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Editorial for Special Issue on Post-Traumatic Stress Disorder after Birth

Post-traumatic stress disorder after birth

Susan Ayers, City University London, Kirstie McKenzie-McHarg, Department of Clinical Health Psychology, Warwick Hospital, & Pauline Slade, University of Liverpool

This year the Millenium Development Goals (United Nations, 2000) will be reviewed, one of which was to improve maternal health. Whilst there has undoubtedly been progress in reducing maternal mortality and physical morbidity (United Nations, 2015), maternal mental health has been less prioritised. This is despite evidence that women's mental health in pregnancy and after birth can have a significant impact on women and the development and health of their baby (WHO, 2013). After birth, the postpartum period is critical for the formation of the mother-baby relationship and establishing patterns of parenting. Mental health problems at this time therefore have a particularly negative impact on these factors and the child's subsequent development (Glasheen, Richardson, & Fabio, 2010; O'Donnell, Glover, Barker, & O'Connor, 2014; WHO, 2013). The cost of perinatal mental health disorders is substantial. A recent report estimated perinatal mental health problems in the UK cost £8.1 billion per annual cohort of women, with 72% of these costs being due to the long term impact on the child (Bauer, Parsonage, Knapp, Iemmi & Adelaja, 2014).

This special issue is devoted to one particular mental health problem that arises in response to events of pregnancy and birth – post-traumatic stress disorder. The evidence that women can develop PTSD in response to difficult or traumatic birth experiences is now substantial. Meta-analyses suggest it affects 3.17% of women after birth at diagnostic levels and around 15% of women in high-risk groups, such after preterm or stillbirth (Grekin & O'Hara, 2014).

Worldwide birth rates (United Nations, 2011) mean a prevalence of 3.17% alone equates to approximately 4.3 million women potentially developing PTSD as a result of childbirth every year. However there are a substantial number of women who suffer with highly distressing PTSD symptoms that are below diagnostic threshold level. The importance of the postnatal phase of life means NICE guidelines recommend these women also have access to effective interventions.

PTSD after birth is important to understand and address for many reasons. It arises in direct response to the events of pregnancy and/or birth so, in theory, a large proportion of postnatal PTSD should be preventable if appropriate care and support is provided at this time. Qualitative research suggests PTSD can have a negative impact on the mother-baby relationship, particularly if the mother associates the baby with the traumatic events of birth (Ayers, Eagle, & Waring, 2006; Nicholls & Ayers, 2007). PTSD can also affect future reproductive choices: fear of birth can mean women suffer severe anxiety in subsequent pregnancies (Ayers et al., 2006; Nicholls & Ayers, 2007); and is associated with maternal preference for elective caesareans (Nieminen, Stephansson, & Ryding, 2009). In some cases women refuse to have more children to avoid going through birth again, despite the desire to have more children (Ayers et al., 2006).

Research on postnatal PTSD is relatively new, in that studies in this area have only been published in the last 20 years. However, the research is rapidly expanding. This special issue is founded on a workshop for key UK researchers and clinicians working in postnatal PTSD, funded by the Society of Reproductive and Infant Psychology. This issue provides an up-to-date summary of the state-of-play of research in this area, and includes papers that illustrate or address some of the gaps and contentious issues.

The first paper provides an expert overview of what we know about postnatal PTSD, what gaps remain in our knowledge, and key issues that need to be considered by researchers. This paper is authored by all the researchers who attended the workshop, so provides their consensus on the state-of-play in the field. The authors highlight five areas of postnatal PTSD research which they consider warrant particular attention. These areas are: (i) prevention and early intervention; (ii) the importance of maternity staff and care pathways; (iii) impact on families and infant; (iv) positive outcomes such as post-traumatic growth; and (v) high-risk populations such as women who have preterm or stillborn babies.

The remaining papers in the special issue look at some of the critical issues raised. The papers by Iles et al and Quinn et al. look at the aetiology of postnatal PTSD with an emphasis on using and developing theory. Theory is notably absent in much research on perinatal mental health but is critical in providing frameworks of understanding that can be tested in order for knowledge to develop (Ayers & Olander, 2014). Jane Iles and colleagues develop a qualitative model of the causes of postnatal PTSD using a grounded theory approach. Their paper provides a good overview of some of the existing quantitative models of postnatal PTSD. Their model highlights the importance of factors identified in other theories, such as support and coping, but also highlights factors not previously considered, such as antenatal expectations and perceptions of other people's views. Kate Quinn and colleagues examine aspects of an existing model of PTSD (Slade, 2006) and look at the importance of women's attachment style in how women experience pain during birth and the development of acute PTSD symptoms. This suggests anxious and avoidant attachment may affect the perception of pain or staff support during birth respectively. Attachment was also associated with acute symptoms of hyperarousal but not re-experiencing or avoidance.

