Post-Traumatic Stress Disorder Due to Childbirth

The Aftermath

Cheryl Tatano Beck

- ***Background:*** Childbirth qualifies as an extreme traumatic stressor that can result in post-traumatic stress disorder. The reported prevalence of post-traumatic stress disorder after childbirth ranges from 1.5% to 6%.
- ***Objective:*** The aim of this phenomenologic study was to describe the essence of mothers' experiences of post-traumatic stress disorder after childbirth.
- ***Methods:*** The qualitative research design used for this study was descriptive phenomenology. The main recruitment approach was via the Internet through the help of Trauma and Birth Stress, a charitable trust in New Zealand. Purposive sampling was used and resulted in 38 mothers participating from the countries of New Zealand, the United States, Australia, and the United Kingdom. The participants were asked to describe their experiences with post-traumatic stress disorder after childbirth. Their stories were analyzed using Colaizzi's method of data analysis.
- ***Results:*** Mothers with post-traumatic stress disorder attributable to childbirth struggle to survive each day while battling terrifying nightmares and flashbacks of the birth, anger, anxiety, depression, and painful isolation from the world of motherhood.
- ***Conclusions:*** This glimpse into the lives of mothers with post-traumatic stress disorder attributable to childbirth provides an impetus to increase research efforts in this neglected area.

- ***Key Words:*** birth trauma · phenomenology · post-traumatic stress disorder

In 1980, post-traumatic stress disorder (PTSD) was first listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (American Psychiatric Association [APA], 1980). Vietnam War veterans were the first individuals to be identified as experiencing PTSD. For the diagnosis of PTSD, the DSM-III criteria require an event considered beyond the range of usual human experience. The DSM-IV provides an expanded view of what constitutes an extreme traumatic stressor. It has broadened the definition to include "direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 1994, p. 424). The individual's response is one of extreme fear, helplessness, or horror. Although the DSM-IV does not specifically identify childbirth as an example of an extreme traumatic stressor, childbirth certainly can qualify as a traumatic event (Beck, 2004). The reported prevalence of diagnosed PTSD after childbirth ranges from 1.5% (Ayers & Pickering, 2001) to 6% (Menage, 1993).

In the most recent review of the literature on PTSD after childbirth, Bailham and Joseph (2003) identified possible features of PTSD presentation in mothers after delivery, including sexual avoidance, fear of childbirth, and mother-infant attachment and parenting problems. They strongly cautioned that these features are speculative at this stage, calling for further research to investigate the clinical presentation of PTSD in mothers as a result of traumatic births.

The purpose of this phenomenologic study was to investigate the essence of mothers' experiences of PTSD after traumatic births. This study focused on sequelae of birth trauma as PTSD rather than the immediate experiences of birth trauma.

Literature Review

A few published studies have described the prevalence of diagnosed PTSD attributable to childbirth and the PTSD symptoms of women after delivery. Two qualitative studies have been conducted: a phenomenologic study on birth trauma (Beck, 2004) and a grounded theory study on the process and impact of traumatic childbirth (Allen, 1998).

Wijma, Soderquist, and Wijma (1997) assessed the prevalence of PTSD after childbirth in Sweden using the Traumatic Event Scale. Among 1,640 women, 28 (1.7%) met the criteria for PTSD. Compared with a group of women who had no diagnosis of PTSD after childbirth, the

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PTSD group had significantly more primiparous women ($p = .003$), reported a higher frequency of psychiatric counseling ($p = .003$), and rated their contact with the delivery staff as significantly ($p = .01$) more negative than did the non-PTSD group.

In Australia, Creedy, Shochet, and Horsfall (2000) reported a 5.6% prevalence of PTSD attributable to childbirth (28 of 499 women). They based their diagnosis on the Post Traumatic Stress Symptoms Interview (Foa, Riggs, Dancu, & Rothbaum, 1993), which was conducted 4 to 6 weeks postpartum. A high level of obstetric intervention during childbirth and the perception of inadequate labor and delivery care were associated significantly with the development of acute trauma symptoms.

