BRIDGING THE CHASM:

Using Current Evidence to Reduce Birth Trauma, Empower Laboring Patients, and Improve Postpartum Mental Health

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No disclosures.

Labor and Delivery Landscape

Patient Desires

Healthy dyad

Provider Desires

Objectives

- Review relevant definitions epidemiology for birth trauma and childbirth-related PTSD
- Explore risk factors and preventative strategies
  - Social connection
  - Labor agentry
  - Education and shared decision making
- Propose best practices

Relevant Definitions

- Potentially Traumatic Event (PTE): “actual or threatened death, serious injury, or sextual violence”.
  - Accumulating evidence suggests events such as racism and childbirth may fall outside of this strict definition but result in significant psychological distress
  - These events do not necessarily predict PTSD symptoms

- Posttraumatic Stress Disorder (PTSD): a diagnosis that requires exposure to a PTE followed by constellation of symptoms in four main categories: intrusive symptoms, avoidance of stimuli, negative alterations in mood, and changes in reactivity

Background- Incidence and Sequelae of Birth Trauma

- Posttraumatic stress impacts nearly 1 in 5 birthing people
  - More common in Black birthing people given increased risk of severe maternal morbidity and higher incidence of mistreatment
- 5.8% of patients will go on to develop Childbirth-Related Posttraumatic Stress disorder (CB-PTSD)
  - Risk factors may or may not be modifiable

Background- Incidence and Sequelae of Birth Trauma

- Long-term impact on patients and families
  - Lower rates of breastfeeding
  - Difficulty with maternal-infant bonding
  - Behavioral difficulty in children
  - Dissatisfaction in relationships with partners
  - Less engagement in health-promoting behaviors
  - Higher incidence of anxiety and depression
- Symptoms can persist for years or even decades
  - May alter plans for future pregnancies

Background- Societal Impact of Birth Trauma

- Patients who have had a negative delivery experience may choose a home birth even in the presence of a contraindication
- These patients are more likely to be transferred to a hospital intrapartum
  - This creates its own source of stress and trauma
- Medical professionals may feel caught between honoring patient autonomy and intervening on behalf of maternal and/or fetal health
  - This can broaden the chasm between patients and providers by creating mutual distrust

A Note on Social Media

- Social media sites such as Reddit and TikTok are now a primary way in which people in the US receive information on healthcare
- May represent a biased viewpoint
  - Of 257 posts related to homebirth from 2017 to 2022, 69% supported and only 20% opposed home births
- Experiences tend to be shared in an anonymous fashion and can be emotionally charged

Background- Secondary Trauma in Providers

- 85% of obstetricians and midwives have been involved in a traumatic birth
  - Trainees are at particularly high risk given tendency to attribute a negative outcome to lack of experience
- Experiences can have cumulative, long term impacts
  - Burnout
  - Sleep disorders
  - Depressive symptoms/depression
  - Somatic and cognitive chronic stress

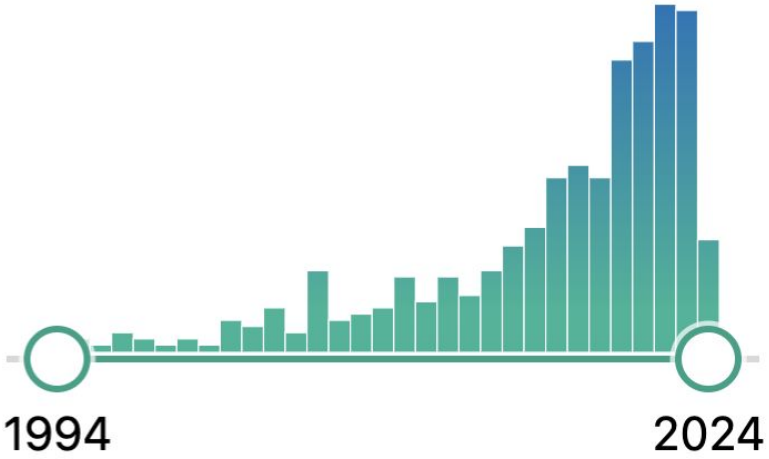
Background- Secondary Trauma in Partners

- Partners are also at a high risk
- Themes from qualitative research:
  - Feeling like “merely a passenger”
  - Mixed experiences with medical staff
  - No systems in place for support
- Feelings of isolation diminish ability to bond with their infants and help with postpartum care for the birthing partner
- Symptoms may worsen over time with increased isolation from support systems

