

# The Psychological Impact of Birth Experience: An Underreported Source of Trauma in the Lives of Women

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The birth of a child, especially a first child, represents a landmark event in the lives of all involved. For the mother particularly, childbirth exerts a profound physical, mental, emotional, and social effect. No other event involves pain, emotional stress, vulnerability, possible physical injury or death, permanent role change, and includes responsibility for a dependent, helpless human being. Moreover, it generally all takes place within a single day. It is not surprising that women tend to remember their first birth experiences vividly and with deep emotion (Simkin, 1992, p. 64).

In her landmark study, Simkin (1991; 1992) described how women vividly remembered details of their first births, even 20 years later. And what they remembered had a lasting impact on how they felt about themselves as women and as mothers. Unfortunately, birth can be a traumatizing experience, with some women likening their birth experiences to sexual assaults. Yet health care providers are often blithely unaware of the havoc they have created, as Beck (2004a) observes.



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outcomes of clinical efficiency and live healthy infants (p. 34).

Several recent studies have found that women can develop posttraumatic stress disorder (PTSD) after birth. Beck (2004b) reviewed this literature and noted that the percentage of women who met full criteria for PTSD following birth ranged from 1.5 percent to 6 percent. The study with 1.5 percent excluded women who had had previous episodes of either depression or PTSD—the women most potentially vulnerable. Even if women do not meet full criteria, up to 30% can have trauma symptoms (Soet, Brack, & Dilorio, 2003). Unfortunately, trauma after birth is by no means a rare problem.

## What Makes an Experience Negative?

When researchers first started studying trauma related to birth, they consistently found that quality of birth experience had relatively little impact on women's mental health. These findings were in stark contrast to the stories women were telling themselves. One reason for this confusion, I believe, was that researchers were often seeking to define "good" and "bad" in terms of objective characteristics: length of labor, use of pain medications, medical interventions, and type of delivery. Indeed, the most typical way that researchers have considered the question of negative birth experiences is

to compare women's reactions to cesarean vs. vaginal births, assuming that vaginal deliveries are usually positive, and cesareans are usually negative. Objective factors do have some influence but they cannot fully explain women's reactions to birth. Indeed, a woman's subjective experience of her care is far more predictive of her reaction.

## Women's Subjective Experience of Events

According to Figley's (1986) conceptualization, events are troubling to the extent that they are "sudden, dangerous, and overwhelming." These characteristics have a great deal of relevance to birth.

- **Suddenness** occurs when an event strikes and there is not time to prepare, devise an escape plan, or prevent the event. This certainly occurs when women are in the hospital and in labor; change can happen in seconds, and there may be little time to react.
- **The dangerousness** of the situation is the second element. Many women perceive that labor is life-threatening for themselves or their babies. In terms of PTSD, it is the mother's perception that matters, not whether her perceptions are medically "true." The situation is similar to a crime victim who believes that she will be killed—even if the criminal had no intention of killing her. What she believes is much more relevant to her subsequent reaction than the medical facts associated with the event. Unfortunately, health care providers often unwittingly compound this reaction by saying something like, "if you had been out on the prairie, you would have died."
- The final element is the extent to which the situation is **overwhelming**. Some women describe being swept away by their birth experiences and the hospital routines. Being overwhelmed leads to a sense of helplessness and loss of control. The same can be true for her partner.

Sally's emergency cesarean had all three aspects that are likely to put women at risk for traumatic-stress reactions. Her baby was born within 15 minutes of when the cord prolapsed after having been in labor for 23 hours. (A prolapsed cord is potentially life-threatening complication that necessitates immediate cesarean delivery.) Her delivery was by cesarean section under general anesthesia.

They had me on the bed, rear end in the air. My head was down between the headboard and the mattress. The nurse had to hold the baby off the cord. All I kept hearing was "OB emergency, OB emergency" over the loud speaker, while the nurse kept saying in my ear that the baby would be fine. Everything happened so quickly, I didn't have time to react.

