Treating PTSD after childbirth

Most parents can gain relief and freedom from PTSD through a variety of non-chemical options.

Create a support network Mums and dads should connect with understanding friends, family and professionals. Avoid spending time with people who are critical or unsympathetic.

Be aware of her limitations Mothers shouldn't try to do too much or blame herself for not coping. Encourage her to accept help when it is offered no matter how small.

Take care of herself Mothers should tend to their own needs and not feel guilty for doing so.

Establish routines Along with feeding and bathing baby, include time for brushing teeth, getting dressed and eating breakfast. During bad times these can seem like insurmountable chores.

Good nutrition is vital Mothers need to eat well in order to care for others, especially if she is breastfeeding. If necessary she should consult her LMC, GP, lactation consultant, pharmacist, nutritionist or dietician for specific advice concerning her particular nutritional needs.

Allow for simple pleasures Mums should try to do at least one thing each day that gives her enjoyment. She should be encouraged to prioritise and be willing to let some things go.

Be adaptable New babies invariably mean a lack of sleep and sleep deprivation can make parents feel they are losing control. Conserve energy, sleep when they can and defer the non essential. Mums may need to talk to someone if they are unable to sleep.

Be unsociable if necessary Mums should not have to always answer the door or the phone or visitors.

Exercise This does not mean keeping up a demanding schedule at the gym or worrying about losing baby weight. A little fresh air, sunshine and gentle exercise will do wonders for stress levels and help her to feel connected to the world outside.

Find a trusted person(s) to talk to about the trauma They need to be empathetic, non-judgmental, and attentive. The father may also be affected by the trauma and may feel blamed or at fault. He may also need to have his feelings heard. Speaking with someone who isn't emotionally involved may be a better option, like the midwife or a counselor experienced with birth trauma..

Seek professional help Several therapies have been proven to be successful in the treatment of PTSD. These include cognitive behaviour therapy, exposure and imagery reprocessing and eye movement desensitisation and reprocessing. It is essential that they are carried out by trained therapists.

Contact Us

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Perinatal Anxiety & Depression Aotearoa
Te mate Tuatea, me te mate Pōuri o Aotearoa

Mothers with PTSD just want to:
Be heard.
Be believed.
Know that they are not alone.

Some women may want an opportunity to talk about their birth experience. The frequency of these conversation will be individual (or vary) for each woman.

Even as a scar will not completely disappear, neither will the effects of trauma. However, survivors can enjoy life again in a meaningful and fulfilling way.

Find out more from:

- Best Practice Advocacy Centre New Zealand - www.bpac.org.nz
- TABS - www.tabs.org.nz
- Perinatal Anxiety and Depression Aotearoa www.pada.nz

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PTSD after childbirth

Far from always being a fulfilling and normal experience, for some women childbirth is traumatic and may lead to Post Traumatic Stress Disorder (PTSD). If not properly identified and treated, PTSD can profoundly and negatively affect the mother, her family/whanau and her psychological health.

PTSD is much more significant than any other form of postnatal depression and the diagnosis must always be made by a health professional. Although often invisible, most symptoms directly affect the body and mind via an 'on alert' adrenal system, so taking up normal responsibilitiies such as looking after a baby and other children can be extremely challenging and sometimes impossible.Professional intervention and ongoing support from family/whanau and friends is critical.

It is important for Lead Maternity Carer's (LMC) and other practitioners involved in perinatal care to understand the events that lead to trauma and how it impacts on the psychology of mothers. It appears that the obstetric and gynaecological history is no longer the only information the LMC and practitioners involved in perinatal care need to be familiar with but also social history and other experiences woman may have endured e.g. family violence, war in countries they may have migrated from and sexual abuse.

The pain of childbirth is an experience outside the normal range and can be distressing for many women. Some mothers manage to control the pain through relaxation; others may require medication or interventions that can seem invasive or threatening. For fathers and others present at this time, witnessing the mother's pain and possible interventions may leave them feeling helpless and overwhelmed.

It is a normal human desire to seek relief. For mothers planning a natural birth with no invasive pain relief, realistic preparation may help them maintain a sense of control. The experience for the partner and other present has sometimes been of not being in control of their feelings. They may fear for the partners and their child's safety but are unable to support or advocate for them.

Fear and being out of control are often associated with childbirth and these strong factors are also present in traumatic experiences. The degree of distress is often less associated with the events themselves but rather with perception of control, attitudes of people around, relationship with the maternity care provider, feelings of not being heard, the level of information provided and ability to consent.

PADA

Perinatal Anxiety and Depression Aotearoa is the national organisation committed to eliminating the stigma around perinatal mental health in New Zealand. We do this by championing awareness and facilitating best practice in perinatal mental health and wellbeing to ensure all families/whanau have access to appropriate information and support.

This resource is available to care professionals to assist in raising awareness of anxiety and depression in fathers.

We gratefully acknowledge the support of Trauma and Birth Stress (TABS) in preparing this resource.

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www.tabs.org.nz

Characteristic features of PTSD

PTSD can be acute (one to three months after the event), chronic (longer than three months) or of delayed onset (showing first symptoms six months after the event). Characteristic features of PTSD are grouped into three sets of symptoms:

- The first set relates to reliving aspects of the trauma, with nightmares or feeling as if it is taking place again.
- The second group comprises symptoms related to persistent avoidance of anything likely to remind the mother of the trauma.
- The third group includes symptoms that indicate heightened arousal, such as irritability, sudden intense startle, hyperarousal, shock reactions, negative alterations in cognition and mood, sleep disturbances, and sudden outbursts of anger.

