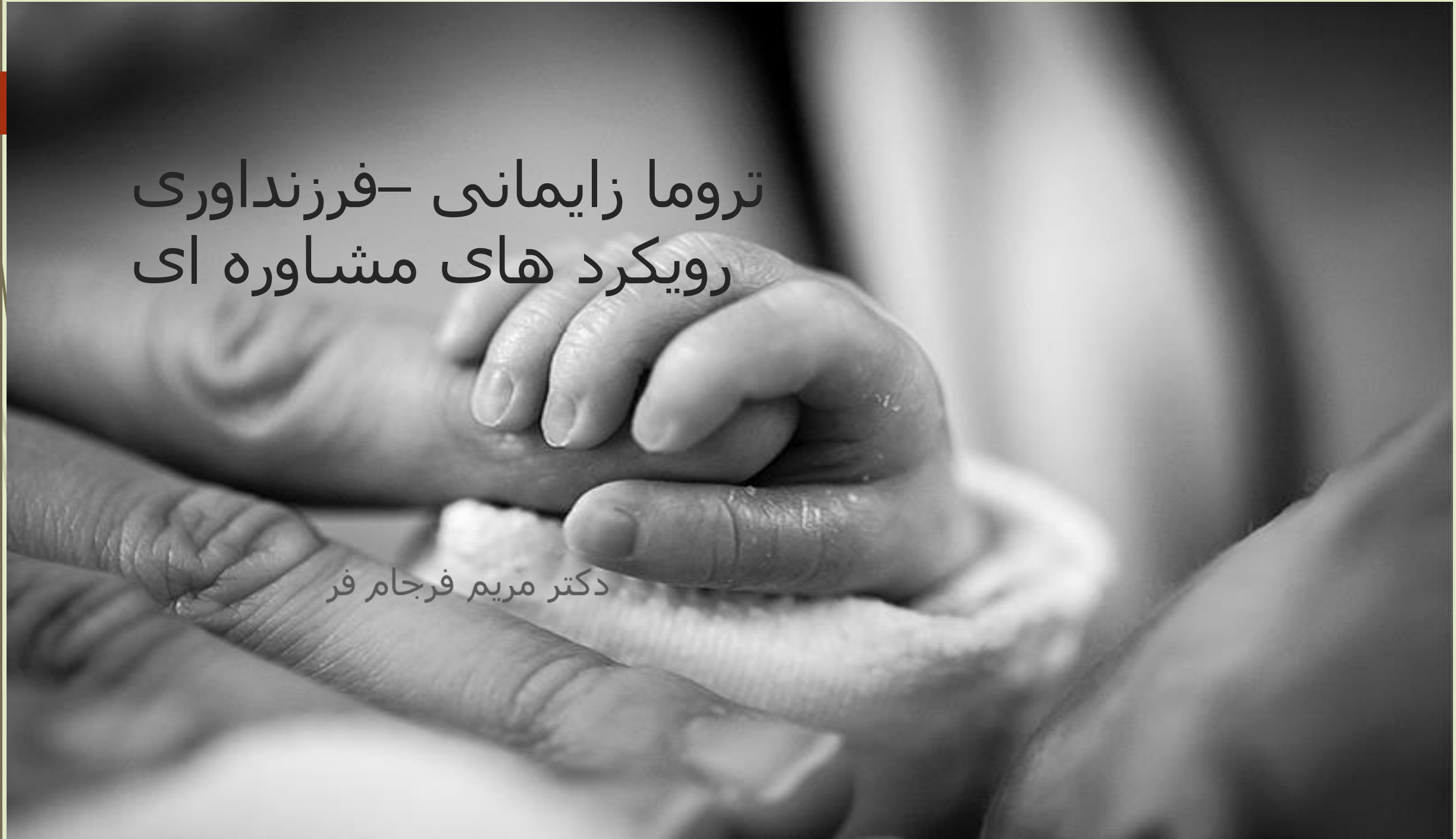


ترومای زایمانی –فرزندآوری
رویکرد های مشاوره ای

دکتر مریم فرجام فر

- between 20% and 48% of women around the world are reporting their birth experiences as traumatic.
- negative outcomes relat to maternal mental health, mother and infant bonding and infant and child development
- appears to be a worldwide phenomenon
- post-traumatic stress (PTS) at a rate of almost 30%
- extreme terminology such as ‘birth rape’ and ‘obstetric violence’

- the aims are to determine whether birth trauma can be predicted prospectively and what midwifery-led interventions or strategies can be used to reduce the number of women experiencing birth as a traumatic event and subsequent negative postpartum outcomes.

birth experience is multidimensional

- birth perception as a subjective judgement of a woman's global birth experience, indicating personal satisfaction with the birth process and outcome
- numerous factors: such as
  - fear for self and the infant,
  - medical interference,
  - perception of personal performance,
  - locus of control,
  - type of delivery,
  - ability to achieve priority expectations of birth,
  - adaptability when birth expectations are not met
  - cultural expectations and environmental factors