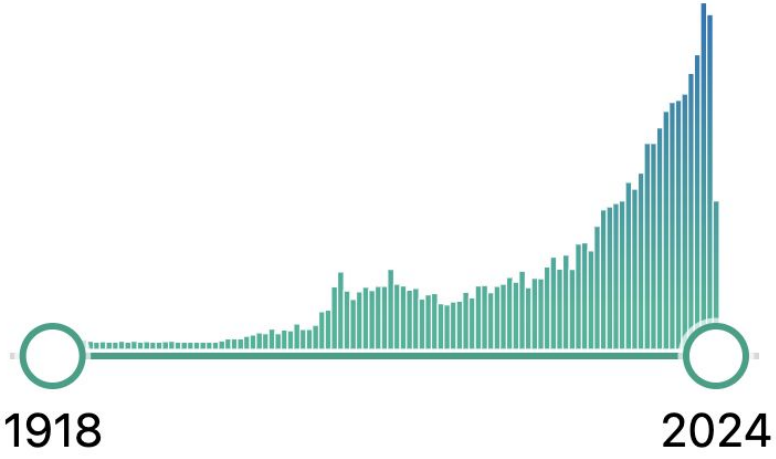
Risk Factors and Prevention

Increased Awareness: A Critical First Step

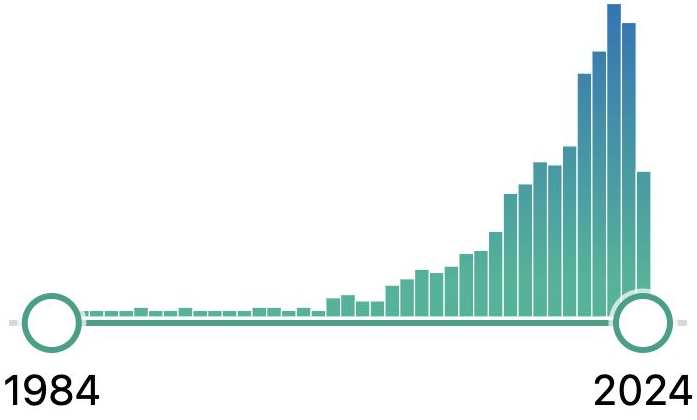
Pubmed search results by year



"Childbirth-Related PTSD"



"Birth Trauma"



"Perinatal Mood and Anxiety Disorders"

Risk Factors for Postpartum PTSD

- Labor and delivery experience
  - Mistreatment and lack of control
  - Complications during delivery
  - Unplanned cesarean section or operative delivery
  - Greater blood loss at delivery
- Neonatal complications
  - NICU admission
  - Low birthweight and preterm birth
- Patient factors
  - Perinatal mood and anxiety disorders and trait anxiety
  - Fear of childbirth (tokophobia)
  - Higher level of education
  - Older age
  - Less social support and low sleep quality

Delivery Experience: Themes from Qualitative Literature

- Interviewees who develop posttraumatic stress report the following:
  - Feeling scared, frighted and upset
  - Feeling “invisible or out of control” and “trapped”
  - Dissociating and not remembering parts of the birth
  - Panic, anger, thoughts of death and mental defeat
- Possible protective strategies cited:
  - Focusing on the present
  - Development of coping strategies prior to delivery
- Recommendations from women of color:
  - Spending quality time, relationship building, person-centered care and partnership in decision making
  - Listening to patient’s feelings

Labor Agentry

- Perceived control over delivery
- Can be measured by a 29-item, validated survey with Likert—scale responses in which patients identify how much they identified with a statement
  - Eg: “I felt confident” or “I felt tense”
- Lower labor agentry is associated with higher rates of postpartum depression, anxiety, and PTSD symptoms
- Interventions could include use of Decision Aids and educational interventions during prenatal care
  - More data is needed

Social Support

- Social support throughout pregnancy is associated with lower rates of perinatal depression and anxiety
  - Group prenatal care improves outcomes
- Abundant evidence for having a continuous support person present
  - Higher rate of spontaneous vaginal delivery, shorter labor, and higher APGAR scores at delivery
  - More positive birth experience
  - Fewer symptoms of postpartum PTSD and depression
  - Reduces experience of institutionalized racism in Black and LatinX birthing individuals
- WHO recommends presence of a continuous support person for all birthing people