Vietnam War veterans were the first individuals to be identified as experiencing PTSD

Ayers and Pickering (2001) also used the Post Traumatic Stress Symptoms Interview (Foa et al., 1993) to measure the prevalence of PTSD at 6 weeks and 6 months postpartum. Among a sample of 218 mothers in the United Kingdom, 2.8% fulfilled criteria for PTSD at 6 weeks postpartum, and this number decreased to 1.5% at 6 months postpartum.

Menage (1993) reported a prevalence rate of 6% for PTSD after childbirth in the United Kingdom. The PTSD Interview (PTSD-I) of the Veterans Administration Medical Center in Minnesota (Watson, Juba, Manifold, Kucala, & Anderson, 1991) was used to diagnose PTSD. The DSM-III-R criteria for PTSD were satisfied by 30 of the 500 mothers. The only such study conducted in the United States to date identified a prevalence rate of 1.9% (Soet, Brack, & Dilorio, 2003). In a sample of 103 women, 2 received a diagnosis of PTSD attributable to childbirth trauma at approximately 4 weeks postpartum.

In other studies, post-traumatic stress symptoms were examined, but a formal diagnosis of PTSD was not included in the design. In Sweden, Ryding, Wijma, and Wijma (1998) compared the psychological impact of emergency cesarean delivery ($n = 71$) with that of elective cesarean delivery ($n = 70$), instrumental delivery ($n = 89$), and normal vaginal delivery ($n = 96$). Post-traumatic stress symptoms were measured using the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) 1 month after delivery. Mothers who had undergone an emergency cesarean delivery reported significantly more post-traumatic stress symptoms than those who had elective cesarean and normal spontaneous delivery, but not in comparison with the women who had instrumental vaginal deliveries.

Lyons (1998) also assessed post-traumatic stress symptoms 1 month after delivery using the Impact of Events Scale (Horowitz et al., 1979) with 42 primiparas in the United Kingdom. Higher post-traumatic stress symptoms were related significantly to the feeling of not being in control during delivery, of being induced, and of having an epidural.

Post-traumatic stress symptoms have been reported at a higher level for mothers of high-risk infants (Callahan & Hynan, 2002; DeMier, Hynan, Harris, & Manniello, 1996) than for mothers of healthy, full-term infants. Holditch-Davis, Bartlett, Blickman, and Miles (2003) examined post-traumatic stress symptoms in mothers of premature infants using a semistructured interview with 30 mothers at 6 months postpartum. The interviews were analyzed for three PTSD symptoms: re-experiencing, avoidance, and increased arousal. Of the 30 women studied, 24 reported that they avoided thinking about aspects of the birth and the neonatal intensive care unit and re-experienced the preterm birth of their infant through intrusive thoughts. Most of the mothers ($n = 26$) described increased arousal that focused on overprotection of their infant as a type of hypervigilance. The mothers reported difficulty sleeping, generalized anxiety, and persistent fears that their children might die or become ill again.

In her grounded theory study, Allen (1998) examined the processes that occurred during traumatic childbirth, the mediating variables in the development of PTSD symptoms, and the impact on postpartum adaptation. In her study, 20 mothers were interviewed 10 months after delivery. The Revised Impact of Event Scale (Horowitz et al., 1979) was used to measure PTSD symptoms. Six of the mothers reported scores above the cutoff point, indicating clinically significant levels of PTSD symptoms after childbirth. Their distress included panic and tearfulness caused by thoughts of the trauma, the anger directed at clinicians and their partners, the decreased closeness in their relationships with their partners, the emotional detachment from the baby, less patience with their other children, and fear of future pregnancy.

