Risk for Traumatic Birth for Women with Pre-Existing PTSD

Julia Seng, PhD, CNM, FAAN, Advisory Board Member, PATTCh

PATTCh focuses on how birth can be a traumatic experience for some women and lead to posttraumatic stress symptoms or disorder (PTSD) in the postpartum period. But some women have PTSD already, before they become pregnant. Our research is showing that they are more likely to experience labor and birth as traumatic—or as *re-traumatizing*. But there are things that women and caregivers can do to prevent or at least prepare for the potentially re-traumatizing aspects of birth. In another post, Mickey Sperlich will talk about "trauma-informed" maternity care. In this post, I'll focus on the link between prior trauma and experiencing birth as traumatic.

Childbirth has the potential to be experienced as traumatic—by anyone—for any number of reasons. These reasons can include emergency situations, but also non-emergency reasons, such as feeling poorly or disrespectfully cared for during labor. However, for women who bring a trauma history and PTSD into pregnancy with them, especially when it's related to childhood maltreatment, anticipating giving birth can "trigger" unwanted re-experiencing of past traumatic experiences. These can take the form of remembering earlier traumatic events when you don't want to, nightmares, or "flashbacks," which are times when you feel—physically or emotionally—like the trauma is happening all over again. It makes sense that pregnant women with PTSD would get triggered because they may have the same concerns about having a safe, satisfying birth and becoming a mother that most women have—but these affect them differently. Worries about having an emergency or not being well-cared for are concerns that run parallel to trauma memories of feeling unsafe and having not been well-parented. So the feelings of what's past and what's current can become hard to distinguish, and the cycle pf PTSD symptoms--re-experiencing, reacting, then trying to avoid being reminded, then low mood—can start to go around and around. This type of "pre-traumatic stress" about giving birth is becoming more widely recognized.[1]

Another way of thinking about this has been well explained by Dr. Pauline Slade, who points out that there are both "predisposing" and "precipitating" factors that increase risk for traumatic birth and postpartum PTSD.[2] Precipitating factors include the birth experience itself. Pre-existing PTSD from maltreatment history is a predisposing factor.

Just how many women have this predisposing factor for birth-related PTSD? In another PATTCh post Heidi Koss discussed risk factors for developing PTSD in the first place, including being a woman and having experienced intense or long-lasting trauma. For instance, it is estimated that between 10 to 51% of women have experienced some form of childhood sexual abuse, [3-6] depending on the way such abuse is defined and the sample of women studied. Women are also at high risk for experiencing intimate partner violence, and it is estimated that nearly 9% of women experience such violence around the time of their pregnancy.[7] Some women with either a history of sexual abuse or who have experienced

intimate partner violence go on to develop posttraumatic stress symptoms/disorder (PTSD). And it makes sense that women who have experienced trauma to their bodies in the context of an important relationship where they should be able to expect to be cared for would be triggered by feeling vulnerable as they head toward the experience of birth—where bodily pain and dependence on a caregiver are unavoidable.

If you have PTSD symptoms in pregnancy, you absolutely deserve help to manage the symptoms, for several reasons. We are coming to understand that having PTSD in pregnancy is associated with increased risk of having a preterm birth or giving birth sooner than is optimal.[8, 9] Research also shows that babies of moms with PTSD may weigh less than they would otherwise.[9] Previous PTSD also increases the risk for developing postpartum depression and not feeling as "bonded" with the newborn.[10,11]

Of course, addressing PTSD from past trauma is not always a short-term project, and it may not be what you need to focus on in pregnancy. It might be a good starting place to focus on preventing experiencing your birth as traumatic. In our research we found that those women with pre-existing PTSD had nearly nine times the odds of experiencing their birth as traumatic.[10] We also found that for some women who had some symptoms of PTSD during the pregnancy but who did not meet the diagnosis, that having a traumatic birth increased the number of PTSD symptoms they experienced to the level that they now met the diagnostic criteria.

For all these reasons, it is clear that it is really important to cope with the "pre-traumatic" stress and PTSD symptoms during your pregnancy. In another post, PATTCh founder Penny Simkin provides excellent suggestions for what anyone can do during a traumatic labor and birth to reduce the likelihood of later PTSD. Knowing that you have PTSD *before* you ever go into labor is also very important – because it lets you start early to prevent or manage things during labor that could trigger you. Even if you can't control how your labor goes, you can get support you need and learn a lot about PTSD. I recommend working on two pathways. First, get the PTSD-related help you need. Second, get the birth-related help you need.