Consent, Shared Decision Making, and Educational Interventions

- Qualitative lit identifies the importance of consent, education, and shared decision making
  - "Unilateral decision-making by maternity healthcare professionals… leaves women feeling distant and estranged from the birth event and experience"
  - Disparity between patient expectations and reality of labor underscores trauma
- Decision Aids offer an opportunity to both educate patients and elicit values

Early Detection and Management

- Immediate response with interventions (1-2 sessions) performed within 72 hours of traumatic birth may be more effective than delaying to 4-6 weeks postpartum
  - City Birth Trauma Scale: A validated screen for detecting childbirth related PTSD
  - Cognitive behavioral counselling, Eye Movement Desensitization and Reprocessing (EMDR) appear to be the most effective
- Data for postnatal debriefing for addressing patient birth trauma is mixed
  - Offers more promising results in managing secondary trauma among clinicians

Preventative Actions by Setting

Prior to delivery	On labor and delivery	After delivery

• Address fear of childbirth, any pre-existing mental health disorders, and previous trauma
 	
• Start discussions related to delivery planning early
  • Consider informed consent to be an ongoing process
  • Set realistic expectations
  • Shared decision making with decision aids
 	
• Group prenatal care/teaching when possible
 	
• Assess social support and make referrals as needed
	• Setting
	  • Support a “home-like” environment
	
	• Practice trauma-informed care
	
	• Encourage involvement from doulas and other support people
	
	• Offer pain control methods
		• Assess for symptoms of trauma early
		  • City Birth Trauma Scale
		
		• Arrange close interval follow-up for patients at risk for development of PTSD
		
		• Medical team debrief after a potentially traumatic event

Partner to Decide

Home | My Choices | Starting Labor | My Values | My Stuff | Donate

English

When is labor induction recommended in healthy pregnancies?

The American College of Obstetricians and Gynecologists recommends offering labor induction between 41 and 42 weeks and recommends labor induction at 42 weeks. 1

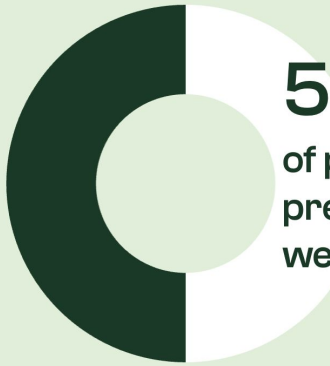
40 Weeks 5 Days | 41 Weeks 3 Days | 42 Weeks

Is it normal to go past my due date?

*without intervention

Yes!

Having a longer pregnancy is more likely if this is your first birth, you are older, or you have had other longer pregnancies. 2



50%

of people are still pregnant at 40 weeks 5 days

What are my choices?

Wait for Labor	41-42 week induction	39-41 week induction
Wait at home for signs of labor.	**Schedule** an appointment between 41-42 weeks.	**Request** an appointment between 39-41 weeks.
QUICK FACTS	QUICK FACTS	QUICK FACTS
Extra check-ups offered after 41 weeks	Possibility the date and time you want isn't available or needs to change	Higher chance the date and time you want isn't available or needs to change
Probably less time in the hospital before baby comes	Possibly more time in the hospital before baby comes	Possibly more time in the hospital before baby comes
Possibly less waiting, fewer interventions	Possibly more waiting, monitoring, and interventions	Possibly more waiting, monitoring, and interventions
You might want this for personal or cultural reasons	You might want this for personal or cultural reasons	You might want this for personal or cultural reasons
Learn More	Learn More	Learn More

Compare All

https://www.inductiondecisionaid.org/Home

What can help me choose?

Think about what is important to you by using our decision aid.

Find Out

Ann Peralta, MPH, DrPH

Founder of Partner to Decide

Who made this tool?

This decision aid was made by a group of public health and medical experts, led by Dr. Ann Peralta. It was tested and updated based on feedback from pregnant people that used the decision aid.