Beck (2004) conducted a phenomenologic study investigating women's experiences of birth trauma. The 40 women in this study participated via the Internet: 23 in New Zealand, 8 in the United States, 6 in Australia, and 3 in the United Kingdom. Women were recruited primarily through Trauma and Birth Stress (TABS), a charitable trust located in New Zealand. The essential components of a traumatic birth that emerged were the mothers' perceived lack of communication and caring by labor and delivery personnel, the provision of unsafe care, and an overshadowing of the trauma by the delivery outcome. Beck (2004) concluded that birth trauma lies in the eye of the beholder. Mothers perceived that their traumatic births often were viewed as routine by clinicians.

A review of the literature located one conceptual framework that focused on the role of PTSD in childbearing. Seng (2002) developed a conceptual framework for research on lifetime violence, post-traumatic stress, and childbearing. Women's lifetime abuse trauma and post-traumatic stress both are considered important factors for guiding future research. Post-traumatic stress disorder is emphasized as a potential factor contributing to adverse maternal and fetal outcomes via both behavioral and neuroendocrine pathways. Seng (2002) proposed three groups of factors that moderate the relation between violence trauma and adverse childbearing outcomes: nonmodifiable factors that affect

pregnancy outcome, life event stress factors, and modifiable healthcare-related factors. This third group of modifying factors, including the quality and amount of obstetrical care, can and should be influenced by clinicians.

The limited quantitative research conducted shows that risk factors for the development of PTSD after childbirth can include emergency cesarean delivery, first pregnancy, high level of obstetric intervention, perception of inadequate care during labor and delivery, premature or high-risk infants, and psychiatric history. No phenomenologic studies were found that described the experience of PTSD attributable to birth trauma.

Women were recruited primarily through Trauma and Birth Stress (TABS), a charitable trust located in New Zealand

Methods

Research Design

Phenomenology is an inductive method that describes a phenomenon as it is experienced by an individual instead of transforming it into operationally defined behavior (Colaizzi, 1978). In descriptive phenomenology, objectivity is faithfulness to the phenomenon under investigation. Objectivity is "a refusal to tell the phenomenon what it is, but a respectful listening to what the phenomenon speaks of itself" (Colaizzi, 1978, p.52).

To help ensure respectful listening, researchers using Colaizzi's (1978) phenomenologic method begin by carefully questioning presuppositions about the phenomenon under investigation. Sample questions could include these: Why am I interested in this topic? How might my presuppositions related to the research influence what I study? Once such questions are answered, the researcher then scrutinizes and examines these presuppositions. A researcher's personal inclinations and predispositions can never be completely eliminated, although Husserl (1970) calls for phenomenologists to eliminate all presuppositions through phenomenologic reduction. Colaizzi supports Merleau-Ponty's (1962) stance that "the most important lesson that the reduction teaches us is the impossibility of a complete reduction" (p. xiv). To "return to the things themselves," phenomenologists strive for descriptive identification of each phenomenon under study (Husserl, 1960). One assumption of descriptive phenomenology is that for any human experience there are essential structures that make it up regardless of individual differences.

Sample

The purposive sample included 38 mothers representing four countries (Table 1). The majority of these mothers lived in New Zealand. The mean age of the women at the time of their participation in the study was 33 years (range, 25-44 years). Of the 17 women who reported their education level, 15 had at least a college degree. Most of the mothers in this sample (n = 32) also had participated in another phenomenologic study evaluating the experience of birth trauma (Beck, 2004). The length of time from the mothers' birth trauma to their participation in this study ranged from 6 weeks to 14 years.

Procedure

Approval was first obtained from the institutional review board. Data collection extended over a 24-month period and occurred via the Internet mainly through the assistance of the chairperson of TABS, a charitable trust in New Zealand. Five mothers who had experienced traumatic births founded TABS (Web site: www.tabs.org.nz; e-mail: ptsdtabs@ihug.co.nz) to support women who have experienced birth trauma and to educate healthcare professionals and the lay public about PTSD after childbirth.

