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Special issue of Midwifery: Fear of childbirth and post-traumatic stress

Fear of Childbirth, Postnatal Post-Traumatic Stress Disorder and Midwifery Care

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The impact of maternal mental health disorders on women and their children is significant. Stress and psychological problems during pregnancy have been associated with preterm labour, poor infant outcomes and greater cognitive, behavioural and interpersonal problems in young children (Glasheen, Richardson & Fabio, 2010). Similarly, postnatal psychological problems have an adverse impact on the woman, child, and relationships. The World Health Organisation lists psychological illness as a significant indirect cause of maternal death in the first year after birth (WHO, 2008). This has led to an international call for the integration of maternal mental health into maternal and child healthcare programmes (Rahman, Surkan, Cayetano, Rwagatare & Dickson, 2013).

In the UK, the importance of women's mental health during pregnancy and after birth has been the focus of a number of recent reports from organisations such as the NSPCC (Hogg, 2013), Royal College of Midwives, Institute of Health Visitors and charities (Boots Family Trust, 2013), and a cross-party parliamentary manifesto (Leadson, Field, Burstow & Lucas, 2013). In November 2013 the Maternal Mental Health Alliance published a report on the importance and role of specialist mental health midwives (MMHA, 2013) and the UK Government announced specialist perinatal mental health staff would be trained for all birthing units by 2017 (Department of Health, 2013).

In this context, recognition of the range of mental health problems that women can suffer from becomes even more important. Historically, research has focused on the most common or severe psychological disorders that occur, namely postnatal depression and puerperal psychosis, which has raised public awareness of these disorders. However, it is clear that women can suffer from a range of disorders at this time including anxiety disorders such as panic, generalised anxiety, phobias and adjustment or stress-related disorders, such as post-traumatic stress disorder (PTSD). Collectively, anxiety disorders appear to be as common as depression. For example, a meta-analysis of postnatal depression suggests it affects up to 19% of women (Gavin et al., 2005). Similarly, a Canadian study found 16% of women had postnatal anxiety disorders (Wenzel, Haugen, Jackson, & Brendle, 2005).

Two, less recognised disorders are particularly relevant to midwifery care because they directly affect women's perinatal experiences or arise as a result of birth experience. These are fear of childbirth (tokophobia) in pregnancy and PTSD in response to difficult or traumatic births. These disorders can have an impact on women throughout pregnancy and after birth. They can also negatively affect women's relationships with their partner and baby (Nicholls & Ayers, 2007; Parfitt, Pike, & Ayers, 2013). These disorders can be inter-related in that tokophobia can arise as a result of a previous traumatic birth experience. The important point is that both disorders are potentially preventable or reducible through appropriate midwifery and perinatal mental health care.

This special issue of *Midwifery* focusses on fear of childbirth and postnatal PTSD in order to inform our understanding and hence prevention and treatment. As a relatively new area of research there are still many gaps in our knowledge. However, research is rapidly increasing and this journal includes papers on key issues as well as reviews synthesising the evidence. The first section focusses on fear of childbirth and includes papers on the aetiology of fear of childbirth, women's perceptions of morbidity, and midwives views on antenatal management. The second section focusses on postnatal PTSD and includes papers examining diagnostic criteria, the role of support, the impact on women, and treatment. Consideration of fear of childbirth, PTSD, and how papers in this issue contribute to our knowledge is provided below.

Fear of childbirth

Intense fear of childbirth occurs in 7 to 26 percent of pregnant women (Fenwick, Gamble, Nathan, Bayes, & Hauck, 2009; Laursen, Johansen, & Hedegaard, 2009), with a smaller proportion developing extreme fear or tokophobia (Nieminen, Stephansson, & Ryding, 2009). The BIDENS study of 7,200 women in six European countries found significant differences between countries with prevalence ranging from 1.9 to 14.2% (Van Parys, Ryding, Schei, Lukasse, & Temmerman, 2012). Symptoms include high levels of anxiety about pregnancy and birth, fear of harm or death during birth, poor sleep and somatic complaints.