Other Factors

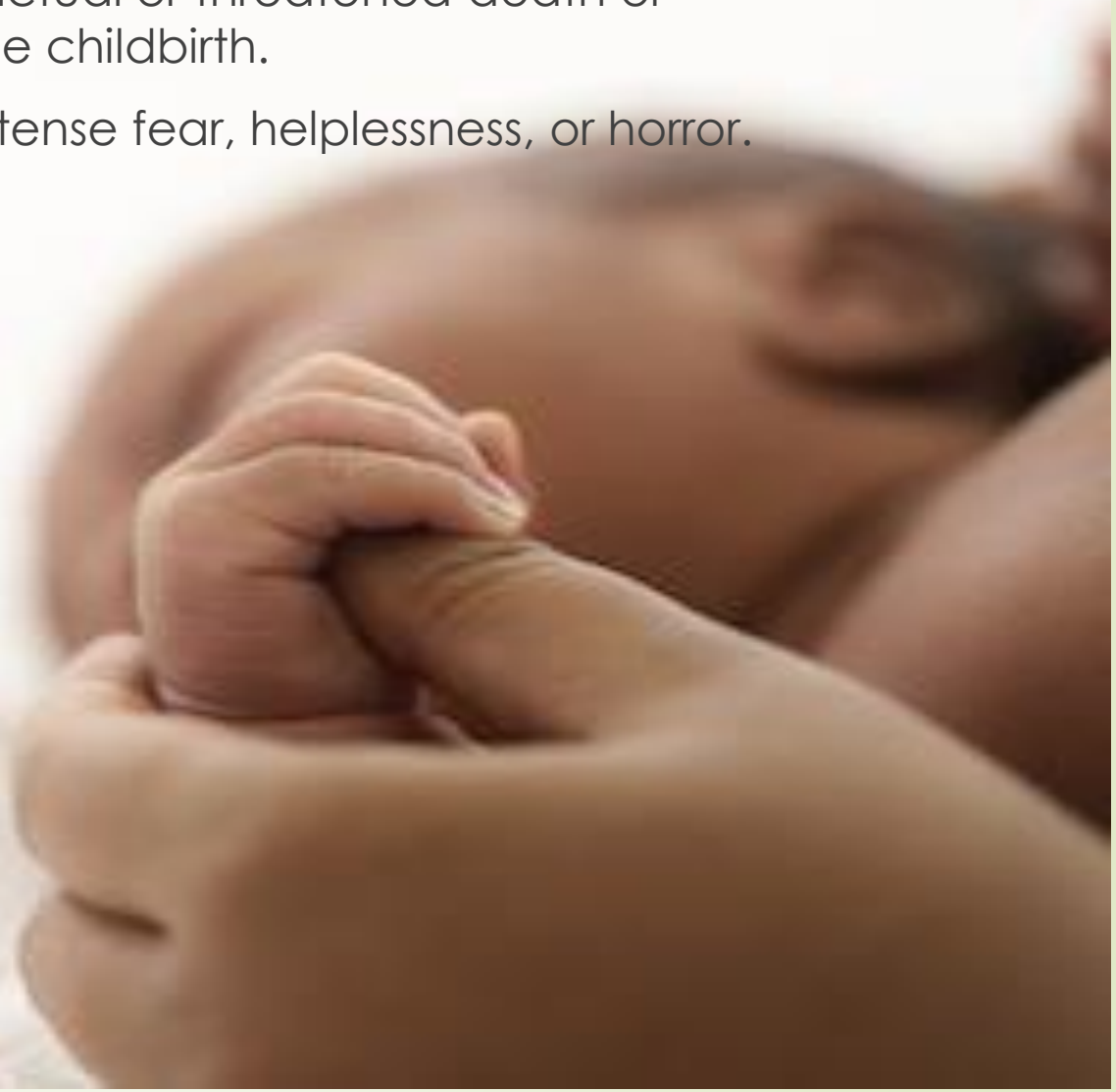
- birth experience is greatly affected by the Quality of the Provider Interactions (QPI) which is defined as the care providers verbal and non-verbal behaviours in relation to meeting the patient's stated and implied needs, as perceived by the patient.
- when women perceive care provider interactions as negative or unsupportive, these are considered to be low QPI. These low quality interpersonal interactions correlated with women's experiences of perinatal trauma symptoms and depression and women's long term memories of negative and traumatic birth experiences
- It was important to note that while the birth experience may appear uncomplicated to care providers, such as doctors and midwives, women may still find the event traumatic if she loses a sense of control or dignity, which can arise from interpersonal interactions that are hostile or disrespectful

antenatal risk factors

- pre-existing mental health morbidity or prior traumatic event.(the world as an unsafe place
- Only 30% of women requiring an emergency caesarean section reported their birth as a traumatic event. This may indicate that other factors were involved or influencing their experience of birth as a traumatic event

PBT

- Had experienced an event that involved actual or threatened death or injury for themselves or their baby during the childbirth.
- Their response about childbirth involved intense fear, helplessness, or horror.



