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What about me? The loss of self through the experience of traumatic childbirth

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ABSTRACT

Background and objective: birth trauma has become an increasingly recognised maternal mental health issue and has important implications for both mother and infant. The importance of subjective birth experience in the development of birth trauma has been identified and may mediate the lack of theoretical consistency in this area. The current study aims to explore the subjective experience of birth trauma among first time mothers in Ireland. It aims to separate the potential effects of peripartum depression (PPD) from this in limiting this qualitative investigation to women who reported birth trauma, without PPD.

Design: mixed methods: Quantitative methods facilitated the recruitment of participants, the selection of a homogenous sample and addressed previous methodological flaws in birth trauma research. Interpretative Phenomenological Analysis (IPA) was used to explore the subjective experience of traumatic childbirth.

Participants: seven, first- time mothers who reported a traumatic childbirth, without significant symptoms of PPD participated.

Measurement and findings: screening measures of birth trauma and PPD were completed by participants. A semi-structured interview was then conducted with each participant about their childbirth experience. Interviews were transcribed and analysed using IPA. The primary superordinate theme recounted how the identity and individuality of women is ignored and discounted, throughout the process of childbirth. Identity is challenged and altered as a result of women's incompatibility with the maternity system.

Conclusions: this study supports the existence of birth trauma in an Irish context and highlights the subjective experience of women as central to the development of birth trauma.

Implications for practice: acknowledgement and inclusion of the mother as an individual throughout the process of childbirth may be protective in limiting the experience of birth trauma.

Introduction

Though traditionally childbirth has positive connotations, up to 30 per cent of women describe it as traumatic (Gürber et al., 2012; Boorman et al., 2014; Mollard, 2014). Of these women, some will go on to develop severe and enduring symptoms as a result of this trauma, comparable to those usually associated with PTSD (McKenzie-McHarg et al., 2015). Birth trauma has become an increasingly recognised maternal mental health issue, with the prevalence of women meeting diagnostic criteria for PTSD following childbirth reported as between zero and seven per cent (Ayers et al., 2008; Creedy et al., 2000; Fenech and Thomson, 2014; McKensie-McHarg et al., 2015). Prevalence rates for birth trauma rely largely on the diagnostic criteria for PTSD, as specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 2000; McKenzie-McHarg, et al., 2015). The changes to PTSD criteria to incorporate the added diagnostic category of negative alterations in mood, outlined in the most recent publication of DSM-5, may increase future prevalence rates of birth trauma reported (APA, 2013; Boorman et al., 2014).

The term birth trauma is used throughout this review to preserve clarity. Birth trauma in this case refers to women who experience symptoms of PTSD following the experience of childbirth, but who do not necessarily meet the diagnostic criteria for PTSD (Ayers et al., 2008). Symptoms of birth trauma include; flashbacks, nightmares,

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feeling stuck in the past, avoidance of birth reminders, anxiety, anger and isolation. Birth trauma can contribute to the avoidance of future pregnancy, elective cesarean section and has been associated in severe cases with suicidal ideation and maternal neonaticide (Beck, 2004; Elmir et al., 2010; Nesca and Dalby, 2011; Rhodes, 2013; Boorman et al., 2014; McKensie-McHarg, et al., 2015).

Birth Trauma and Peripartum Depression (PPD)

Many of the risk factors implicated in the development of birth trauma are similar to those associated with PDD. These include unanticipated obstetric interventions, dissatisfaction with labour, physical sickness during pregnancy, unplanned pregnancy and low parenting self-efficacy (Beck, 2001; Beck et al., 2011; Abdollahi, et al., 2014; Dennis, 2015). This crossover in symptomology supports the high levels of comorbidity reported between PPD and birth trauma (White, et al., 2006; Goutaudier et al., 2011; Dennis, 2015).

The co-morbidity between birth trauma and PPD yields multiple interpretations. Birth trauma and PPD may exist as separate disorders which regularly co-occur, given the increased risk of mental health issues conferred by childbirth (Jolley and Betrus, 2007). The development of birth trauma may precede PPD or develop as a consequence of it (Shahar et al., 2015). Birth trauma and PPD may also exist on a continuum of maternal distress, representing different symptoms of a common underlying difficulty. It is also possible that PPD, being more widely recognised, may have been misdiagnosed in cases where mothers were in fact experiencing birth trauma. The existence of birth trauma in isolation, in the absence of clinical symptoms of PPD, supports its existence as a distinct form of distress (Czarnocka and Slade, 2000; White et al., 2006; Iles and Pote, 2015;). Accordingly, this study views birth trauma as a distinct mental health issue, separate from PPD. It is necessary to distinguish birth trauma from PPD to justly understand the experience of women, in addition to linking them with the most appropriate treatment. This is especially pertinent as the recommended front line treatment for PTSD and depression differ (NICE 2005; White et al., 2006; Wylie et al., 2011; NICE 2014).