What happens when someone experiences PTSD

When confronted with danger, humans have similar choices to animals; 'fight, flight or freeze'. Traumatic events not only alter brain chemistry but the actual structure of the brain.

Early recognition is important to ensure the timely discussion of treatment options.

Psychological trauma results when an individual experiences an adverse event which causes undue stress and is perceived to be beyond their control. When the event is unforseen and becomes an emergency for example developing pre-eclampsia or needing a caesarean section, it can be overwhelming.

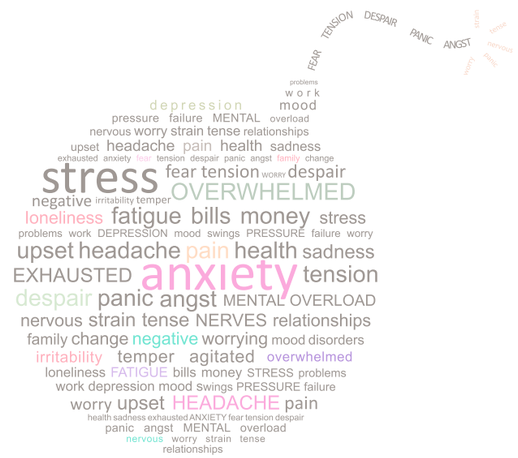
The emotional shock of extreme trauma causes the release of abnormally high levels of adrenalin and noradrenalin which inhibit the normal processing of memories. The sufferer is left with neurohormonal brain changes, which are vulnerable to surges of noradrenalin thus prompting alarm states.

The sensation of any sort of adrenalin surge acts as a cognitive cue for the sufferer to have flashbacks. These can be so distressing that the person will do anything to avoid a repetition of their trauma and so avoid stimuli which may symbolise some aspect of the traumatic occurrence. It may cause the woman to avoid all memory of her childbirth experience by not attending postnatal check-ups or having smear tests, or being reluctant to resume sexual activity or to have more children.

A recent UK study found that if one partner is distressed professionals need to be aware that the other partner may also need help; this is important in the context that healthcare professionals' main contact is currently with mothers. Men's distress appears to influence women's subsequent symptoms so more attention to men's mental health following the partner's childbirth may be beneficial to both

Caring for the carers

It is important for midwives, doctors and other health professionals to understand and monitor their own responses to traumatic events in the workplace.
All health care professionals should be familiar with the support provided within their professional community so they are able to talk the event through with a nonjudgemental and sympathetic person or a counsellor.



How PND and PTSD are differents

Postnatal depression (PND) is a major depressive, manic or mixed depressive disorder that occurs any time in the first year following childbirth, usually in the first four weeks). Symptoms include:

- frequent crying or feelings of sadness
- inability to sleep
- appetite changes
- difficulty in concentrating and making decisions
- feelings of worthlessness
- obsessive thoughts of inadequacy as a person and parent
- lack of interest in usual activities
- lack of concern about personal appearance
- persistent anxiety, irritability and hostility.s

PTSD is a psychological disorder that can occur following exposure to a traumatic event either as a victim or witness. The person has experienced an event that is outside the range of usual human experience and this trauma is persistently re-experienced as intrusive recollections of the event, distressing dreams of the event, flashbacks, and intense stress at exposure to events that symbolise the traumatic event. Symptoms include:

- Persistent avoidance of stimuli associated with the trauma
- Numbing of general responsiveness, such as deliberate avoidance,
- amnesia, diminished interest in activities, detachment, restricted range of emotions, sense of a foreshortened future.
- Persistent symptoms of increased arousal such as difficulty in falling or staying asleep, reactivity on exposure to events that resemble the traumatic event, outbursts of anger.

Factors that contribute to PTSD after childbirth

- Managed labour or induction
- Poor pain relief
- Feelings of loss of control
- Traumatic delivery
- Lack of contnuity of care
- Staff related problems
- Feelings of loss of control
- Not being believed or listened to
- Lack of attention to dignity
- Obstetric emergencies
- Invasive procedures without explanations or consent
- Forceps, suturing without adequate analgesia
- Conflicting advice
- Having baby/ies admitted to SCBUor NICU
- Severe postnatal anaemia
- Post Partum Haemorrhage
- Poor, or lack of, care
- Prior trauma, especially sexual or medical
- Unmet need to debrief, review or to understand what happened
- Post Natal problems

What the numbers tell us

THE NUMBER OF BIRTHS IN NEW ZEALAND IN 2018:

58,020

PREVALANCE OF PTSD FOLLOWING CHILDBIRTH OF WOMEN WHO HAVE ALL THREE CLASSIC SYMPTOMS OF PTSD:

2-6%

THE PERCENTAGE OF WOMEN WITH PARTIAL SYMPTOMS OF PTSD THAT CAN IMPACT TRANSISTION TO BEING A MOTHER:

20-30%

THE NUMBER OF WOMEN EACH YEAR WITH PARTIAL SYMPTOMS OF PTSD:

11,448 – 17,173

THERE IS NO NEW ZEALAND DATA ABOUT PTSD PREVALANCE, SO THESE FIGURES ARE BASED ON OVERSEAS STUDIES.