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PTSD After Birth

AIMS Journal, 2008, Vol 20, No 1

Midwife Kate Simpson looks at PTSD as a result of oppression

Post Traumatic Stress Disorder (PTSD) was first listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III)[1] as affecting Vietnam War veterans. Over the past 25 years PTSD has been diagnosed in those having had experiences 'beyond the range of usual human experience' and often includes military personnel, police and fire fighters.[2] The symptoms of PTSD are now well documented[3, 4, 5, 6, 7, 8, 9] and although we can use the literature to identify women who have encountered these symptoms, they seem to go largely unnoticed by the NHS system that propagates the belief that they will have access to 'high quality maternity services designed around their individual needs'[10] Why have these women experienced such catastrophic disintegration of their physical and mental wellbeing?

Birth is a phenomenal event in a woman's life, an experience that is fuelled with heightened emotion bought about by endorphin release that both enables her to manage pain effectively and to bond with her newborn baby.[11, 12] This also gives the woman a greater awareness of her experiences during this time aiding vivid memories of her birth. The technocratic male dominated birth culture which now controls women's health is well documented[8, 9, 13, 14, 15, 16, , 17, 18, 19, 20, , 21] and results in possibly thousands of women experiencing traumatising treatment, as indicated in AIMS Journal 19 No1.

A woman recently described her feelings to me, *'My birth keeps going round and round in my head; I wish I had been more assertive and feel the outcome was my fault. I can't stop thinking about it, trying to put the pieces together. My antenatal support was brilliant, but care in hospital was fragmented and the bed situation took precedence. All this has put my relationship under strain as I still have problems with my body image.'*

The initial research into PTSD was concentrated on military personnel and those in 'high risk' jobs, which are predominately male. Therefore, the diagnosis and treatment criteria are not particularly suited to either women or to the context of childbirth. By 1997 post traumatic stress following childbirth was being highlighted, ,5 but concentrated on women's previous experiences as its primary cause. Fortunately forward thinking feminist writers and AIMS have identified one essential factor common to all mothers' stories - staff behaviour and their attitudes towards birthing women. This is compounded by the difficulty that institutions and the professions within them have in recognising that they have behaved so badly. As much of the diagnostic criteria for PTSD are patriarchal in nature, measuring quantifiable symptoms common to those who have experiences 'beyond the range of usual human experience', those suffering similar symptoms following birth are often ignored, as birth, is, or should be, a 'normal' event. Clearly birth trauma is unique.

Normal response to birth or iatrogenic harm?

Some faithful to the medical model view childbirth as only normal in retrospect; indeed in any other circumstances some of the rapid changes that occur in the female body during pregnancy would be incompatible with life.4 The medicalisation of birth and its harmful effect on women's ability to birth naturally is well documented. This modern phenomenon has ensured a male dominated wealthy monopoly of women's health care, resulting in the intuitive practice of birthing women and midwives being measured against protocols, guidelines, targets and timed 'against the clock'. This frequently results in a cascade of intervention,19 as women fail to labour quick enough, birth fast enough or conform to the ideologies and positions deemed more appropriate than instinct. The norm in this system is to be cared for by stressed, midwives who are caring for several women at once. The reality for these midwives is that they too are often traumatised by their working conditions, unable to support women through their labour due to excessive work loads in a climate which values and counts actions and interventions rather than less visible and measurable care and serves to undermine the very essence of midwifery which is embodied in relationships. Midwives encounter bullying in the workplace, and unfortunately midwives popular within the system are often those conforming to and propagating the medical ideologies. For women and midwives in the system this is normal.

I have known many women leave hospital in a state of disbelief and shock, with images in their minds playing over and over again. Primarily these are of the care they received, and not necessarily the birth outcome itself. Women are frequently reminded that they have a healthy baby, and told to 'put the experience behind them'. Frequently a woman is 'rescued' with antidepressants when postnatal depression is incorrectly diagnosed. 2, 4

For those faithful to the medical model, enjoying the comfort zones of standards, protocols, guidelines and relishing the glory of 'successful birth outcomes', to acknowledge that for some women the outcome has had a life long catastrophic effect on her spiritual, emotional and possibly physical state may be easier to ignore.

As the financial ties between Doctors and the NHS enjoy a flirtatious relationship, maintaining power and control of both practice and research,13 women's 'distress' can go on being ignored. The money for research is encouraged to be spent on something more 'worthwhile', usually something that can be proven to attract more money to the organisation and rarely on women's health.

For those viewing bir th as normal only in retrospect, and viewing it only in terms of birth outcome, faithful to a system implemented to ensure male domination of childbirth, birth trauma could indeed be viewed as normal. After all, we are seeing it all the time. For others, reflecting on women's stories, with an abundant understanding of embedded and intuitive knowledge, embracing the notion that our thoughts and our bodies are so deeply connected to ensure a good birth outcome, we understand the way in which we communicate around a birthing woman can have a profound effect on her ability to birth.

Clearly we could argue that Post Traumatic Stress Disorder after birth is not a normal response to the way in which we normally give birth, but as one of the most deeply disturbing causes of iatrogenic injury in women's health.

Iatrogenic Harm:The problem of diagnosis

Proving PTSD following childbir th as iatrogenic injury is steeped in as many layers of political influences as acquiring the condition itself. Wagner13 goes some way to explaining how male dominant discourses maintain a monopoly of women's health care, maintaining control of research projects, and how those employed to deal with 'consumer complaints' are trained to ward off potential litigation.

To fund research on birth related PTSD, and risk the inevitable findings that it does exist as a direct result of treatment by individuals, could potentially cost the organisations millions, with catastrophic consequences for the professionals involved. This would provide further evidence to support one to one midwifery care, a decline of intervention and a rise in normal birth. It would inevitably leave women feeling empowered and positive about their ability to birth and to be successful mothers. All this would be at the cost of leaving the highly paid obstetricians out of work, so no such research exists.

Litigation is another contributing factor to the lack of PTSD being associated to iatrogenic injury. Finding a lawyer willing to take on the medical profession on the basis of a woman's emotions is difficult. The likely outcome will be that the carers will be defended as they provided the best 'evidence based care' based on the 'safety' of the mother and baby at the time of the event. Women who attend their GPs are often met with minimising statements, and those trained in dealing with PTSD, par ticularly after bir th, are difficult to access. Proven iatrogenic harm resulting in PTSD is rare. Arguably not because it doesn't exist, but because it is kept hidden in a system designed to keep women silenced.

What for Women Now?

There is hope. The work of AIMS, Marsden Wagner, Mavis Kirkham and many other influential writers are bringing PTSD to the attention of the professions. Shelia Kitzinger has created Birth Crisis Network,

and with consent of the women, many of the conversations have been recorded. Kitzinger and Kitzinger[3] have developed a method of using conversation analysis to provide expert training for those who come into contact with women suffering from PTSD, as many of the professionals continue to ask women provocative questions, unearthing a mountain of emotions and suppressed memories, without the skills to deal with the disclosures, possibly leaving women in a worst state[2] than when they met.

The findings of the Confidential Enquiry into Maternal Death[21] refer only to postnatal psychosis or depression causing suicide. The NICE guidelines in response to this have insisted that any woman with a history of Postnatal Depression (PND) should have consultant led care, making a home birth almost impossible. Considering the number of women incorrectly diagnosed with PND rather than PTSD, is the system setting her up for another similar experience?

More work must be done on preventing PTSD. Communication and its effect on birthing women should become a key subject in midwifery and obstetric training.

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