Incidence

- A United States-based study reported the incidence of PBT as 34%;
- 34.3% of those experiencing trauma, had some PTSD symptoms and 5.7% were fully symptomatic .
- 54.5% of women in Iran reported their birth experiences as traumatic

Complication of birth trauma

- Birth trauma can have a profound psychological impact on women, such as having intense negative responses towards themselves and others and developing dysfunctional coping strategies to deal with nightmares and flashback related to their birth experiences
- felt a *great sense of loss* related to their experience of birth, motherhood, ideal family and/or sense of self.
- Other symptoms reported included *sexual dysfunction* and *intimacy issues*, *difficulty forming positive attachment with their infant*, *disruption to family life* and *suicidal ideation*
- A major theme was fear of childbirth or secondary **tocophobia**, which was associated with women making a conscious decision to not have any further pregnancies or elect to have a caesarean section for future births

Risk factors for postpartum post-traumatic stress disorder

- 1.7–9% of childbearing women
- particular symptoms such as
  - persistent, involuntary and intrusive memories,
  - avoidance of stimuli,
  - recurrent distressing dreams,
  - dissociative reactions,
  - altered mood state and
  - intense or prolonged psychological distress following exposure to a traumatic event

risk factors for developing PTSD following childbirth

- prior diagnosis of PTSD symptoms,
- quality of interactions with medical staff and
- perceived social support
- had unplanned pregnancies
- had no health insurance,
- were pressured to have their labour induced or
- use epidural analgesia in labour,
- experienced birth by caesarean section,
- did not breastfeed as long as they desired,
- had less partner support postpartum and
- experienced increased physical problems after birth

Birth experience as a risk factor

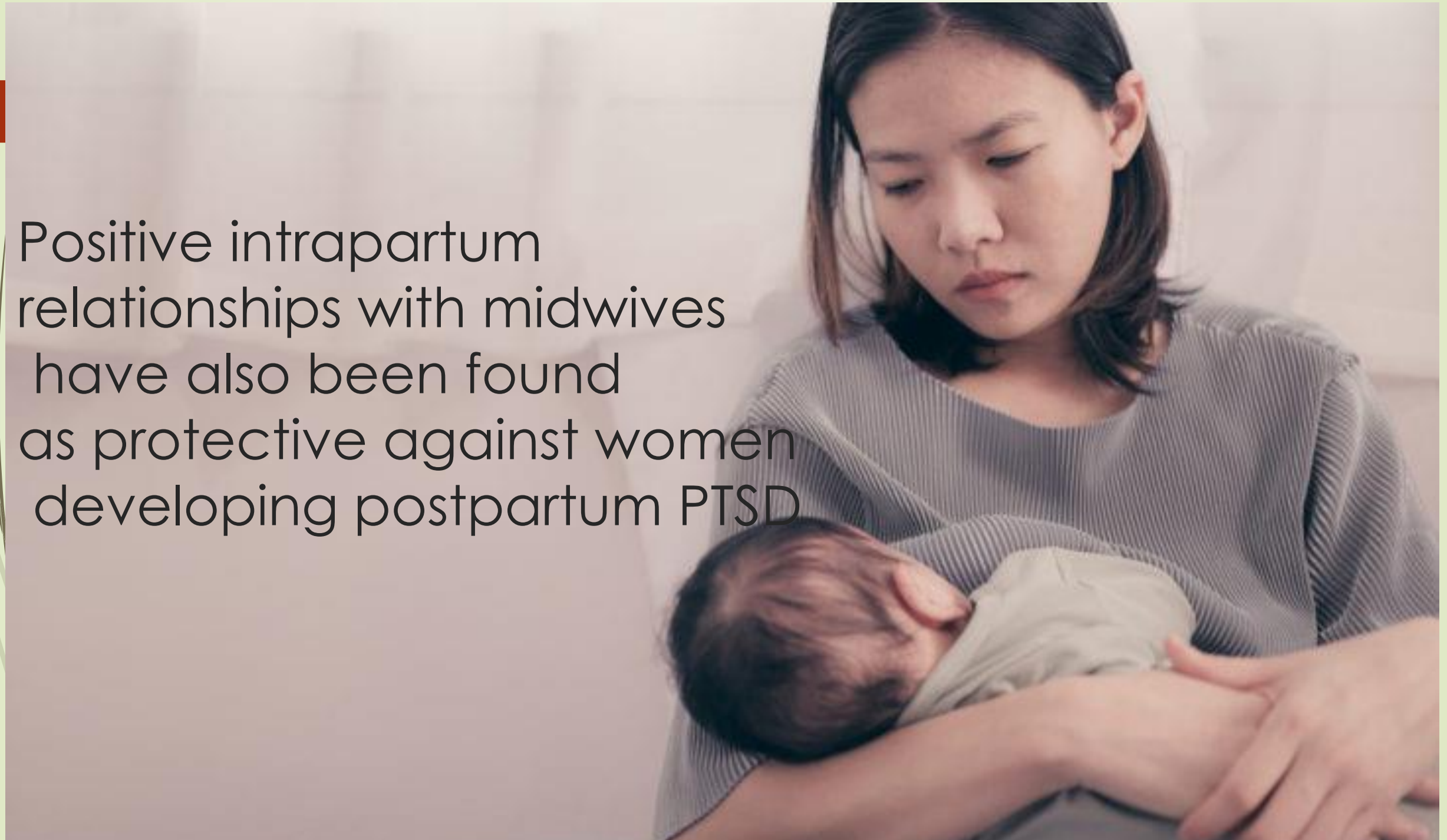
- A lack of control over the birth experience as a risk factor for developing PTSD
- depression during pregnancy and the number of interventions experienced during labour and birth,
- although the association between obstetric intervention and PTS symptoms in general was described as weak

Pathological symptoms

- irritability and sleep disturbance are somewhat normal in the postnatal period. It is suggested that screening for symptoms such as intrusive thoughts and nightmares related to the birth experience may be more indicative of postnatal PTSD.

it was concluded that the most important predictive factor for developing postpartum PTSD was a prior traumatic life event