The two criteria for inclusion in the sample required that a woman had experienced PTSD attributable to birth trauma and that she was willing to articulate her experience. The diagnosis of PTSD was made by the mother's self-report that this disorder had been identified by a healthcare professional. Members of TABS were informed of the study through a letter written by the chairperson of the self-help organization. An announcement to recruit mothers also was printed in the TABS newsletter. Women interested in participating in the study contacted the researcher using her e-mail address. Directions for the study and an informed consent were sent by e-mail attachment to prospective participants. Women electronically signed the informed consent and returned it by attachment to the researcher.

Each mother was asked to describe her experience of PTSD after childbirth in as much detail as she wished and could remember. Two women handwrote their stories and sent them to the researcher by regular postal mail. Of the 38 mothers in the sample, 36 sent their PTSD stories over the Internet to the researcher as e-mail attachments.

After the researcher had read the mother's description of her PTSD attributable to birth trauma, she e-mailed the woman if she had questions about any part of the mother's story that needed clarification. At the same time, the researcher e-mailed the mother asking her to provide specific examples of a point she had made in her story. For example, the researcher once e-mailed the following back to a responding mother: "You mentioned that in terms of mothering, the playing of your traumatic birth nonstop for almost 6 weeks definitely had been a distraction. Could you please explain that to me in more detail?"

From the perspective of the mothers, the process of participating in this study via the Internet was beneficial to them. One mother wrote, "I feel by writing about it, my story is outside me and no longer inside filling me up with anxiety. It has taken a couple of months to get my story out, but it's been a very therapeutic exercise doing so." As another woman shared, "Writing about my experience has helped consolidate lots of things that happened during that time, and also has said to part of my memory 'forget about some of the details for awhile; have a rest—it's all written down if you want to come back to it.'"

TABLE 1. Demographic and Obstetric Characteristics of the Sample (*N* = 38)

Characteristic	*n*	%
Country		
New Zealand	22	58
United States	7	18
Australia	6	16
United Kingdom	3	8
Marital status		
Married	34	90
Single	2	5
Divorced	2	5
Education (*N* = 17)		
Graduate	6	35
College	8	47
Partial college	2	12
High school	1	6
Parity		
Primipara	12	32
Multipara	26	68
Delivery		
Vaginal	21	55
Cesarean	17	45
Induction		
Yes	16	42
No	22	58

Preliminary findings after 12 months of data collection were validated by nine mothers who had participated in the study. The researcher met with these mothers while speaking at a conference in New Zealand. The final results were reviewed over the Internet by four mothers and one father. All five persons agreed with the themes that had emerged from the mothers' stories.

Data Analysis

The mothers' (n = 38) stories of their PTSD after childbirth were analyzed using Colaizzi's (1978) method of phenomenologic analysis. Colaizzi's method begins with a reading and rereading of all the participants' descriptions of their PTSD after traumatic births and ends with a final description of the essence of that phenomenon. The middle steps of Colaizzi's thematic analysis focus on extracting significant statements that pertain directly to the experience of PTSD and formulating their meanings. Next, the formulated meanings are categorized into theme clusters and referred back to the mothers' original stories. At this point in the thematic analysis, the theme clusters are integrated into an exhaustive description of PTSD after childbirth. Colaizzi (1978) called participants in a phenomenologic study co-researchers. On the basis of this perception, the Colaizzi method involves asking some of the co-researchers to validate the exhaustive description.

Results

Analysis of the 38 stories describing PTSD after childbirth resulted in five themes that described the essence of this experience for the mothers (Figure 1).

Theme 1. Going to the Movies: Please Don't Make Me Go!

Mothers who experienced PTSD were bombarded not only during the day with flashbacks in which they relived their traumatic births, but also during the night with terrifying nightmares. These mothers repeatedly used the image of a video on automatic replay or loop tracks imprinted in their brains to describe how uncontrollable the distressing memories or "movies" of their traumatic childbirths were to them.

A primipara who had a failed vacuum extraction followed by a forceps delivery and a fourth-degree tear provided an illustration of these loop tracks that left her feeling as if she was "faking it" and stuck in the past, unable to enjoy the present with her infant:

> I lived in two worlds, the videotape of the birth and the "real" world. The videotape felt more real. I lived in my own bubble, not quite connecting with anyone. I could hear and communicate, but experienced interaction with others as a spectator. The "videotape" ran constantly for 4 months.