As with most psychological problems the cause of fear of childbirth is multifactorial. It has been associated with factors such as nulliparity (Rouhe, Salmela-Aro, Halmesmaki, & Saisto, 2009), increased gestation (Rouhe et al., 2009), poor mental health (Laursen, Hedegaard, & Johansen, 2008; Storksen, Eberhard-Gran, Garthus-Niegel, & Eskild, 2012), a history of abuse (Lukasse, Vangen, Oian, & Schei, 2011; Nerum, Halvorsen, Sorlie, & Oian, 2006), younger age (Laursen et al., 2008), lower education (Laursen et al., 2008), and low self-efficacy (Salomonsson, Gullberg, Alehagen, & Wijma, 2013). Although fear of childbirth is more common in nulliparous women, women who have a negative or traumatic experience of birth are almost five times more likely to report fear of childbirth in a subsequent pregnancy (Storksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013).

The importance of fear of childbirth for midwifery is apparent from the impact it has on women's preferences for intervention during birth. There is good evidence from large epidemiological studies that women with fear of childbirth are more likely to want interventions such as epidural analgesia and caesarean sections (Nieminen et al., 2009; Rouhe et al., 2009). Evidence on the relationship between fear of childbirth and birth outcomes is inconsistent, however the balance of evidence suggests fear of birth is associated with negative outcomes such as increased labour duration (Adams, Eberhard-Gran, & Eskild, 2012) and caesarean section (Laursen et al., 2009; Sydsjo et al., 2013; Waldenstrom, Hildingsson, & Ryding, 2006). The inconsistent findings (e.g. Sluijs, Cleiren, Scherjon, & Wijma, 2012) may be due to the role of confounding factors such as parity. For example, Fenwick et al (2009) found fear of birth was associated with emergency caesarean section but this relationship was no longer significant when parity was controlled for.

One question that remains is *why* women are afraid of childbirth, particularly nulliparous women and men who have not had previous negative or traumatic experiences of birth. This is examined in this issue by **Stoll and colleagues** who carried out a survey of 3,680 Canadian students and found that fear of birth was highest in students who reported the media shaped their attitudes towards pregnancy and birth, suggesting an important role of the media in contributing to fear of birth.

Consistent with previous research, students with fear of birth were more likely to want epidural anaesthesia and caesarean section. However, interestingly, students who reported the media was the *only* influence on their attitudes to pregnancy and birth were more likely to want caesarean sections than those with multiple sources of influence. In a related paper, **Faisal and colleagues** examine why primigravidae in Iran with a normal pregnancy request caesarean section. Qualitative interviews with 14 women found requests for caesarean sections were related to fear of childbirth (in particular fear of pain), concern about complications after vaginal birth, and trust in obstetricians compared to mistrust of maternity ward staff.

Combined, these two studies provide interesting insights into what processes underlie why nulliparous/primiparous women may be afraid of birth. They confirm previous work showing that women are predominantly frightened of pain and injury during vaginal birth, and that these women would prefer caesarean sections. However, these studies also indicate the importance of social context in terms of family, friends and the media shaping women's attitudes and fear of childbirth; as well as the social relationships in terms of trust in different healthcare professions influencing women's preferences and choices about type of birth.

The care provided by midwives and other healthcare professionals during pregnancy and birth therefore has the potential to reduce or increase fear of childbirth. In this issue **Fontein-Kuipers and colleagues** look at midwives' intentions with regard to screening and managing women's distress in pregnancy in a survey of 112 community midwives in the Netherlands. They show that the main predictors of whether midwives intend to support women with distress or not are whether midwives find psychological distress interesting and have a positive attitude towards it. This supports the recent move in the UK to training specialist mental health midwives, who will presumably be those who are interested and positively inclined towards managing women's mental health in pregnancy.

Finally, the impact of pregnancy and birth on men's fear of childbirth and psychological wellbeing is an area which has not been widely examined. The few research studies that have been carried out suggest between 10 and 13% of men report intense fear of childbirth (Bergstrom, Rudman, Waldenstrom, & Kieler, 2013; Eriksson, Westman, & Hamberg, 2005; Hildingsson, Johansson, Fenwick, Haines, & Rubertsson, 2013). In this issue, **Hildingsson and colleagues** report results from a study of 1047 expectant fathers in Sweden. Similar to previous research, this study confirms 13% of men report fear of birth and fear is associated with worries about complications in pregnancy and birth, less attendance at antenatal classes, a preference for caesarean birth, poor physical and mental health, and parenting stress one year after birth (Hildingsson et al., 2014a; Hildingsson et al., 2014b). This suggests fear of childbirth in fathers has a similar pattern to women in terms of an overlap with other mental health problems. It also shows the impact of fear of childbirth on men, their engagement with the pregnancy, and parenting stress; highlighting the importance of addressing fathers' fear of childbirth as well as mothers.