Positive intrapartum relationships with midwives have also been found as protective against women developing postpartum PTSD



The impact of a traumatic birth experience on women, infants and families

- women feel overwhelmed, angry, disappointed and a sense of loss after a traumatic birth which was overwhelmingly due to poor or unsupportive care from midwives, nurses and doctors
- Disconnecting from their partners and infants and experiencing symptoms of depression, sometimes with reports of suicidal ideation.
- Infants of women with poor mental health often had poorer cognitive functioning, physical, psychosocial, emotional and behavioural disturbances and impaired language functioning
- importance of assessing and managing postpartum PTS symptoms early, in order to improve maternal mental health and reduce negative impacts of these symptoms on mother and infant bonding

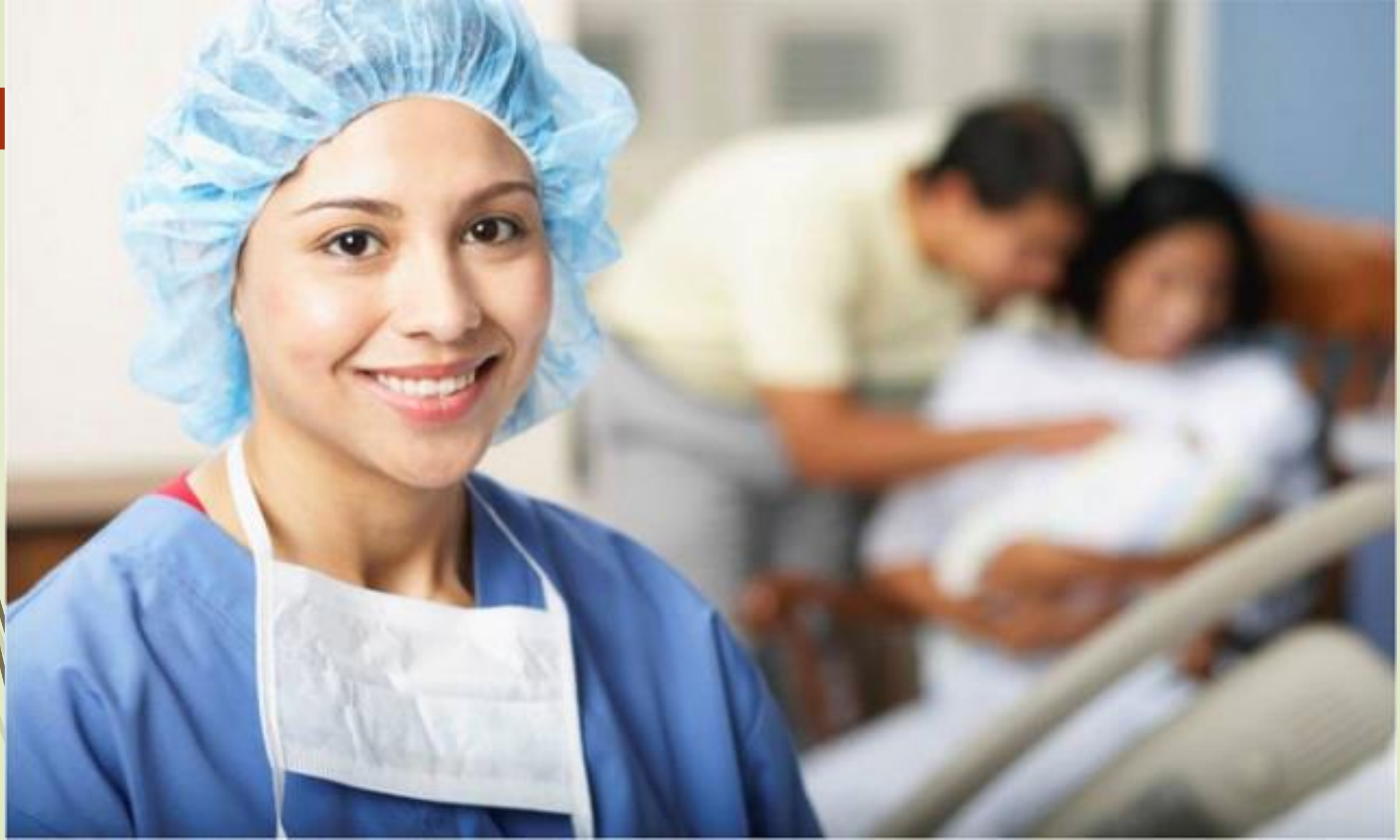
fear of childbirth, or secondary tocophobia, resulting in requests for elective caesarean section and avoidance of further pregnancies

Midwifery-led interventions

- postnatal debriefing
- opportunity to discuss their birth experience and validate their feelings
- specific counselling intervention: a midwife-led
- counselling intervention, known as PRIME (Promoting Resilience In Mothers Emotions)
- In the antenatal period, one strategy involved flagging women who had pre-existing mental health concerns, such as anxiety, depression and previous experience of a traumatic event
- It is vital that women develop a good rapport with their care providers and that their labour and birth care is tailored to meet their individual needs

Table 4 Themes, categories and perceived strategies to reduce PBT amongst childbearing women