Another mother, who also had a failed vacuum extraction followed by a forceps delivery, desperately wanted to get out of the nightmare in which she was starring. She explained:

> I had nightmares of my delivery doctor as a rapist, coming knocking on my door. I also believed when my son was born that the doctor had ripped his head off. These two images were what affected my existence.

One woman who had been refused an epidural and subsequently experienced an "agonizing forceps delivery" experienced "extraordinarily realistic nightmares." She described her experience as follows:

> Like Lady MacBeth, I became terrified of sleeping! I would go without sleep for about 72 to 96 hours. I always knew I'd have to fight the nightmares again. I was scared that this time I wouldn't have the strength to fight it, that it would succeed in destroying me.

Flashbacks and nightmares of the traumatic births affected mothers' relationships not only with their children, but also with their husbands. One multipara who had experienced a high level of medical intervention during the delivery shared:

> After about 6 months, my husband and I still hadn't had sex since before the birth. When we began to try, I had flashbacks to the birth. At the moment of penetration, I would have a flashback to the instant when my body was pulled down the operating table during one of the failed forceps attempts.

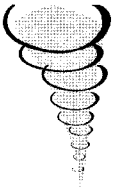
Theme #		Theme
1		Going to the movies: Please don't make me go!
2		A shadow of myself: Too numb to try and change
3		Seeking to have questions answered and wanting to talk, talk, talk
4		The dangerous trio of anger, anxiety, and depression: Spiraling downward
5		Isolation from the world of motherhood: Dreams shattered

FIGURE 1. Five essential themes of post-traumatic stress disorder due to childbirth.

Theme 2: A Shadow of Myself: Too Numb to Try and Change

Traumatized by their birth experience, mothers experiencing PTSD considered themselves only a shadow of their former selves. This numbing of self and actual dissociation experienced by some women can began immediately after delivery. One woman who had an emergency cesarean and postpartum hemorrhage vividly described that after delivery she was put in a room with two other mothers:

> I had a drip, a catheter, and was silent. I felt completely numb. I did what was required and I felt my head was floating way above my body. I struggled to bring it back onto my shoulders. I still feel dissociated like this sometimes.

Another mother who had hemorrhaged on the delivery table recalled that she was wheeled out to the recovery room:

> My parents were there, as was my sister. I did not cry or smile. I watched them looking happy. I was completely numb and could not remember any emotional context to do with my delivery day. The midwife pointed my baby out to me in the nursery as I was wheeled by. He was so big. I felt no recognition. I felt nothing.

Once home, the mothers reported that these feelings of numbness and detachment continued. One primipara who had undergone a terrifying experience with an epidural shared: "I'd wake up numb unable to feel a thing. I'd drag myself through the day. I am having the hardest time trying to overcome this feeling of being dead." Another woman poignantly described herself feeling as though her soul had left her and she was now only an empty shell:

> Mechanically I'd go through the motions of being a good mother. Inside I felt nothing. If the emotion did start to leak, I quickly suppressed it. I'd smack myself on the hand and put my "robot suit" back on.

Theme 3: Seeking to Have Questions Answered and Wanting to Talk, Talk, Talk

Mothers who experienced PTSD had an intense need to know the details of their traumatic births and to get answers to their questions. These women obsessed over trying to understand what had happened and why it had happened. This obsession took on many different forms. For some women, it entailed making repeated appointments with the physicians or midwives who had delivered their infants to have their questions answered and to go over their hospital records. Others read obstetrical textbooks during their free time when they were not caring for their infants.

Revisiting the delivery room became necessary for some women even as long as a year after the birth. One multipara whose request for pain medications during labor had been denied, shared:

> At the first birthday of my little daughter, I had a horrible recurrence of the PTSD. I insisted that the hospital let me visit the delivery room and threatened them with a lawsuit if they didn't grant my request.

