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Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in North-West England

Gill Thomson, BSc, MSc, PhD, FHEA (Dr)[a,*], Soo Downe, RM, MSc, PhD, OBE (Dr)[b]

[a] Maternal and Infant Nutrition & Nurture Unit (MAINN), University of Central Lancashire, Preston, Lancashire PR1 2HE, United Kingdom
[b] Research in Childbirth and Health Unit (ReaCH), University of Central Lancashire, Preston, Lancashire, England PR1 2HE, United Kingdom

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ABSTRACT

Objective: to identify the emotional and support needs of pregnant multigravida women who have experienced adverse responses associated with a previous childbirth experience.
Setting: four maternity hospitals in North-West England.
Design: 100 surveys were distributed at an anomaly scan clinic in each of four maternity hospitals (total $n=400$). The survey included an adapted version of a Post-Traumatic Stress Disorder Symptom Scale to explore trauma responses at two broad time points: (a) following a previous birth and (b) during the current pregnancy. Participants were also asked about the optimal time to receive support post-birth, and the type and provider of support they had accessed/would have liked to access. Descriptive and inferential statistics were undertaken on the quantitative data. The qualitative data were analysed using a basic thematic approach.
Participants: multigravida pregnant women aged 18+ years.
Findings: the overall response rate was 28% ($n=112$); 43% ($n=46$) of the women had experienced negative/trauma responses associated with a previous birth, 74% of whom ($n=34$) continued/re-experienced adverse responses in their current pregnancy. Most commonly reported trauma responses were difficulties in recalling the previous birth(s), avoiding memories associated with it, and the distress associated with these memories when they were recalled. Approximately 54% ($n=25$) had received some form of support post-birth, and variations in preferred timing of postnatal support provision were reported. Information on available support and opportunities to discuss the birth with a maternity professional were identified most frequently as preferred support options.
Conclusion and implications for practice: women's views about what might work should form the basis for effectiveness studies in this area. Among the participants in this study there was evidence of unmet support needs relating to negative or traumatic responses to a previous birth. The range of preferred timing and types of support indicate that flexible needs-based support options should be provided. Further research should assess if these findings are reinforced in a more diverse sample with a higher response rate.

Introduction

Perinatal mental health (PMH) is a burgeoning public health issue affecting up to 20% of women at some point during the perinatal period (Bauer et al., 2014). Post-traumatic stress disorder (PTSD) following childbirth is reported to be a major cause of psychological distress, characterised by hallucinations, intrusive memories, avoidance, and hyper-vigilance (American Psychiatric Association (APA), 2013). A recent meta-analysis of 78 studies revealed that PTSD rates post-birth were 3.1% in community samples and 15.7% in 'at risk' (i.e. experienced previous trauma, history of mental health disorders) women (Grekin and O'Hara, 2014). Psychopathology during pregnancy was also reported to be the highest predictor of PTSD in the community sample (Grekin and O'Hara, 2014). While not all women who experience a traumatic birth will develop PTSD, studies have reported that between 20% and 48% experience PTSD symptoms at a sub-diagnostic level (Ayers et al., 2009; Alcorn et al., 2010; Polachek et al., 2012).

There have been recent changes to the Diagnostic and Statistics Manual of Mental Disorders (DSM) criteria for PTSD. The first concerns the event criteria in that while an individual still has had to experience or witness 'actual or threatened death, serious injury or sexual violation' (A1), it no longer requires an individual to

* Corresponding author.
E-mail addresses: gthomson@uclan.ac.uk (G. Thomson), sdowne@uclan.ac.uk (S. Downe).

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respond to an event with intense fear, helplessness and horror (A2) (DSM-V, APA, 2013). Second, the previous DSM-IV criteria specified that individuals had to experience symptoms in three categories (re-experiencing, avoidance and hyperarousal) in order to meet a diagnosis of PTSD. The revised DSM-V has now extended the symptom categories to four by including a negative cognitions and mood domain. The implications of the removal of criterion A2 in the DSM-V has been investigated, with a doubling of the prevalence rate of PTSD following childbirth (Boorman et al., 2014). However, as yet the wider implications of these changes in terms of whether they will reduce or decrease PTSD following childbirth is uncertain (McKenzie-McHarg et al., 2015).

A history of psychological problems or previous trauma, trait anxiety, obstetric procedures, negative staff–mother interactions, loss of control and lack of partner support are reported to be key risk factors of PTSD following childbirth (Olde et al., 2006; Grekin and O'Hara, 2014). A number of authors also argue that women's subjective interpretations of the birth are the most important predisposing factors (Verreault et al., 2012; Garthus-Niegel et al., 2013). A meta-ethnography undertaken by Elmir et al. (2010) into women's experiences and perceptions of a traumatic birth highlighted that poor quality care from health professionals was a key contributory factor, especially when it was experienced as degrading. The psychosocial difficulties and consequences of a traumatic/distressing birth include difficulties in mother-infant attachment relationships; a negative impact on social, marital, familial and sexual relationships; lowered emotional well-being and self-esteem, as well as classic PTSD responses (Fenech and Thomson, 2014).