Skill-builder knowledge	Responsible caregiving	The alliance of prenatal and antenatal care	Reconstruction of the structures
Birth preparedness	***Support loop***	***Continuity of care***	***Efficient management****
1. Providing realistic information about childbirth	1. Birth companion	1. Continuity of care by the same midwife(s) from prenatal to postpartum	1. The adoption of new laws*
2. Birth adjustment skills training	2. Caregivers' supportive behavior	2. Supporting the private sector of maternity care*	2. Monitoring the implementation of laws*
3. Upgrading the quality of childbirth courses	3. Supporting through one to one care	***Coordination of prenatal and antenatal caregivers***	3. Financing the personnel*
4. Birth plan preparation	4. Special support in emergency situations	1. Coordinating the goals of prenatal and childbirth care*	4. The use of human resources*
5. Encouraging mothers to take part in childbirth courses*	5. Gaining support from mother' s social networks during pregnancy	2. National electronic prenatal-care records system*	5. The appropriateness of the description of tasks with the capacity of labor*
6. Setting up virtual childbirth courses	6. Providing conditions for support from peers*	3. Setting the regional referral system to connect health-centers and hospitals*	6. Scoring system for health settings*
7. Reproductive health education to different age groups*	***Good behavior of the caregivers***	4. The clarity of prenatal records for birth attendants	***Rebuilding physical structures****
Mothers' empowerment in maintaining mental health*	1. Good-humored health staff		1. Creating an inviting labour wards*
1. Self-care for mental health*	2. Respectful maternity care		2. Covering any visible hospital equipment*
2. Promoting Spiritual Health*	3. Knowledge and prosperity are the cornerstone of good behavior*		
Understanding the importance of mental care in maternity services*	***Deepening trust***		
	1. Getting familiar with the birth attendant during prenatal period		
	2. Getting mother's trust from the first encounter		
	3. Providing timely information for		



Skill-builder knowledge

- Information that can potentially create or reinforce a person's skills is called Skill-builder knowledge.
- The strategies of this theme are training the mother and the medical staff. (referred to strategies that will improve the mother's skills in adjusting to the labour process through education)
- ***mothers' psychosocial empowerment training***
- ***"Maternal mental health can be promoted through special education.*** **Prenatal training should** ***include skills for effective communication, coping with stress, managing interpersonal relationships, and decision making in critical situations".***

Responsible caregiving

- Clinical caregivers can reduce the likelihood of PBT by modifying their approach and changing the way(s) that maternity care is provided
- Supporting mother was identified as the most valuable evidence-based approach in preventing childbirth trauma, which is provided by the birth companion, relatives of the mother, caregiver staff, and peers in group care*, all of whom can be accessed through direct supervision and guidance of the one responsible for mother's care.
- Some data suggested that fear and anxiety would be far from the mother if she had deep trust in her caregiver.
- Caregivers should therefore adopt approaches that can strengthen the mother's trust during pregnancy, throughout e.g. responding to their needs

Responsible caregiving

- health system should consider measures that can identify individuals with high-risk mental problems during pregnancy, so caregivers will be able to provide some special interventions for those individuals
- Labour pain relief is an issue related to the responsible caregiving
- pain reduction methods, i.e. epidural anesthesia cannot prevent the development of PBT on their own. Rather, accepting the labour pain is mentioned to be an effective way for preventing PBT

The alliance of prenatal and antenatal care

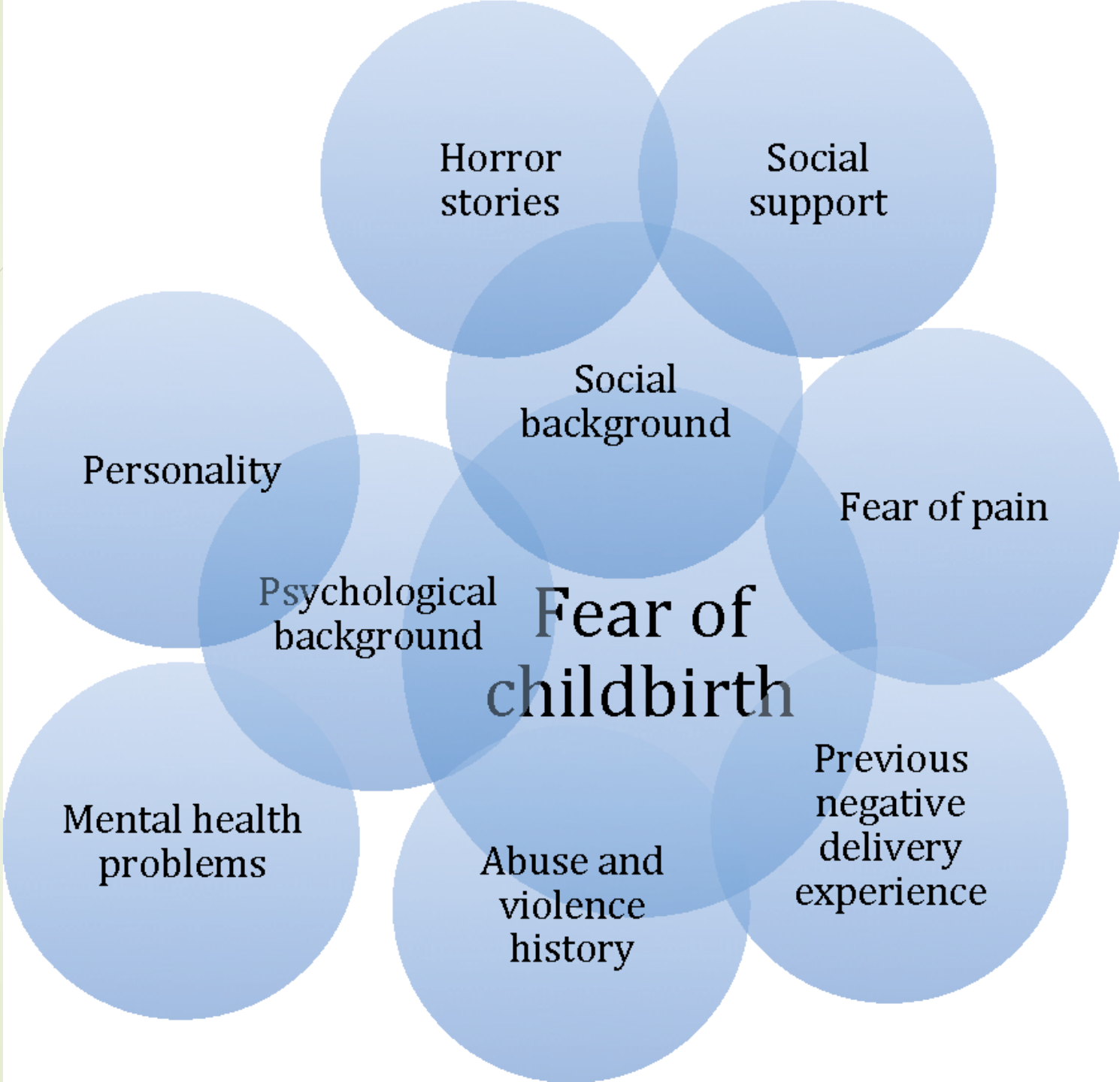
- The inconsistency between prenatal care goals and childbirth care is among the most important identified problems.
- continuous care by one person or a specific care team from the beginning of pregnancy until childbirth, as an effective solution for preventing PBT
- alternative methods such as national electronic prenatal-care records systems* were proposed for coordinating caregivers