Women experiencing PTSD reported that they wanted to talk excessively about their traumatic births, but they quickly discovered that healthcare providers and family members became tired of listening. After a traumatic delivery a mother of multiples said:

> I was so devastated at people's lack of empathy. I told myself what a bad person I was for needing to talk. I felt like the Ancient Mariner doomed to forever be plucking at people's sleeves and trying to tell them my story which they didn't want to hear.

Eventually, some women stopped discussing their traumatic births, but this became detrimental to their mental health. As one woman explained, "I didn't communicate with anyone anymore. The room I was in became my cave. I was consumed by my birth demon." Their unasked, unanswered questions "gnawed away" at them.

One mother of multiples who had undergone an emergency cesarean poignantly tried to express in words what happened:

> Not only does PTSD isolate me from the outside world; it isolates me even from those I love. How do I explain the sort of blind terror that overtakes me without warning and without obvious logical cause? And what of my family and friends? They don't know how I feel. They don't know what to say, and they cannot make it better, so they end up feeling useless. That's the real problem with PTSD. It separates people at the time when love and understanding are most needed. It's like an invisible wall around the sufferer.

After repeated unsuccessful attempts to get satisfactory answers about their traumatic births or at least an apology from their healthcare providers and the hospital, some women took their quest to a higher level. Examples of this next step included taking their cause to the Health and Disability Commissioner, filing an accident compensation claim, and submitting a formal complaint to the State Medical Board. When, for instance, the State Medical Board sided with the physicians, women stated they were "retraumatized." One woman who had experienced an emergency cesarean delivery painfully shared that "the emotional pain of this secondary wounding was worse than the actual physical pain of labor."

Theme 4: The Dangerous Trio of Anger, Anxiety, and Depression: Spiraling Downward

This trio of distressing emotions permeated the daily lives of mothers experiencing PTSD. The women experienced these emotions on a heightened level. Anger was rage; anxiety turned into panic attacks; and depression left many mothers suicidal. Anger was directed in multiple directions, lashing out at healthcare providers, family members, and self. Marital relationships were at times strained to the limit. As one mother whose firstborn infant had died explained:

> To live daily with the fact that you were like a time bomb ready to go off was dreadful. As time went on, I knew I was personally "too hot to handle" and not nice to be with, as invariably you could not help but have some of your inner state ooze or jump out at those who did come close.

Another woman stated:

> Powerful seething anger would overwhelm me without warning. To manage it I would go still and quiet, then eventually "come to," realizing that one or all of the children were crying and I had no idea for how long.

Mothers experiencing PTSD also turned their anger inward at times toward themselves. A mother who had given birth to twins shared that she was so full of anger at herself. "How could I have let this happen? Why did I trust the doctors? How could I have been so stupid?"

Women were angry at the labor and delivery staff, who they perceived had betrayed their trust and let them down. This anger was not a fleeting emotion. A mother whose infant had sustained a skull fracture from a vacuum extraction 3 years earlier shared that she sometimes "relives" the traumatic birth and still is angry and mistrustful of doctors.

Anxiety also plagued women with PTSD attributable to birth trauma. For some mothers, the anxiety began on the delivery table. As a woman who had experienced "excruciating" pain once her membranes had been artificially ruptured shared: "I had intense pains in my chest from the first moment after the birth that have been extremely difficult to get rid of. They turned into anxiety." After a traumatic birth, one primipara became extremely anxious regarding intercourse, causing her to have a nonintimate relationship for most of the next 9 years. One mother was so anxious that she "made sores in my scalp and face." Women who had never experienced panic attacks before their birth trauma began to be plagued by them. One mother whose infant had received cuts and bruises attributable to a forceps delivery experienced panic attacks whenever she went to a hospital or doctor's office.

Depression at times became severe enough to lead some mothers to contemplate ending their own lives. A mother of multiples shared as follows:

> I wanted to kill myself. My life was a mess. Death seemed like a wonderful idea. I'd fight with myself while driving, "Put your foot on the brake, the light's red. No, don't put your foot on the brake," and so it went on.

