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# Post-Traumatic Stress Disorder (PTSD) after Childbirth

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**Background.** There has been discussion about the possible occurrence of post-traumatic stress disorder (PTSD) in mothers after difficult childbirth.
**Method.** Four cases with a symptom profile suggestive of PTSD commencing within 48 hours of childbirth are presented.
**Results.** The PTSD was in each case associated with the delivery. In each case, there was an associated depressive illness. All four had persistent disorders, and two had difficulties with mother/infant attachment.
**Conclusion.** As confirmed by other reports, the prevalence of PTSD associated with childbirth is a matter of concern.

Description of the stress-response syndromes (Horowitz, 1974) has stimulated a debate about individual vulnerability and the severity of stressors; historically, diagnoses such as 'traumatic neurosis' and 'neurosis precipitated by trauma' (Horowitz *et al*, 1980) have been used. Specific categories such as 'rape trauma syndrome' (Burgess & Holstrum, 1974) and 'combat neurosis' (Grinker & Spiegel, 1945) paved the way for the recognition of a general category of post-traumatic stress disorder (PTSD) (DSM–III; American Psychiatric Association, 1980), introduced after the description of 'post-Vietnam syndrome' (Figley, 1978).

The essence of the disorder is the presence of symptoms such as intrusive thoughts and images, nightmares, hypervigilance and increased arousal, in association with other forms of generalised or specific anxiety, frequently complicated by depressive symptoms, after a major life trauma. PTSD is defined in the DSM–III–R (American Psychiatric Association, 1987) as a psychiatric syndrome which follows an event beyond the usual range of human experience. The event must be re-experienced in at least one of several suggested modes, there must be avoidance of stimuli associated with the trauma, and there must be persistent symptoms of arousal. In addition, the symptoms must last for at least one month.

PTSD is common in war veterans (Atkinson *et al*, 1984) and those subjected to major disasters (McFarlane, 1989), but it is uncommon in the general population (Helzer *et al*, 1987). Childbirth, even with modern obstetric care, can sometimes be an excruciating and terrifying experience. Beech & Robinson (1985) have commented upon a number of reports of prolonged nightmares in recently delivered mothers, and Arizmendi & Affonso (1987), exploring various stresses before and after delivery, discussed stress reactions to delivery in several mothers, although neither paper describes the clinical picture or course of the disorder.

In 1978, the two French obstetricians, Bydlowski & Raoul-Duval, described *'la névrose traumatique post-obstétricale'*. The authors describe ten cases among 4400 deliveries during a two-year period. All the cases were brought to their attention during a subsequent pregnancy, by the continuing effects of the trauma experienced in the previous delivery. All involved long, hard labours; five included forceps delivery, and three the birth of a dead or damaged infant. The consequences included the avoidance of childbearing, and the return of symptoms in the last trimester of the next pregnancy, with nightmares so terrifying that they resulted in conditioned insomnia (fear of sleeping).

The current paper describes the clinical picture and course of disorder in a group of subjects with stress reactions after delivery, and relates the symptom profile to that of PTSD.

## Case reports

### Case 1

This 32-year-old mother was the adopted child of caring parents. After an uneventful childhood, she obtained nursing qualifications. She was happily married to a divorced man 11 years her senior, with two grown-up sons. She had an outgoing, confident premorbid personality and no history of psychiatric illness.

After a planned and welcome pregnancy in which she "bloomed" with health, the patient was delivered, on 26 August 1991, of her first child by emergency caesarean section, which was done for transverse lie, under epidural anaesthesia. The epidural was not fully effective, and she experienced



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excruciating pain during an operation which took 10 minutes. She was screaming, shouting, and struggling to get off the operating table during the procedure, and was held down by attendants while the anaesthetist attempted to supplement the epidural with nitrous oxide.

Afterwards, she experienced recurrent images of the experience. She would stand at the kitchen sink and relive the operation again and again (PTSD–B), feeling protracted terror, as well as sweating and trembling (PTSD–D). She had nightmares during which she would dream about all sorts of operations, and wake as the surgeon was about to insert the knife, crying, sweating, and shouting for him to stop (PTSD–B,D). She felt, "worked up", as if she were going to explode – "a walking time bomb" (PTSD–D). This continued for four months (PTSD–E). She also developed depressive symptoms fulfilling Research Diagnostic Criteria (RDC; Spitzer *et al*, 1978) for major depression, felt tired all the time, and woke early. She felt she was being watched by family and friends on the lookout for a mistake, and was self-conscious in company. Some days she sat in a chair, not bothering to dress, and plotting suicide. Although she had sung to and chatted with her baby during pregnancy, after the delivery she did not feel that this was her own baby. She let her husband take over baby care, and used to look at the baby thinking that it was his fault for what she had been through, avoiding contact with the baby because of the resulting intrusive recollections (PTSD–C). Once she said, "I hate you. Why did I have to have you?" Occasionally she felt like shaking him. Because of her difficulties, her parents moved from northern England to help. She recovered fully by March 1993.