Reconstruction of the structures

- adoption of new laws*, monitoring the implementation of laws*, financing personnel*, the use of human resources*, appropriateness of the description of tasks with the capacity of labor*, and the renewal of labour wards
- new laws:“increasing the autonomy of the midwives”, “hospitals’ grading based on their quality of care”, and “fair-wage pay for midwifery care”

PBT in Iran

- In Iran, where the prevalence of PBT(Psychological Birth Trauma) is higher than the global average (54.5%) , most of these strategies are not widely used.
- Mothers might not be wellprepared for labour, medicalization is common among caregivers, no companions are allowed in many labour wards, prenatal care is entirely separate from childbirth care, and clinical monitoring and evaluation are not perfect.
- Few of PBT strategies are available in some public and private health centers in Iran, which may benefit from major reforms. This might be inevitable, because most birth preparation courses in Iran are not skill generating and deal only with physiology of childbirth


Horror stories
Social support
Social background
Personality
Fear of pain
Psychological background
Fear of childbirth
Mental health problems
Previous negative delivery experience
Abuse and violence history

FOC
Cognitive Behavioral Therapy

- Internet-based cognitive behavioral therapy (ICBT):consists of self-help material that is accessible online, divided into modules with homework assignments designed to help women with FOC learn to recognize and cope with their emotions about the upcoming birth

FOC
Individual Counseling and Group Therapy

- Women with severe FOC receiving individualized counseling based on both antenatal psycho-education and CBT were more likely to opt for VB than those not receiving such counseling
- Primiparous women receiving individual counseling based on Gamble and Creedy's counseling model that draws on CBT had reduced FOC scores . This type of intervention focused on attitudes towards childbirth, communication, developing plans to manage negative events, and expressing and managing emotions during pregnancy

FOC
Individual Counseling and Group Therapy

- women receiving counseling from midwives, obstetricians, psychologists ,social workers, or psychiatrists had FOC scores 1 year after birth five times higher than those who did not receive counseling
- Group therapy sessions focused on mentalization and the mind-body connection is a viable treatment option. When administered by psychologists trained in group therapy and pregnancy issues, it was found to be effective in reducing FOC and negative emotions about birth

FOC
Educational Interventions

- "BELIEF" (Birth Emotions and Looking to Improve Expectant Fear) investigated the efficacy of a telephone psycho-education intervention given by midwives to women with high FOC
- Childbirth education sessions designed to provide pregnant women with information about labor and birth, familiarizing women with the delivery room, and breathing techniques were found to decrease FOC significantly , with no effect on CS rates

FOC
Alternative Treatments

- self-hypnosis training
- Haptotherapy: is a type of complementary therapy that involves the use of touch to achieve mental relaxation, as well as interventions, such as talking and counseling, to assist individuals in getting in touch with their feelings. It is based on haptonomy, referred to as a science that combines thoughts, feelings, and words through a "psycho-tactile" contact.
- exercise classes

PTSD

- PTSD is a diagnosis that is applied when the traumatic event or events result in a constellation of symptoms:
- negative changes in cognition and mood,
- intrusion (unwanted memories or thoughts),
- avoidance,
- and a state of hyperarousal. Not all survivors of trauma have a memory of the traumatic event, though they may manifest symptoms and signs of trauma with or without PTSD.