Locating Birth Trauma within a theoretical framework

Research in the area of birth trauma has remained largely a-theoretical (Ayers, 2008; Ford et al., 2010; McKenzie-McHarg et al., 2015).

Efforts have been made to locate birth trauma within existing theoretical frameworks, with modest degrees of success, including cognitive, attachment and assumptive world theories, (Janoff-Bulman, 1989; Brewin and Holmes, 2003; Iles et al., 2011). Qualitative theories of birth trauma share common findings, for example, the importance of feeling 'in control' during childbirth, however numerous methodological shortcomings limit their explanatory power (Iles and Pote, 2015). These include a lack of homogeneity in samples investigated, failure to screen for trauma symptoms and the failure to account for the potential role of PPD in the experience of birth trauma. Therefore, further research is needed to establish a greater theoretical understanding of birth trauma.

The Importance of Subjective Birth Experience

The lack of theoretical consistency surrounding birth trauma may be mediated by the role of subjective birth experience, enabling some women to navigate childbirth without distress while others experience trauma. The importance of subjective birth experience in the development of birth trauma has been highlighted consistently (Creamer et al., 2005; Andersen et al., 2012; Garthus-Niegel et al., 2013). Births often labeled as 'routine' by clinicians are sometimes experienced as traumatic by mothers (Beck, 2004). Conversely, enduring a life threatening experience during childbirth does not necessarily mean that a woman will develop symptoms of PTSD (Ayers, et al., 2008).

A number of important points emerge from this brief review. Firstly, the identified importance of subjective birth experience merits its further investigation in the context of birth trauma. Furthermore, the lack of consistency regarding the theoretical underpinnings of birth trauma highlights the need for further exploration of this issue. Finally, any exploration of birth trauma should account for the potential role of PPD, given their high rate of co-occurrence (Mollard, 2014).

The current study

The current study aims to explore the subjective birth experience of birth trauma among first time mothers in Ireland using the interpretative framework of IPA.

In order to build upon previous qualitative findings regarding birth trauma, this study employs a mixed-methods approach to address previous methodological flaws. A screening questionnaire will ensure the random sampling of a homogenous group for interview selection. This is a methodological strength, as generally qualitative studies involve a sample of convenience. Due to the importance of screening for symptoms of distress, this questionnaire will screen for symptoms of PTSD as specified by the newest edition of DSM-5 (APA, 2013). This is the first known study of birth trauma to include a measure of PTSD based on current diagnostic criteria.

This study focuses exclusively on the experience of first-time mothers, given the reported uniqueness of their experience (Iles and Pote, 2015). This study seeks to explore the subjective experience of birth trauma among women who have given birth within the previous 12 months, to control for the wide variability reported throughout studies of birth trauma regarding time since childbirth.

This study attempts to explore the experience of birth trauma as distinct from PPD, by screening for the presence of PPD and excluding participants accordingly. This is the first known qualitative exploration of birth trauma, which attempts to explore the experience of first time mothers in isolation from Peripartum Depression.

Methods

Design

This study used a mixed-methods approach, with a focus on qualitative methodology. Quantitative methods attempted to recruit a homogenous population from which a random sample could be drawn. This aimed to rectify the large variation within samples, characteristic of birth trauma research, particularly with regard to time since childbirth and prima parity versus multiparity. The voluntary, 'opt-in' nature of participation in phase two of the study, facilitated by quantitative methodology, attempted to maximise informed consent among participants. Furthermore, quantitative methods enabled the differentiation between the experiences of PPD and birth trauma. Quantitative methods identified first-time mothers who endorsed clinical symptoms of PPD, who were subsequently excluded. This facilitated the exploration of birth trauma as separate to PPD for the first time. The inconsistent use of screening tools in previous studies of birth trauma was addressed in this design by including well -validated, brief screening measures of PPD and PTSD. In particular the inclusion of a screening measure based on the most recent diagnostic criteria for PTSD, the PTSD Checklist for DSM-5 (PCL-5), allowed for the exploration of trauma symptoms alongside the subjective experience of traumatic childbirth.

Due to the focus on the subjective experience of first time mothers, Interpretative Phenomenological Analysis (IPA) provided the optimal theoretical framework to explore the experience of birth trauma. IPA places central importance on the individual meaning ascribed to salient experiences (Smith and Rhodes, 2015). Though previous studies have explored birth trauma using an IPA framework, no known studies have