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Childbirth and criteria for traumatic events

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ABSTRACT

Objective: for some women childbirth is physically and psychologically traumatic and meets Criterion A1 (threat) and A2 (intense emotional response) for Posttraumatic Stress Disorder of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV).This study differentiates Criterion A1 and A2 to explore their individual relationship to prevalence rates for posttraumatic stress, each other, and associated factors for childbirth trauma.
Design and setting: women were recruited at three hospitals from October 2008 to October 2009. Questionnaires were completed at recruitment and at 14 days post partum.
Participants: women in the third trimester of pregnancy ($n=890$) were recruited by a research midwife while waiting for their antenatal clinic appointment. Participants were over 17 years of age, expected to give birth to a live infant, not undergoing psychological treatment, and able to complete questionnaires in English.
Findings: this study found 14.3% of women met criteria for a traumatic childbirth. When the condition of A2 was removed, the prevalence rate doubled to 29.4%. Approximately half the women who perceived threat in childbirth did not have an intense negative emotional response. Predictors of finding childbirth traumatic were pre-existing psychiatric morbidity, being a first time mother and experiencing an emergency caesarean section.
Key conclusions: the fear response is an important diagnostic criterion for assessing psychologically traumatic childbirth. The identification of risk factors may inform maternity service delivery to prevent traumatic birth and postpartum approaches to care to address long-term negative consequences.
Implications for practice: prevention and treatment of traumatic childbirth are improved through knowledge of potential risk factors and understanding the woman's subjective experience.

Introduction

Recent research in Australia found that 45.5% of women giving birth are likely to report childbearing as traumatic (Alcorn et al., 2010), leading to a projected 135,000 Australian women each year self-rating childbirth as traumatic. Experiencing a traumatic birth can negatively impact on a woman's emotional well-being, her relationship with her new baby and her spouse (Beck, 2004a; Ayers et al., 2006; Parfitt and Ayers, 2009), extinguish her desire for more children (Allen, 1998), and increase her likelihood of requesting a surgical delivery for future births (McCourt et al., 2007). Traumatic birth may lead to the development of Posttraumatic Stress Disorder (PTSD), with estimated prevalence rates ranging from 1% to 6% at four to six weeks post partum (Creedy et al., 2000; Soet et al., 2003; Adewuya et al., 2006; Soderquist et al., 2006; Edworthy et al., 2008; Alcorn et al., 2010).

The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV: American Psychiatric Association, 1994) defines a traumatic event as 'where the person experienced, witnessed, or was confronted with event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others' (Criterion A1) and where the same person experienced an intense emotional response of fear, horror, or helplessness (Criterion A2). Both criteria must be endorsed to meet the guidelines for a traumatic event (as opposed to self-describing an event as 'traumatic'). In the development of the fifth edition of the diagnostic manual, it is proposed that Criterion A2, the emotional response, be removed (American Psychiatric Association, 2010).

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A recent study of women's experience of childbirth found that almost half (45.8%) of women who met Criteria A1 of threat did not report fear, horror or helplessness (Alcorn et al., 2010). A better understanding of how Criteria A1 and A2 relate to emotional pathology, and each other, would inform the design of successful resilience interventions for women most at risk of developing PTSD following a traumatic childbirth. This study examines the prevalence and associated factors of a traumatic birthing experience, and its immediate effect on emotional well-being of new mothers. First we gauged the prevalence and tested the relationship between Criteria A1, A2 and overall experiencing of a traumatic birth (A1 and A2 together). We then tested if each criterion was related to adverse emotional reactions in women. As interventions to prevent such reactions are desirable, we then tested which pre-existing characteristics of the mother and her birth predict traumatic childbirth.

Method

The present study was part of a larger randomised control trial evaluating the efficacy of a counselling intervention on mental health outcomes of emotionally distressed postpartum women (Fenwick et al., 2011). Measures used in this study were collected prior to intervention.