warning signs of possible prior trauma and/or PTSD

- Physiologic reaction of distress, such as a startle response to loud sounds
- Negative alterations in cognition and mood, such as flat or angry affect, that can arise unpredictably or with subtle triggers
- Somatic symptoms including headache, insomnia, weight loss, abdominal pain, and sexual dysfunction
- Avoidance behavior of any sensory reminders of the traumatic event
- Hyperarousability, hypervigilance, and/or increased anxiety
- Dissociation
- Extreme distrust or dislike of the provider or others in positions of power

Preventing post-traumatic stress disorder following childbirth and traumatic birth experiences: a systematic review

- When women evaluate their delivery, four factors predominate in the rating of this birth experience:
- the availability of support from caregivers,
- the quality of relationships with caregivers,
- being involved in decision-making,
- and having high expectations or having experiences that exceed expectations

- maternal PTSD leads to a lower birthweight and lower rates of breastfeeding

Preventing post-traumatic stress disorder following childbirth and traumatic birth experiences: a systematic review

- All evaluated secondary prevention, and none primary prevention
- Interventions included debriefing, structured psychological interventions, expressive writing interventions, encouraging skin-to-skin contact with healthy newborns immediately postpartum and holding or seeing the newborn after stillbirth.
- The large heterogeneity of study characteristics precluded pooling of data.
- The writing interventions to express feelings appeared to be effective in prevention.
- A psychological intervention including elements of exposure and psycho-education seemed to lead to fewer post-traumatic stress disorder symptoms in women who delivered via emergency cesarean section.

- Continuous support during delivery was found to have a significantly positive effect on the birth experience.
- women attribute their traumatic childbirth experience to:

✓ a lack or loss of control,

✓ to suboptimal communication with health practitioners,

✓ and to too little practical and emotional support.

➢ Consequently, awareness of these factors among health practitioners could lead to a different role during labor and consequently to fewer traumatic events.

- an active approach to prevent or treat PTSD and PTSD symptoms at an early stage could perhaps also lead to fewer or less severe cases of PTSD.
- This can primarily be done by identifying women who had a traumatic birth experience.
- Because a seemingly uncomplicated childbirth can lead to PTSD symptoms, the first step in recognizing a traumatic birth experience is openly to ask each postpartum woman about her feelings and thoughts concerning the delivery.

questionnaires

- Wijma Delivery Expectancy/Experience Questionnaire (version B)
- the Delivery Satisfaction Scale

Table 5. Maternal satisfaction scale for caesarean section

Each question is followed by a Likert scale as below.

☐ ☐ ☐ ☐ ☐ ☐ ☐

Strongly disagree Strongly agree

ANAESTHETIC

1. I was pain free during my caesarean section.
2. I felt the anaesthetic I received was safe for me.
3. I felt the anaesthetic I received was safe for my baby.

INSERTION OF NEEDLE IN THE BACK

4. I had no pain when the needle was put into my back.
5. The needle was put easily into my back.
6. I was in a comfortable position when the needle was put into my back.

SIDE-EFFECTS

During the caesarean section, I did NOT experience the following:

7. Shivering
8. Dry lips/mouth
9. Dry throat
10. A change in mood

After the caesarean section, I did NOT experience:

11. Back Problems
12. Itchiness

ATMOSPHERE

In the operating room, during the surgery, I was able to:

13. Interact with my partner
14. Bond with the baby
15. Have a sense of control
16. Communicate with the staff
17. See the baby after delivery
18. Hold the baby after delivery

19. I knew what the staff were doing during the operation.
20. I found the atmosphere in the operating room comfortable.
21. I was able to nurse my baby after delivery

PTSD

- CBT(ICBT)
- Education : antenatal education with role play reduced the severity of PTSD symptoms in nulliparous women
- midwife-led interventions(Studies of midwives who received special training to address perinatal psychological issues showed promising results)
- Debriefing
- Hypnosis

Coping skills training

- these interventions do not focus on the patient's trauma

- Role playing
- Assertiveness training
- Stress management
- Relaxation exercises
- Biofeedback (eg, using electromyography, heart rate, or respiration rate)
- Teaching sleep hygiene
- Recommending exercise

EYE MOVEMENT DESENSITIZATION AND REPROCESSING(EMDR)

- The technique involves the patient imagining a scene from the trauma, focusing on the accompanying cognition and arousal, while the therapist moves two fingers across the patient's visual field and instructs the patient to track the fingers.
- The sequence is repeated until anxiety decreases, at which point the patient is instructed to generate a more adaptive thought.
- An example of a thought initially associated with the traumatic image might include, "I'm going to die," while the more adaptive thought might end up as, "I made it through. It's in the past."

OTHER PSYCHOTHERAPIES

- INTERPERSONAL THERAPY
- MINDFULNESS-BASED STRESS REDUCTION
- Acceptance and commitment therapy (ACT)
- Psychodynamic psychotherapy
- Eclectic psychotherapy

INTERPERSONAL THERAPY

- which focuses on disorder-specific symptoms and impairment in the context of current interpersonal relationships, has demonstrated efficacy for PTSD in a clinical trial

MINDFULNESS-BASED STRESS REDUCTION

- which teaches patients to attend to the present moment in a nonjudgmental, accepting manner, led to modest reduction of PTSD symptoms in a clinical trial

APPROACH TO TREATMENT

- It's suggested trauma-focused cognitive-behavioral therapy (CBT) as first-line treatment of patients with acute stress disorder (ASD) rather than other psychotherapies or medication

- CBT for ASD patients should typically be provided by a trained clinician over **six weekly sessions of 60 to 90 minutes**; additional sessions can be added if necessary.
- The intervention is typically delivered at least **two weeks after trauma** exposure. This allows the individual additional time for transient symptoms to abate and for post-trauma stressors to ease
- The commencement of therapy should be timed with respect for other stressful events stemming from the trauma. The patient may find it difficult to focus attention on therapy if distracted by trauma-related events or experiences, such as pain, surgery, legal proceedings, relocation, or other stressors.