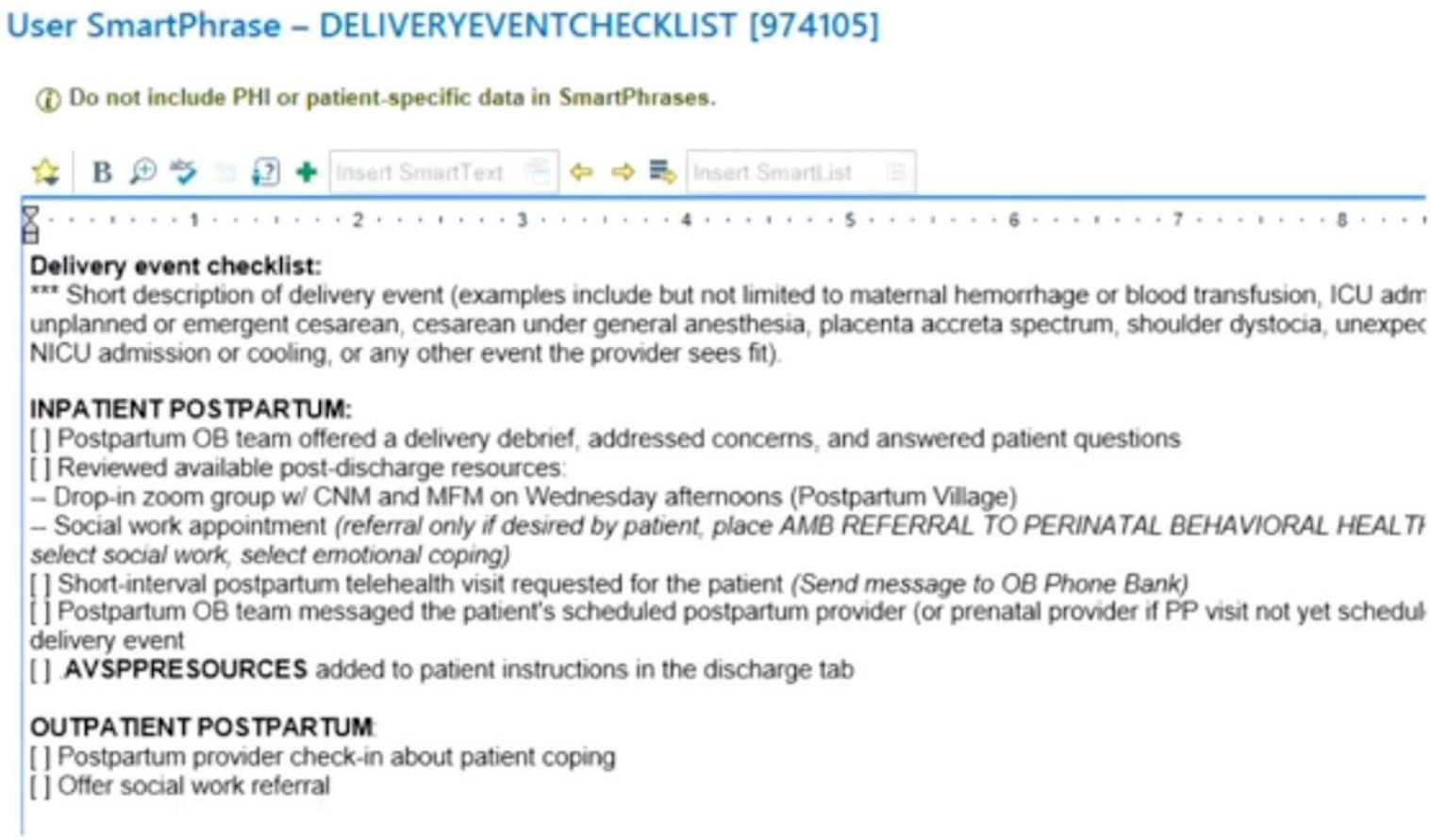
See a summary here.

About Us

Partner to Decide is a US-based 501(c)(3) non-profit organization that strives to improve decision-making quality in maternity care.

Learn more about us.

Improving Patient Experience After a Difficult Birth: An Obstetrics QI Intervention at UCSF



Presented by Arianna Cassidy, MD, UCSF at SMFM 2024

Conclusions

- Birth trauma and development of childbirth PTSD are common and sequelae can be serious
- There is abundant research that is increasing visibility and helping to generate effective treatment
  - Most revolves around risk factors/prevalence but interventional trials are becoming more common
- Simple interventions offer great promise in helping our patients

Thank you!

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Questions and Comments?

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