Sample

Women in their third trimester of pregnancy ($M=35.39$ weeks, $SD=3.29$), recruited at antenatal clinics across three hospitals—two public hospitals (Gold Coast Hospital in Queensland and King Edward Memorial Hospital in Western Australia) and one private hospital (Pindara Private Hospital in Queensland) from October 2008 to October 2009 participated in this study. Women were recruited by a research midwife while waiting for their antenatal clinic appointment. Participants needed to be over 17 years of age, expected to give birth to a live infant, and able to complete questionnaires and interviews in English. As this study formed part of a larger randomised control trial involving a counselling intervention, 21 women who reported undergoing psychological treatment at time of recruitment were excluded to avoid potential contamination of the larger treatment study. Fig. 1 details the flow of the 1040 participants recruited to the study.

Data from a total of 890 women were used in the final analysis in the present study. The median age of women was 30 years (ranging from 18 to 44, $M=30.00$, $SD=5.71$), and 43.7% had no prior children. This was consistent with the median age (30.7 years) and prior birth (43% first time mothers) of women giving birth in Australia in 2008 (ABS, 2010). Most participants were married (54%), but fewer than the national average of childbearing women (66%: ABS, 2010). At time of recruitment, 30.2% of women were still working, 25.6% were on leave, and 40.0% were not in paid employment.

Procedures

Following consent women completed the first questionnaire (time one). Women completed a second questionnaire (time two) either in paper form while still in hospital (61.7%) or over the phone ($M=82.25$ hours after birth, $SD=81.41$, range: 1–840 hours).

Ethics

Approval was obtained from the Human Research Ethics Committees at Griffith University and each of the participating hospitals.

Measures

The questionnaires incorporated socio-demographic data, prior life trauma details, birth event details, criterion A1 and A2 assessment, and validated measures of depression, anxiety and stress.

Traumatic birth experience—measure of Criterion A1 and A2

Criterion A1 was met if women responded 'yes' to one of two questions about the birth: 'At any stage during your pregnancy or labour and birth, did you think you or your baby's life was at risk?' and 'Did you think you or your baby would be seriously injured or permanently damaged?'

Criterion A1 was included in the DSM-IV (and earlier editions) to try and objectively categorise a stimulus type (traumatic versus non-traumatic). However, there is no guidance regarding who should be appraising the event, with recent evidence suggesting that Criterion A2 (subjective response) is a better predictor of longer term dysfunction in childbearing women than A1 (a rating of the traumatic nature of the event; Devilly et al., submitted for publication) and that a wide interpretation of A1 acts as a better informant of later pathology generally (Roberts et al., 2012). With

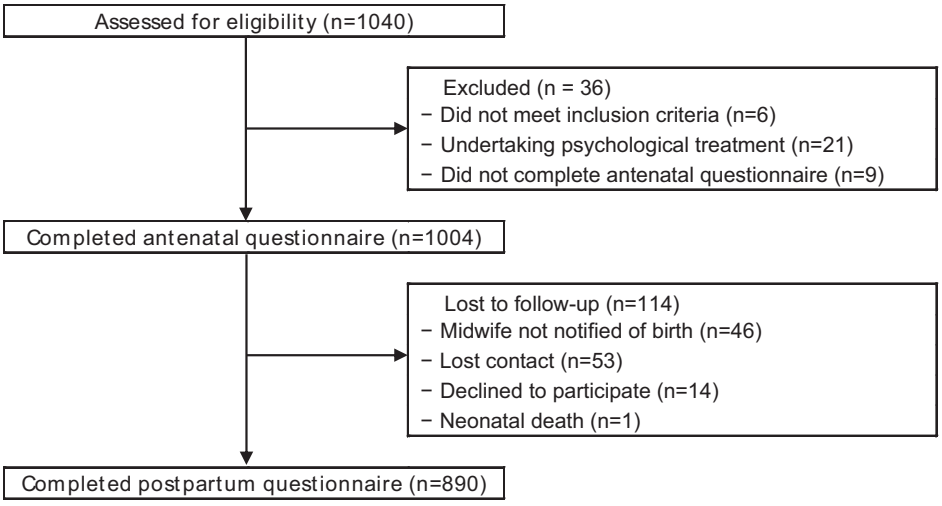

Fig. 1. Flow of participant response at recruitment and within 14 days after the birth.