The papers by Feneche et al., Ayers et al. and Sawyer et al. (2015) all examine women's responses to birth. Giliane Fenech and Gill Thomson report analyses from a meta-synthesis of traumatic birth that focus on the different psychological defence mechanisms women use to cope with the trauma. Susan Ayers and colleagues focus on hyperarousal symptoms following traumatic or non-traumatic births and show that, although hyperarousal symptoms are more common in women who have traumatic births, a significant proportion of women who have non-traumatic births also report these symptoms. Hyperarousal symptoms were not very discriminative, suggesting they should only be used in conjunction with other diagnostic criteria. Alexandra Sawyer and colleagues examine positive responses to birth in two European countries and show that 33 to 44% of women report at least moderate levels of growth after birth. They results from surveys of women in the UK and Croatia highlight some interesting cultural differences, which remind us that a country's culture around pregnancy and childbirth has a strong influence on how women respond to pregnancy and birth.

The last two papers in the special issue focus on the critical issues of prevention and treatment: Kayleigh Sheen and Pauline Slade review the literature on midwife-led debriefing with a particular focus on whether there is a case for targeted intervention. The literature on midwife-led debriefing is controversial. Mixed results from randomised controlled trials have led to clinical recommendations not to use debriefing (NICE, 2005). In many of these RCTs debriefing is applied universally to all women. Therefore some of the issues that have not been addressed in this literature concern the varied format of 'postnatal debriefing, whether debriefing should be targeted and, if so, whether it is effective under these circumstances. Sheen and colleagues conclude that there is case for targeted input and this should be labelled a 'birth review' to disaggregate it from formalised debriefing methods.

Finally, Antje Horsch and colleagues review the literature on stillbirth to inform healthcare practice with this high risk group. Their review highlights how many common practices in the care of parents following stillbirth do not have an adequate evidence base. In particular there are conflicting findings over whether the common practice of parents spending time with their dead baby is associated with more positive or negative outcomes. There is preliminary support for targeted psychotherapy for women with high levels of distress. However, once again the evidence base is very limited.

The papers in this special issue therefore illustrate some of the critical issues in postnatal PTSD research. These papers suggest new directions and highlight some of the gaps that need addressing. They emphasise the importance of using and developing theoretical frameworks to further our understanding of postnatal PTSD. We also need to recognise the complexity of women's responses to traumatic birth, which include different types of defence mechanisms and positive growth. Methodologically, when measuring PTSD we should remain mindful that some symptoms, such as hyperarousal, may be common in many women after birth and not necessarily indicative of pathology. Finally, there is an urgent need for research on prevention and treatment so that we can adequately inform clinical practices in maternity and perinatal mental health care.

References

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health and Medicine, 11*(4), 389-398.

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). The costs of perinatal mental health problems. Centre for Mental Health and London School of Economics. http://www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf

Glasheen, C., Richardson, G. A., & Fabio, A. (2010). A systematic review of the effects of postnatal maternal anxiety on children. *Archives of Women's Mental Health, 13*(1), 61-74. doi: 10.1007/s00737-009-0109-y

Grekin, R. & O'Hara, M. (2014). Prevalence and Risk Factors of Postpartum Posttraumatic Stress Disorder: A Meta-Analysis. *Clinical Psychology Review*, 34(5), 389-401. doi: 10.1016/j.cpr.2014.05.003

National Institute for Health and Clinical Excellence (2005). *Post-traumatic Stress Disorder Clinical Guidelines.* London, U.K, NICE.

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12*(4), 491-509.

Nieminen, K., Stephansson, O., & Ryding, E. L. (2009). Women's fear of childbirth and preference for cesarean section--a cross-sectional study at various stages of pregnancy in Sweden. *Acta Obstetrica Gynecologica Scandinavia, 88*(7), 807-813. doi: 10.1080/00016340902998436

O'Donnell, K. J., Glover, V., Barker, E. D., & O'Connor, T. G. (2014). The persisting effect of maternal mood in pregnancy on childhood psychopathology. *Developmental Psychopathology, 26*(2), 393-403. doi: 10.1017/s0954579414000029

World Health Organization (2013). Maternal mental health & child health and development. Retrieved 28th October 2013 from http://www.who.int/mental_health/prevention/suicide/MaternalMH/en/

Slade, P. (2006). Towards a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics and Gynecology, 27*(2), 99-105.

United Nations Data. (2011). Annual number of births. Available from United Nations Retrieved 28/10/2013, from United Nations Children's Fund http://data.un.org/Data.aspx?d=SOWC&f=inID%3A75

United Nations (2000) Millenium development goals and beyond 2015 website home page. Retrieved 13th March 2015 from http://www.un.org/millenniumgoals/.

United Nations (2015). Millenium development goals and beyond 2015 website. Retrieved 13th March 2015 from http://www.un.org/millenniumgoals/maternal.shtml retrieved 13th March 2015.

World Health Organization (2013). Maternal mental health & child health and development. Retrieved 13th March 2015 from http://www.who.int/mental_health/prevention/suicide/MaternalMH/en/