PTSD

PTSD can affect women in pregnancy and after birth. PTSD in pregnancy is usually due to non-obstetric events such as abuse or other trauma. After birth, a substantial proportion of PTSD is associated with the events of birth itself. Research on PTSD in pregnancy and postpartum is relatively new but clearly demonstrates the importance of recognising and treating women with PTSD at this time. Women with PTSD in pregnancy are at greater risk of pregnancy complications

and poor health behaviours that can have a negative impact on the woman and foetus. In community studies, up to 7% of women report PTSD in relation to birth (Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008). Rates of PTSD are higher in high risk groups such as women who have preterm or stillborn infants or life-threatening complications during pregnancy or labour (Elklit et al., 2007; Kersting et al., 2009; Turton et al., 2001). Unlike other postpartum psychopathology, this is an area where there is clear potential to prevent or minimise postpartum PTSD through changing maternity care and services.

The impact of postnatal PTSD on women is substantial. A number of qualitative studies have illustrated the wide ranging effects postnatal PTSD can have on women and their relationships with their partner, baby and future reproductive choices (Beck, 2004; Gottvall & Waldenström, 2002; Nicholls & Ayers, 2007). In this issue **Fenech and colleagues** provide a meta-synthesis of this qualitative evidence and identify three main impacts on women: intense negative emotions after birth, a sense of loss of self and family ideals, and shattered relationships. The quotes in this paper illustrate the profound cascade of negative effects traumatic birth can have on some women and shows the importance of preventing and treating postnatal PTSD to prevent such long-term negative impacts.

As with fear of childbirth, the causes of PTSD are likely to be due to a combination of women's pre-existing vulnerability factors and risk factors during and after birth. To date, there is evidence for women being more vulnerable if they have current or previous psychiatric problems, a history of PTSD and/or fear of childbirth in pregnancy (Ayers & Ford, in press). The events of birth are critical in causing postpartum PTSD and the diagnostic criteria require that the event (birth) involves perceived threat of serious injury or death (American Psychiatric Association (APA), 2000). Previous diagnostic criteria specified that women also had to respond to the event with intense fear, helplessness or horror but this was removed in a 2013 revision. This change in criteria has repercussions for events such as birth where it might be relatively common for women to perceive a threat of injury. In this issue **Boorman and colleagues** examine this further. In a survey of 890 women they found that 29% thought they or their baby would die or be seriously injured during birth. However, only half these women (14% overall) responded to this with intense fear. Boorman and colleagues therefore argue that for postnatal PTSD, intense fear during birth may be more diagnostically accurate than perceived threat of injury or death. This has important implications for screening and identifying women who had traumatic births and might benefit from early intervention in the postnatal period.

A long-standing debate within this field has been around the relative importance of obstetric events or morbidity compared to women's subjective experience. On the one hand, there is evidence that women who suffer extreme complications, such as stillbirth or life threatening events, during pregnancy and labour are at greater risk of developing PTSD. Research also suggests that assisted delivery or emergency caesarean section can increase risk of PTSD (Ayers, Harris, Sawyer, Parfitt, & Ford, 2009; Creedy, Schochet, & Horsfall, 2000; Maclean, McDermott, & May, 2000; Soderquist, Wijma, & Wijma, 2002). On the other hand, studies that examine the relative importance of obstetric and subjective experiences clearly show subjective experience is more important in postnatal PTSD. For example, a study of 1,499 women in Norway examined the role of fear of childbirth, subjective and objective experience of birth in postnatal PTSD symptoms. They found that subjective birth experience had the strongest effect on postpartum PTSD symptoms and mediated

the relationships between fear of childbirth, obstetric factors and PTSD (Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013).

In this issue, **Furuta and colleagues** inform this debate with a meta-synthesis of qualitative research looking at women experiences and perceptions of severe maternal morbidity. They show that women who experience severe morbidity have an immediate physical, perceptual and emotional reaction to the event but their experiences in the aftermath are also important. For midwifery, key findings from this study are that women's reactions can be influenced and modified by other factors, including high quality care. Conversely, their reaction can be compounded by poor clinical management and care.