### Case 2

A 34-year-old mother had moved to the UK from Kenya, where her elderly father and mother were alive and well. Her sister had suffered from postnatal depression. The patient had trained as a teacher, had a degree in theology, and was the wife of a minister. She had a 10-year-old son. She had a long history of back pain, and had had two episodes of iritis. After coming to England, she studied for a master's degree at an English university, but failed to obtain her degree after three attempts, a failure which severely affected her self-esteem. As a result of this failure, she felt she had no excuse not to accede to her husband's wish to have another child.

She was first seen in April 1992. She had been readmitted to the maternity unit four days after the birth of her baby, because of concern about a depression which had continued since two months before the birth. She stated that she had no love for the baby, although she was breast-feeding him, and had an intense desire to run away. She had gained a great deal of weight, of which her husband complained. The depression was resistant to treatment with amitriptyline. In June, she would stare at her 10-year-old son trying to convince herself that he was her son, and she had similar feelings about her husband and baby. That month, she was given a course of eight electroconvulsive treatments, with considerable but only temporary effect.

She described her delivery as follows: "The whole experience turned to more or less a torture. As a result, for seven months to date, I get nightmares, and the experience has left a mental scar" (PTSD–E).

The delivery itself had been problem-free although pain control was not optimal. She had, however, been left alone for long periods during the labour and had felt very unsupported.

The nightmares focused on the delivery experience and her extreme pain. She continued to have these most nights (PTSD–B). She also had frequent intrusive thoughts and visual images of the delivery while awake (PTSD–B), associated with persistent feelings of panic and autonomic arousal (PTSD–D). Seeing her own baby or other babies tended to precipitate the onset of intrusive thoughts and anxiety (PTSD–D). She resented her baby for "putting her through this", avoiding any form of emotional interaction with the baby and feeling quite unable to make eye contact with him (PTSD–C).

In November 1992, she again caused concern by driving off in the car, in a confused and agitated state of mind; it emerged that she had continued problems from the unhealed episiotomy wound, and worries about her 86-year-old father, who was ill. Her son cried often, did not sleep, and got on her nerves. "He screams inside my brains and I don't know what to do with him. I do not like him any more – he has given me a lot of troubles". Her husband had difficulty in understanding why she could not put her difficult delivery behind her. She had a disorder of attachment to her son, with whom she had difficulty in playing or talking, feeling a sense of 'distance' from him. She could not accept that he was her baby. She was admitted three times to a psychiatric hospital (either an acute ward without her son, or to the mother and baby unit with her son). The reason for each admission was her severe depression, together with auditory hallucinations telling her to go on hunger strike and that her hands were not her own. On each occasion, she was discharged completely recovered.

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**Case 3**

The 27-year-old patient was not very close to her rather punitive mother. She shared with other family members obsessional traits and insisted that her children clear up their toys meticulously. Her first three children were of mixed race, and her fourth had been fathered by a new partner, who was concerned and helpful. There was a problem with her 11-year-old eldest child, whom she disliked and often hit in the face.

A large lady with a marked preoccupation with the subject of her delivery, the patient presented with aggression to her husband and children, fatigue, loss of libido, and constant worry. All this had resulted from a traumatic delivery nine months before (PTSD–E). She had had high glucose levels during pregnancy, and the baby was overweight. Delivery had been complicated by shoulder dystocia, and the baby suffered cardiac arrest and had to be resuscitated, fortunately without ill effects. The child has achieved normal developmental milestones.

The psychological effects on the patient, however, were long-lasting. Within hours of delivery, she had intrusive recollections (PTSD–B) which continued for several hours each day. She remembered the moribund baby – "All I could see was the corpse" – when looking at her healthy 9-month-old child; she saw her "white-faced, wax-like, wrapped in a shroud". The visual imagery was intense and could occur at any time (PTSD–B), associated with persistent emotions of anger and tension (PTSD–D). She became obsessively angry and ruminated about possible mistakes which had been made by the obstetric team, such as delay in doing the episiotomy. She kept repeating, "I need to know why it happened", and said of the consultant, "I could really hit him". It was difficult to get her off the subject. She was pathologically anxious about her 9-month-old baby, to the point of having her in bed with her to hear her breathing. At the same time, she tended to avoid the child, because vivid recollections of her traumatic delivery were triggered by contact (PTSD–C). Thus, she had four complications of a traumatic delivery: post-traumatic stress disorder, pathological anxiety about the baby, and querulous reaction in the setting of depressive illness.