Cheryl Beck, in her study of women who had traumatic deliveries, also found that perceived danger predicted negative reactions. She noted that birth trauma was likely to occur

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## Psychological Impact of Birth...

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when the women perceived that they or their babies were in danger, and the birthing women themselves experienced “overwhelming fear, helplessness, loss of control or horror” (2004a, p. 28). Related to that is women’s perceived level of care. If women felt cared for during their births, they were more likely to perceive them positively. In contrast, women in Beck’s study described their care providers as cold, mechanical or uncaring, and that they felt degraded or raped after their experiences.

Women’s sense of power and control can also influence their reactions. Women who felt like they had no control were more likely to react negatively. Perceived control can also explain why women can feel positively about an objectively difficult birth: if they felt that they had a say in what happened to them vs. that others made the decisions about their care (Kendall-Tackett, 2005).

Elizabeth’s story illustrates this point. Her chart would, no doubt, indicate that her birth went well, with no complications. However, that was not her interpretation of events. And she was still troubled by her experience several years after it occurred. Her birth took place in a large, respected New York City hospital.

I had 25 hours of labor. It was long and hard. I was in a city hospital. It was a dirty, unfriendly, and hostile environment. There was urine on the floor of the bathroom in the labor room. There were 100 babies born that day. I had to wait 8 hours to get into a hospital room post-delivery... There were 10-15 women in the post-delivery room waiting for a hospital room, all moaning, with our beds being bumped into each other by the nursing staff. I was taking Demerol for the pain. I had a major episiotomy. I was overwhelmed by it all and in a lot of pain. I couldn’t urinate. They kept catheterizing me. My fifth catheterization was really painful. I had lots of swelling and anxiety because I couldn’t urinate. My wedding ring was stuck on my finger from my swelling. The night nurse said she’d had patients that had body swelling due to not urinating and their organs had “exploded.” Therefore, she catheterized me again. They left the catheter in for an hour and a half. There was lots of pain. My bladder was empty but they wouldn’t believe me. I went to sleep and woke up in a panic attack. I couldn’t breathe and I couldn’t understand what had happened.

Beck (2004a) noted how women in her sample were terrified by the hospital experience itself. These women trusted the hospital staff to provide safe care—trusting not only their lives, but the lives of their babies—and the doctors and nurses provided unsafe care. In summarizing these women’s experiences, Beck (2004a) noted the following.

Women who perceived that they had experienced traumatic births viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance (p. 34).

## A Tale of Two Births: One Woman’s Story

In this section, I share one woman’s story of her two births. Each birth was difficult, but for different reasons. Both of these stories have elements that I described above—fear of dying, overwhelming pain, experiences that overpowered her, and re-experiencing of events.

When Peter was born, the birth itself was pain free. He was small, especially his head and shoulders, and it truly didn’t hurt at all. I kept insisting I wasn’t really in labor up until two minutes before he was born, when the doctor told me to lie down, shut up and push! But afterwards, he was born at 9:30, they told us he had Down syndrome at noon, and by 4 p.m., I was hemorrhaging so badly that I came within two minutes of death. I had to have an emergency D & C with no anesthesia (talk about PAIN!!) and a big blood transfusion.

That night, they told us Peter needed immediate surgery and had to go to a hospital in another city. A very traumatic day, to say the least. And then they sent me home the next day with no mention at all that I might want to talk to somebody about any of this—the Down syndrome, the near-death experience, nothing. I can still call up those memories with crystal clarity. And whenever we hear about another couple, I have to re-process those feelings. Interestingly, most of them relate to the hemorrhaging and D & C, not to the Down syndrome “news.” They’re all tied up together. Maybe it’s good to remind myself every so often of how precious life is.