Trauma-focused CBT

- Trauma-focused CBT for ASD typically includes:

1. patient education,
2. cognitive restructuring,
3. and exposure

Patient education

- Patients are educated about:
- stressful reactions to trauma,
- trauma-related disorders,
- and treatment options

Educating patients about stressful reactions to trauma should aim:

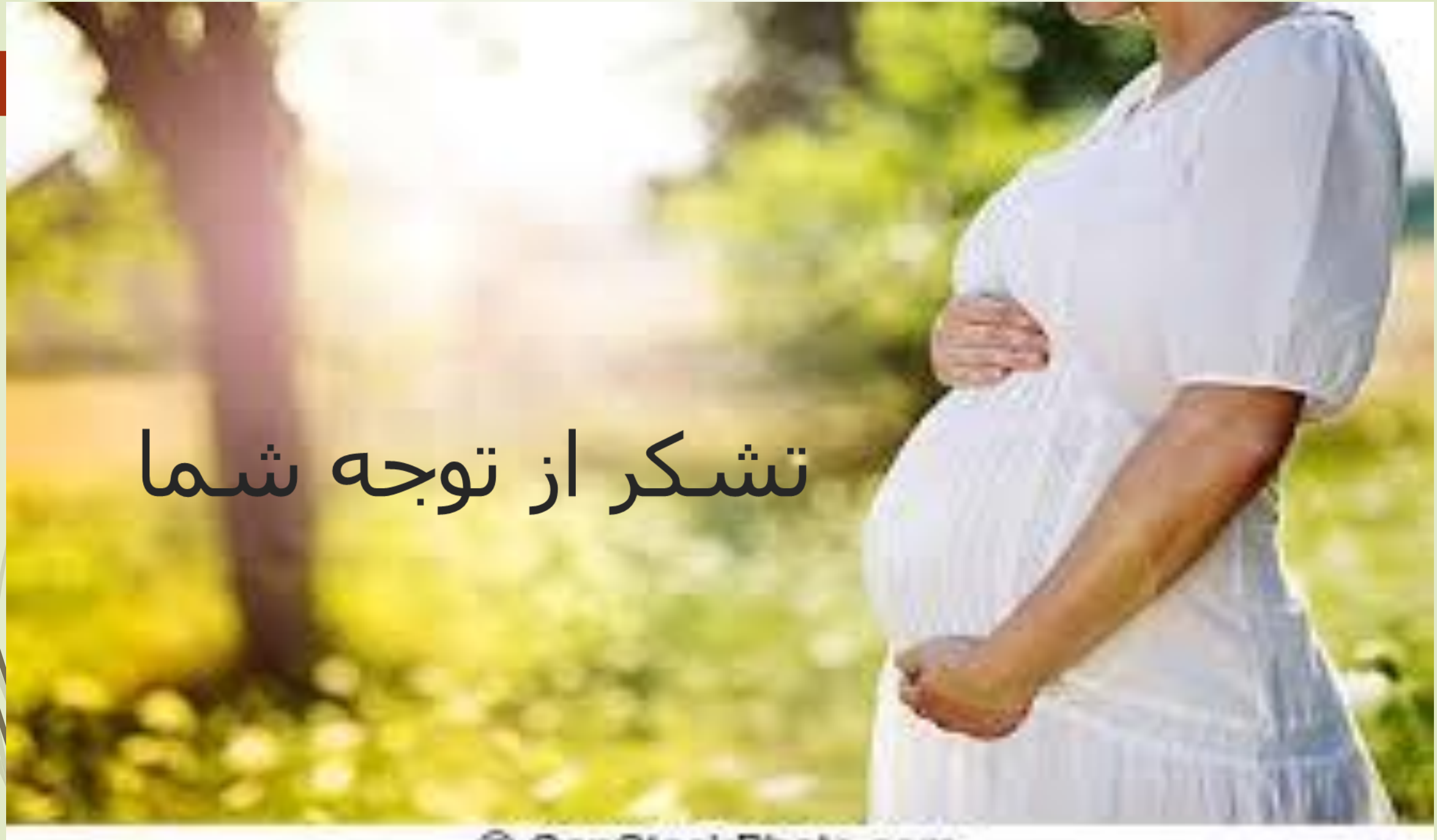
- Normalize the stress response
- Heighten expectancy of recovery
- Explain the stress responses in terms of conditioning models that require the patient to learn that reminders are no longer dangerous

Cognitive restructuring

- Cognitive restructuring is used to address maladaptive or unrealistic appraisals the patient may have about the *trauma*, his or her *response to the event*, and *fears of potential future harm*.

Exposure

- Exposure therapy assists patients in confronting their feared memories and situations in a **therapeutic manner**
- Re-experiencing the trauma through exposure allows it to be emotionally processed so that it can become less painful
- includes both imaginal exposure and in vivo exposure


تشکر از توجه شما