Getting the PTSD-related help first is optimal, because you'll learn a lot about PTSD that will help you plan for the birth. And you'll be feeling better, and more empowered. Kathleen Kendall-Tackett's PATTCh post has excellent suggestions for effective trauma-focused treatments, including Cognitive-Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and medications. Finding a therapist who has experience working with clients with a history of trauma is important; not all therapists do trauma work. A great resource for helping you to find a trauma-informed therapist is the Sidran Institute; they maintain online resources for trauma survivors, including links to a database of trauma-informed therapists and treatment centers across the country, and links to organizations and peer-support groups. They also have an article you can read that helps you choose a therapist who will be right for you. You can access all this at their webpage: http://www.sidran.org/help-desk/497-2/. Remember that you don't necessarily have to

make “curing” PTSD the goal. You can set a therapy goal that is “present-focused,” which involves working on how your trauma history and PTSD are getting in the way of how you want things to be now. CBT and EMDR can be used to reinforce your strengths.

Once you have a good sense of how your trauma and PTSD are affecting you, you’ll be in a better position to work with your midwife or doctor to discuss your needs for birth, breastfeeding, and the early weeks of mothering. One very practical way to get help for preparing for and negotiating your upcoming birth is to hire the services of a doula. The DONA International website has an online doula locator to assist you in this process: http://www.dona.org/mothers/find_a_doula.php. More and more there are nurse home-visiting programs. In the past these have been mostly for women considered “vulnerable” because they are young or live in poverty. But even if you’re not vulnerable in those ways, you could ask for a visiting nurse to work with you and give support for the ways that being a “survivor mom” is challenging. Currently we are working to produce an education program that will help pregnant women with a history of childhood maltreatment, so in future that will be a resource too.

Just because you have had trauma in the past, or PTSD, does not mean that you will have a traumatic birth, or any of the possible bad outcomes mentioned. But it does mean that you are at increased risk. The good news is that there is a lot you can do to look out for your well-being, and there is help available to support you to increase the odds of a good birth experience and a sense of satisfaction and capability as you move into motherhood.

References

1) Soderquist J., Wijma, G., Thorbert, G., & Wijma, K. (2009). Risk factors in pregnancy for post-traumatic stress and depression after childbirth. *BJOG, 116,* 672-680.
2) Slade, P. Toward a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics and Gynecology, 27,* 99-105.
3) Cougle, J. R., Timpano, K. R., Sachs-Ericsson, N., Keough, M. E., & Riccardi, C. J. (2010). Examining the unique relationships between anxiety disorders and childhood physical and sexual abuse in the National Comorbidity Survey-Replication. *Psychiatry Research, 177*, 150-155. doi:10.1016/j.psychres.2009.03.008
4) Kendler, K. S., Bulik, C. M., Silberg, J., Hettema, J. M., & Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric substance use disorders in women. *Archives of General Psychiatry, 57,* 953-959. doi:10.1001/archpsyc.57.10.953

5) Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994). *Child Abuse & Neglect, 33*, 331-342. Retrieved from http://hdl.handle.net/2445/28067

6) Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakersmans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79-101. doi:10.1177/1077559511403920

7) Saltzman, L. E., Johnson, C. H., Gilbert, B. C., & Goodwin, M. M. (2003). Physical abuse around the time of pregnancy: an examination of prevalence and risk factors in 16 states. *Maternal and Child Health Journal*, *7*(1), 31-43. doi:10.1023/A:1022589501039

8) Yonkers, K. A., Smith, M. V., Forray, A., Epperson, C. N., Costello, D., Lin, H., & Belanger, K. (2014). Pregnant women with posttraumatic stress disorder and risk of preterm birth. *JAMA Psychiatry, 71*(8), 897-904.

9) Seng, J. S., Kane Low, L., Sperlich, M., Ronis, D., & Liberzon, I. (2011). Posttraumatic stress disorder, child abuse history, birthweight and gestational age: A prospective cohort study. *British Journal of Obstetrics and Gynaecology, 118*, 1329-1339. doi: 10.1111/j.1471-0528.2011.03071.x. Epub 2011 Jul 27. PMID: 21790957

10) Seng, J. S, Sperlich, M., Kane Low, L., Ronis, D. L., Muzik, M., & Liberzon, I. (2013). Child abuse history, posttraumatic stress disorder, postpartum mental health, and bonding: A prospective cohort study. *Journal of Midwifery & Women's Health, 58*, 57-68. doi: 10.1111/j.1542-2011.2012.00237.x. PMID: 23374491

11) Sperlich, M. (2014). Trauma exposure, posttraumatic stress, and depression in a community sample of first-time mothers. Wayne State University, Detroit, MI.

Julia Seng is a nurse-midwife and professor of nursing, obstetrics, and women's studies at the University of Michigan. She studies the effects of PTSD from childhood maltreatment on women's health and childbearing outcomes. She works with Mickey Sperlich to develop and test education interventions for "survivor moms" to use during and after pregnancy. She is co-author with Dr. Sperlich on the book, *Survivor Moms: Women's Stories of Birthing, Mothering, and Healing after Sexual Abuse*.