My third birth was excruciatingly painful—baby was 9 lbs 3 ounces, with severe shoulder dystocia—his head was delivered 20 minutes before his shoulders. I had some Stadol in the IV line right before transition, but that’s all the pain relief I had. I thought I was going to die, and lost all perspective on the fact that I was having a baby. I just tried to live through each contraction.

That night, after Alex was born (at 9 in the morning), I could not sleep at all because every time I tried to go to sleep, my brain would start re-running the tape of labor, and I would feel the pain and the fright and the fears of dying all over again. I stayed up all that night and the next day, and didn’t sleep until I was home in my own bed.

In these stories, we see some classic symptoms of a posttraumatic response: fear of dying, re-experiencing the event, sleeplessness. She did eventually come to a place of peace over her experiences, but the memories of those two episodes of labor have remained vivid.

## What Might We Expect in Ethnic-Minority Populations?

Research on this topic is relatively new. And as has been the case with other areas of women’s health research, White middle-class women were the first to speak out on this issue. Researchers have not yet documented the experiences of ethnic-minority women and other populations that might be more adversely impacted by a typical American birth. However, clinicians working with a perinatal population can make some reasonable hypotheses based on clinical experience. Ethnic-minority women, particularly immigrant women who may not speak English, may find themselves even more overwhelmed by American hospitals than their White counterparts.

Health disparities between White and minority women are also obvious when it comes to birth. Ethnic-minority women have dramatically higher rates of both preterm birth and infant mortality—increasing the likelihood that their

births are dangerous and high risk (Banks et al., 2005). In addition, women who are teens or low-income may also have late or no prenatal care and may be giving birth without preparation. What these clinical observations suggest is that what White women experience as dangerous or frightening can be even more so for women of color.

### Summary

Childbirth is a very common event in the lives of women. Unfortunately, it can also severely impact women in ways that have them reeling for months and years after. And because there is generally a happy outcome associated with their experiences (i.e., a healthy baby), women may find that no one wants to talk with them about what happened. Birth can cause psychological trauma on its own, and it can trigger memories of previous traumatic events. In working with trauma survivors, or researching trauma in the lives of women, it's important to recognize this relatively common source.

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## Pediatric Psychology Partnership for Abuse Prevention: An Exportable Model for Teaching Graduate Psychology Trainees to Assess for and Intervene in Intimate Partner Violence

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Intimate partner violence (IPV) is prevalent and takes a significant toll on the psychological and physical health functioning of women and their children (e.g., Golding, 1999; Kitzmann, Gaylord, Holt, & Kenny, 2003; Plichta, 2004). In 1999, the American Psychological Association adopted the Resolution on Male Violence Against Women (American Psychological Association, 1999), asserting, among other things, that psychologists play an important role in recognizing, intervening and preventing violence against women through research, practice and policy efforts. Moreover, the resolution urged enhanced training of psychologists to recognize and treat victims of violence. Excellent recommendations for educating trainees in assessing for/intervening in partner violence exist in the form of specialized IPV courses (e.g., Intimate Partner Abuse

and Relationship Violence Working Group, 2001); however, graduate psychology programs are often unable to augment already full courses schedules with an additional specialized course or add specialty training tracks. If psychology hopes to prepare psychologists in the area of partner violence, training programs need exportable curricula that can be integrated within the existing program design. The Pediatric Psychology Partnership for Abuse Prevention (PPPAP) is a Graduate Psychology Education project, funded by the Health Services and Resources Administration since 2002, designed to enhance graduate education in recognizing and intervening in IPV using culturally sensitive methodologies. The curricular enhancements, which were integrated within the extant graduate program, provide guidelines on how psychology trainees can receive universal exposure to IPV-related issues and how subsets of trainees can receive in-depth training (for an overview of the project, see Weaver, Hughes, Friedman, Edwards, & Holmes, 2006). This article will describe the process of universal integration of IPV training within the clinical program and provide an in-depth examination of the case-based strategy used to educate graduate trainees in a team setting.



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