Symptoms should continue for more than a one month period in order to qualify for a diagnosis of PTSD (DSM-V, APA, 2013). However, in a childbirth related context, the course and onset of PTSD is unclear. Women may have late presentation of symptoms due to being overwhelmed with having a new infant. The symptoms may also be ascribed to post-natal depression (PND) (Beck, 2011), as the rates of comorbidity between PTSD and PND are high (Stramrood et al., 2011). As women are repeatedly exposed to the reminder of their trauma (i.e. their infant), this could also ameliorate or exacerbate their symptoms (Ayers et al., 2008). Research indicates that PTSD symptoms following childbirth tend to decrease over time (e.g. Ayers and Pickering, 2001). However, longitudinal studies to assess the prevalence of PTSD after six months postnatal are limited (McKenzie-McHarg et al., 2015). Women who have experienced a previous traumatic/distressing birth can experience increased fear, stress and anxiety during a subsequent pregnancy (Ballard et al., 1995; Thomson and Downe, 2010), and have an increased likelihood of requesting a caesarean section (Ryding et al., 2015). As susceptibility for re-trauma and postpartum distress in a subsequent birth has been reported (Beck and Watson, 2010), this raises important, and currently unanswered questions about the potentially long-lasting nature of childbirth related trauma symptoms.

The optimal time to intervene and provide treatment for PTSD following childbirth is a topic of debate, particularly due to concerns that early intervention could pathologise women's normal responses (McKenzie-McHarg et al., 2015). Currently there is a lack of good quality research on the effectiveness of treatment interventions, such as cognitive-behaviour or eye movement desensitisation for PTSD following childbirth (McKenzie-McHarg et al., 2015). Two randomised controlled trials (RCT) of midwifery-led counselling interventions have been undertaken in Australia. The first involved at-risk women receiving telephone counselling at 72 hours and six weeks postnatal. Trauma and depression symptoms and feelings of self-blame, were reduced when compared to those in the control group (Gamble et al., 2005). The second study involved two telephone sessions of psycho-education provided at 24 and 34 weeks gestation to women who had high levels of childbirth fear (Fenwick et al., 2015). While the main outcome of a reduction in caesarean rates was not achieved in this study, women who received the intervention were less likely to experience distressing flashbacks during the post-natal period (Fenwick et al., 2015). Other psycho-social support options reported or suggested to be helpful for pregnant women who had previously experienced a self-defined traumatic birth include: an opportunity to review their case notes with a maternity professional, birth partners being involved in co-counselling sessions, opportunities to re-visit the delivery suite and targeted antenatal planning (Kitzinger, 2006; Beck and Watson, 2010; Thomson and Downe, 2010). To date, however, there are limited empirical insights into what types of support women themselves would choose for their trauma related responses, both following the birth and during a subsequent pregnancy.

To provide a baseline for future research in this area, we undertook a scoping survey study with pregnant multigravida women. The survey was designed to explore the nature of women's negative/trauma responses following a previous birth and during the current pregnancy, and the kind of support women themselves would prefer, when they had experienced adverse birth responses.

Methods

Measures

A survey was designed with public and patient involvement (PPI). An advert requesting input to the study was posted on a family care research blog at one of the local hospital trusts with a maternity service. Members of the North West Clinical Midwifery Research Network also contributed expert opinion. Overall six mothers and five professionals provided feedback. Requests for language revisions, additional options (i.e. on who should provide support), and question re-ordering were incorporated into the final version. Additionally, the concept of 'blame' was included in the survey tool in line with PTSD DSM-V revisions (APA, 2013).

The final survey tool included the following components:

Initial screening question

The first question asked women to indicate whether they had ever experienced negative emotions/responses associated with a previous birth. Women who responded 'no' were directed to the end of the survey, asked to provide demographic information and thanked for their participation.

Women who responded 'yes' were asked to complete, an adapted version of the Post-Traumatic Stress Disorder Symptom Scale (PSS) (Foa et al.,1993) twice. Participants were asked to respond using a scale of 0 ('not at all-never') to 3 ('very frequently/extremely so') to 19 statements to record whether the symptom was experienced at two broad time points: a) following the birth and b) currently, i.e. within the last seven days. The included statements represented all symptom classifications of the DSM-V in terms of avoidance (i.e. avoiding memories, thoughts, reminders of the birth, $n=2$); re-experiencing (i.e. spontaneous thoughts, flashbacks, nightmares of the event, $n=3$); arousal (i.e. aggressive, self-destructive behaviour, hyper-vigilance, $n=5$) and negative cognitions and moods (i.e. disrupted memories, sense of blame, isolation from others, low affect, $n=9$). Any participants who scored 0 to all of the symptoms were directed to the end of the survey.

In line with the DSM-V diagnostic criteria (APA, 2013), women were asked to indicate whether they had experienced negative/trauma responses for more than a one month period. A free text option to record any additional responses not captured within the