Theme 5: Isolation From the World of Motherhood: Dreams Shattered

The tightening grip of PTSD after childbirth choked off three lifelines to the world of motherhood: the woman's infant, the supporting circle of other mothers, and hopes for any additional children. Concentrating first on the present, some women shared that much to their dismay, PTSD distanced them from their infants. As one mother who had an unplanned cesarean delivery painfully remembered:

> At night I tried to connect/acknowledge in my heart that this was my son and I cried. I knew that there were great layers of trauma around my heart. I wanted to feel motherhood. I wanted to experience and embrace it. Why was I chained up in the viselike grip of this pain? This was my Gethsemane—my agony in the garden.

The walls that the birth trauma erected between mother and infant did not appear to be temporary for some mothers. A multipara who had survived a severe postpartum hemorrhage 3 years earlier painfully shared that PTSD still holds a destructive grip on her relationship with her son:

> My child turned 3 years old a few weeks ago. I suppose the pain was not so acute this time. I actually made him a birthday cake and was grateful that I could go to work and not think about the significance of the day. The pain was less, but it was replaced by a numbness that still worries me. I hope that as time passes I can forge some kind of real closeness with this child. I am still unable to tell him I love him, but I can now hold him and have times when I am proud of him. I have come a long, long way.

Post-traumatic stress disorder also caused women to isolate themselves from other mothers and babies. Mothers with PTSD could not tolerate or cope with being around other women who had not experienced traumatic births. One mother would ask the nurse to schedule her baby's well child checkups 15 minutes before the clinic opened so she would not see or meet other mothers.

To have more children or not? What a heart wrenching decision this was for mothers experiencing PTSD. The only choice for three of the women was to have a tubal ligation, and one woman asked her husband to have a vasectomy. The following passage illustrates this:

> I couldn't envision *ever* having another baby. There was no way I could expose myself again to that degree of vulnerability and abandonment. My little girl was the most precious thing in my life, but events that occurred at her birth mean that I will not be having any more children. I had a tubal ligation, and I grieved for the babies I thought I wouldn't have.

Other women, although terrified at the prospect of going through another childbirth, opted to have another child. Proactive planning and an "ironclad" birth plan helped prepare the PTSD mothers for a second childbirth. Throughout her second pregnancy, one mother kept a diary as she struggled with her PTSD. One entry from her diary vividly illustrates how vulnerable and fragile these women are as they bravely face another childbirth:

> While I am trying to put my PTSD behind me, I am having to prepare for the birth of my second child. My reality is that I am scared, heart and womb. I need special care. My heart is fragile, and I am trying to protect it.

Another mother who had an emergency cesarean with her first delivery kept a list of questions to ask different midwives as a help in choosing a midwife she felt she could trust. A sampling of these questions from her diary includes the following:

> Why are you a midwife? How would you describe your approach to women in labor? What is the difference between being delivered and giving birth? What do you do when a woman in labor starts saying "I'm scared" as you commence a procedure?

Of the 38 women in the study, 16 (42%) went on to have other children after experiencing traumatic births. Not all of these subsequent pregnancies, however, were planned. During these subsequent pregnancies, the mothers were terrified of having to go through another labor and delivery. One woman experienced panic attacks while pregnant. Another woman said, "I was in the most terrible state once I found out I was pregnant. I couldn't eat or sleep, crying all the time and having suicidal thoughts."

Two mothers described their subsequent births as positive experiences. As one of these women explained, "I felt cocooned and cared for this time in the hospital. My second pregnancy and birth helped me recover from my first traumatic experience." The second mother said, "Last year I had a home birth, the most amazing, healing, uplifting, empowering thing that has ever happened to me. That birth experience has given me the strength and confidence to do many things, including writing my birth trauma story."