**Case 4**

A 42-year-old woman was first seen in January 1993, presenting with depression and anger over the circumstances of the birth of her third child in November 1989. She had had an uneventful childhood, one of two sisters, with close family relationships. She was happy and popular at school and worked for 18 years at a jeweller's. She had been married for 15 years and had three children aged eight, six, and three years. Her husband was generally supportive, although unhappy about the constant discussion of her delivery experience three years before.

She had been referred to the hospital in question because her own local hospital could not always provide epidural anaesthesia. In the event, the midwife in the delivery room did not talk to her at all, and her demands for pain relief during this pregnancy were not met. Her labour was long, and she had endured two nights without sleep. She "went into shock and disbelief" when she realised that she was expected to have the child without analgesic medication. A "very difficult", authoritarian hospital sister said she could not be in such bad pain. Entonox was ineffective, and "it was torture". When her daughter was born, weighing 8 lb 5 oz, the patient could not speak, did not touch her, and "did not care if she was dead". The midwife was off-hand and ignored her request not to have her perineum sutured. She "felt like kicking this woman off" her.

The patient was left with a mild prolapse of the rectum into the vagina (causing a dragging sensation), and a skin tag which had to be excised. She claimed that the stitches had never dissolved. She felt the midwife did not know whether the anti-D injections carried a risk of AIDS. She had nightmares about her delivery (PTSD–B), and woke early because of them, usually sweating profusely (PTSD–D). She wrote, "How do I get rid of these recurring dreams?" They recurred daily for about two months (PTSD–E), and she had learned to stop them by waking up. During the day, she could not read or watch anything about babies or anaesthetics, without becoming weepy, anxious, and angry (PTSD–D). Consequently, she avoided a range of television programmes and magazines (PTSD–C). During the interview, she wept with anguish as she recounted these events. She also burst out crying in the supermarket when she thought about these matters. She could not stand the thought of childbirth, which disgusted her and made her feel physically sick. Her daytime thoughts were of the "out-of-date, punishing attitudes of the 1950s still apparent in some midwives today. The system must be wrong which allows these so-called experts to have control over someone's ability to withstand pain". Of vengeful feelings, she said, "It seems awful, but I feel like beating this midwife to a pulp". She complained to the consultant, receiving a "nice letter" in response, but then wrote again to the

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hospital authorities over two years later, about the punitive attitudes of the midwives. Treatment by listening to a tape of her experiences made her feel more angry.

## Discussion

All four patients described had symptoms from categories B, C, and D of the DSM-III-R criteria for PTSD, showing a strong similarity to this condition, although there was a marked variation in severity and presentation. Each of the deliveries was traumatic emotionally, one because the baby suffered cardiac arrest, one because of anaesthetic failure, and two because of poor pain control. It could certainly be argued that two of these mothers had experienced trauma beyond merely a difficult delivery. Each of the four patients had an early onset of PTSD symptoms within 48 hours of delivery, and all at sometime fulfilled the RDC for major or minor depression. The post-traumatic stress symptoms tended to be frequent and persistent. Symptom resolution had not occurred in any of the subjects, symptoms having persisted for at least a year in three of the four mothers. In addition, three of the four mothers felt the need to avoid contact with their infants.

It is difficult to comment on possible causes from a small series of patients; however, long or complicated labour with the feeling of a 'lack of control' over the situation were described as important by each patient. Continuing problems in the mother/infant relationship developed in two of the four mothers, mainly because the infant reminded them of the unpleasant birth experiences. Bydlowski & Raoul-Duval (1978) also described prolonged and difficult labour as an important aetiological factor.

Two of 163 consecutive patients surveyed appeared to have PTSD, suggesting a prevalence of approximately 1% among patients referred to the West Midlands Regional Mother and Baby Service. Bydlowski & Raoul-Duval (1978) identified 10 cases from 4400 deliveries, although ascertainment was not systematic. In view of the reports made to patients' organisations (Beech & Robinson, 1985), it is likely that the prevalence is much higher. This is a matter of concern, because most cases are probably not being recognised. Some patients appeared to be suffering from a prolonged disability that could impair mother/infant relationships.

A prompt apology by hospital staff in cases of adverse incidents might avert some of these protracted sequelae. Such a course is already recommended after adverse anaesthetic events (Cooper *et al*, 1993).

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