrical variables and PTSD following childbirth

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- Only obstetrical variable that does predict PTSD is mode of delivery:

Emergency cesarean section

Instrumental vaginal delivery

(Ayers 2004)

- Otherwise it is not the interventions per se but the experience of the events that counts



# How often is emergency cesarean a trauma (DSM IV Criterion A)?

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# Experience of obstetrical care – associations with post-traumatic stress symptoms following childbirth

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- Feeling violated by staff, negative experiences of health care previously
  - (Ryding, Wijma 1998)
- Dissatisfaction with staff, especially with professionalism and technical skills
  - (Creedy 2000 – acute trauma symptoms)
- Blaming staff, experience of low support by staff
  - (Czarnocka, Slade 2000)
- Lack of adequate information, feelings of powerlessness and low support
  - (Soet 2003)
- Level of support by staff has a greater effect on women's emotional reactions than stressful events
  - (Ford, Ayers 2008)

# What can we do in obstetrical health care in order to prevent traumatic stress?

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- We may try to avoid uncaring or inadvertently abusive behavior by staff - education, supervision and support
- Postpartum “debriefing” probably not helpful. Most women however like to talk about their birth, and some trials of counselling have a more promising outcome.
  - Gamble 2004, Rowan 2007

# Care after traumatic childbirth

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No evidence for best treatment! - but try:

- Information about the delivery
- Information about post-traumatic stress
- Support during hospital stay
- Evaluation of risk factors for PTSD
- Evaluation of mother-child attachment
- Information about possible follow-up
- Optimism

# What to do about those already suffering?

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We may try to

- identify women and men with a traumatic delivery and offer follow-up
- identify women and men with acute trauma symptoms and offer counselling
- identify women and men with post-traumatic stress symptoms and offer counselling or brief psychotherapy

We must

- identify women and men with post-traumatic stress disorder following birth and motivate them for psychotherapy

# How do we identify those people?

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- By asking every patient about delivery experience, at maternity ward and at post partum check-ups
- By checking for symptoms in women with previous trauma, psychiatric history, low social support and after emergency obstetrical operations
- Remember PTSD as differential diagnosis in postnatal depression



# Conclusion

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- Unplanned operative delivery is a risk factor for PTSD
- Subjective experience counts; aim for best possible quality care and communication
- Respect and support staff
- Identify women and men with symptoms of post-traumatic stress
- Refer to appropriate treatment