In summary, the essence of mothers' experiences of PTSD attributable to childbirth can be portrayed as a life haunted by terrifying nightmares and flashbacks of the birth and at times consumed with seeking answers to questions about the traumatic birth. On a daily basis, anger, anxiety, and depression pervaded mothers' lives to the point that the women were only a shadow of their former selves. Mothers' dreams were shattered as they became isolated from the coveted world of motherhood.

Discussion

The themes that emerged from analysis of the mothers' gripping stories illustrate the characteristic symptoms of PTSD within the context of new motherhood (e.g., flashbacks and persistent avoidance of stimuli associated with the trauma). This study supports previous quantitative research regarding precipitating events of PTSD such as increased obstetric intervention and perceptions of inadequate care (Creedy et al., 2000), painful labors, and feel-

ings of powerlessness (Soet et al., 2003). Themes 1, 4, and 5 confirm Allen's (1998) qualitative findings that women with severe PTSD symptoms after childbirth experience anxiety attributable to thoughts of the trauma, anger, and emotional detachment from their partners and babies, and to fear of future pregnancies.

For these women, the extreme traumatic stressor that triggered their PTSD was childbirth. Obviously, the best intervention is to prevent birth trauma in the first place so that PTSD will not develop. In addition to providing safe care, the basic skills that all healthcare professionals are taught need to come to the forefront with each and every mother: to be caring and to communicate effectively.

Clinicians should play a proactive role in helping to prevent PTSD attributable to birth trauma. Knowledge concerning predictors of PTSD after childbirth, such as high levels of obstetric intervention, is crucial for healthcare providers so they can be alert to these high-risk women. Clinicians also need to be vigilant in symptomatic recognition during the prenatal, intrapartum, and postpartum periods (Church & Scanlan, 2002). Symptoms of PTSD or previous trauma that clinicians should recognize during labor include: extreme fear and lack of trust of healthcare providers, flashbacks that may cause some women to cry or scream when a clinician can see no apparent reason for this extreme emotional behavior, dissociation as women psychologically escape from their current labor, and an intense need to control their labor (Crompton, 1996; Kennedy & MacDonald, 2002). The labor and delivery process can retraumatize women who have experienced previous trauma. Crompton (1996) urged clinicians to be aware of the suffering a woman may have endured already in her life. She believed that the best approach to ensure that fewer mothers are traumatized during childbirth is for clinicians to treat all women as if they all had been survivors of previous trauma (Crompton, 2003).

Debriefing sessions may be helpful in reducing trauma symptoms for women who perceive their delivery experiences as traumatic (Allen, 1998; Gamble, Creedy, Webster, & Moyle, 2002). Support and trauma counseling are essential for diminishing the impact of traumatic childbirth. Crompton (2003) suggested that access to a support group, such as TABS, composed of other women who have had birth trauma and PTSD attributable to childbirth is of primary importance.

The theme of isolation from the world of motherhood powerfully alerts clinicians to the specific effects of PTSD when the traumatic event is childbirth. Not only can PTSD have devastating effects on the mother; it also can affect the developing relationship with her child. Mother-infant attachment problems have been addressed in a few studies on PTSD after childbirth (Allen, 1998; Ballard, Stanley, & Brockington, 1995; Reynolds, 1997; Weaver, 1997). For some mothers, their infants were reminders of their traumatic births, and in keeping with one characteristic of PTSD, the women avoided any stimuli associated with the trauma. Further complicating these fragile mother-infant dyads was the numbness the women experienced. Functioning as only a shadow of their former selves took a heavy toll on the attachment some mothers felt with their infants. Routine assessment of mother-infant interaction during the postpartum period can provide one way to identify women struggling with PTSD.

Studies focusing on women who have gone on to have other children even after experiencing PTSD attributable to birth trauma are needed. A purposive study of women who had a healing experience with this subsequent labor and delivery could examine how this healing childbirth was different from the previous traumatic birth. Studies can be designed to evaluate the effectiveness of PTSD intervention using childbirth support groups or specific prevention strategies. ▼

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