This emphasises the importance of support during birth, which is consistent with a substantial body of literature showing continuous support is associated with better obstetric outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2007). Lack of supportive care is also associated with postnatal PTSD (Soet, Brack, & Dilorio, 2003; Creedy et al., 2000; Czarnocka & Slade, 2000; Wijma, Soderquist, & Wijma, 1997). A pertinent issue here is that positive support and lack of support are likely to have different effects. Whilst positive support may ameliorate or buffer a woman against the negative impact of morbidity, a lack of support can be perceived as abandonment or neglect therefore, like maltreatment, women can perceive this as traumatic in itself. For example, a study of 675 women's worst moments during birth ('hotspots') found almost third were due to interpersonal problems between women and the healthcare staff, and these were as likely to be associated with PTSD as severe obstetric events (Harris & Ayers, 2012).

In this issue, **McConville** from the **White Ribbon Alliance** outlines the importance of respectful maternity care and dignity for all women in the UK and internationally. This is followed by a paper by **Moyer and colleagues** looking at maltreatment during labour of women in Ghana. In a qualitative study of 128 women, community members and healthcare providers they find that although most women had positive experiences, many also spontaneously reported experiencing physical and verbal abuse, neglect, and discrimination during labour. Combined, these papers show the importance of providing positively supportive care to women during birth in order to positively shape their experience and buffer against negative perceptions and responses. The meta-synthesis by Furuta and colleagues adds to emerging evidence that support can be even more critical in difficult circumstances where women experience complications during labour or have pre-existing vulnerability such as a history of trauma.

Management and treatment of postnatal PTSD

Very little research has examined screening or treatment for postnatal PTSD, although intervention is possible at many levels (Ayers & Ford, in press). Postnatal debriefing is commonly provided in the UK through services such as Birth Afterthoughts but there is little evidence of its efficacy. This may partly be due to the lack of clear definition of what postnatal debriefing comprises, as well as the methodological heterogeneity of the evidence to date. This issue has three papers that make an important contribution to this area. The first, by **Reed and colleagues**, looks at midwives who were trained to provide counselling interventions for women who had traumatic births (Gamble & Creedy 2009). A qualitative study of the experiences of 18 of these midwives found four themes: the challenges of learning to change, working with women differently, making a difference to women

and themselves, and finding it a challenge not to be overcome. This study illustrates the challenges midwives face when changing their normal care to address psychological problems, as well as the difficulty of being confronted by women's emotional responses to a traumatic birth. This work could be used to inform training of specialist mental health midwives.

The final two papers in this issue are reviews of treatment for postnatal PTSD. **Baxter and colleagues** review current practice in postnatal debriefing services and draw on all the available evidence, including qualitative, quantitative research and reviews. They conclude that although there is no evidence debriefing is effective at reducing morbidity, women value the service. In a broader review of any midwife-led intervention for postnatal PTSD **Borg-Cunnen and colleagues** synthesise a slightly different evidence-base of both debriefing and counselling interventions. They also conclude there is no evidence that midwife-led interventions are effective treatment for postnatal PTSD. It is clear from these reviews that we need to find alternative treatment options. Although midwife-led debriefing or counselling could be a valued part of screening and treatment pathways it is not effective by itself. Recommended treatment for PTSD generally is psychotherapy, in particular trauma-focused cognitive behaviour therapy (CBT) or eye movement desensitisation reprocessing (EMDR) (NICE, 2005). Research is therefore needed to examine whether these are effective treatments for postnatal PTSD.

In conclusion, the papers in this special issue make a strong contribution to our understanding of fear of childbirth and postnatal PTSD. As already stated, the important point with fear of childbirth and PTSD is that they are both potentially reducible through appropriate midwifery care. The research here illustrates how fear of birth affects women and men's choices about birth intervention; and how subjective experience and fear during birth are central in the development of postnatal PTSD. It suggests the care provided by midwives has the potential to shape women's experiences and (at best) buffer against adverse events or (at worst) be part of the trauma. Although the reviews of treatment for PTSD conclude midwife-led interventions are not effective, focussing on preventing or reducing fear of childbirth and PTSD through changes to maternity care may be more productive. Similarly, research is needed to explore and evaluate alternative treatments for postnatal PTSD.

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