Empirical support has accumulated for evidence of posttraumatic stress symptoms following approximately 30% of childbirth experiences (Olde, van der Hart, Kleber, & van Son, 2006). In the wake of postpartum posttraumatic stress disorder (PTSD), the personal, relational, and societal implications can be far-reaching for women and their families and can pose a grim public health concern. Women who experience intrusive memories of a traumatic birth can develop sexual avoidance (O’Driscol, 1994), and secondary tokophobia (fear of childbirth following a traumatic delivery) (Hofberg & Brockington, 2000). Further, some women, in order to avoid future distressing birth experiences, will request a planned cesarean section for subsequent births (Ryding, 1993), which is accompanied by greater risks. Some women avoid future pregnancies altogether even when they want more children (Beck, 2004).

Additionally, researchers have found inadequacies in prefrontal cortex functioning in individuals with PTSD, which is associated with diminished cognitive activation and compromise of executive functioning (Rothbaum, Kozak, Foa, & Whitaker, 2001; van der Kolk, 1996). Individuals with PTSD typically have abnormally high levels of stress hormones and when reminded of the traumatic event, have increases in heart rate, skin conductance, and blood pressure (van der Kolk). Taken together, these altered physiological responses may result in overall poor health for postpartum women. Additionally, in an attempt to numb intrusive thoughts associated with a traumatic event, women are at a high risk for developing alcohol or other drug dependence (Sartor et al., 2010).

In addition to the deleterious effects on the health and well-being of new mothers, PTSD can negatively affect an individual’s ability to parent effectively. Albers (2005) argued that not only is a “safe birth” an appropriate goal of maternity care, “[A new mother’s] optimal health should be a high priority of caregivers because newborn well-being depends so greatly on her health and functional status, thereby equipping her to undertake the complex and demanding task of mothering an infant with confidence” (p. 68). There is empirical evidence that anxious mothers tend to be more intrusive and less sensitive in their interactions with their infants in the first year (Feldman, Greenbaum, Mayers, & Erlich, 1997). Further,
postpartum PTSD can be associated with avoidance of the infant (due to the infant being a possible reminder of the traumatic delivery) and impaired mother-infant bonding (Allen, 1998; Ballard et al., 1995). Women with a history of trauma have reported decreases in overall parenting satisfaction compared to women without such a history (Banyard Williams, & Siegel, 2003).

Difficulties resulting from PTSD have additional relationship implications. Women have reported negative effects of a traumatic birth experience on their relationship with their partner, including difficulty with intimacy, poorer communication, and feeling abandoned (Nichols & Ayers, 2007). Given that partner support is considered a protective factor against the development and maintenance of postpartum PTSD, marital problems can be an especially significant problem.

Furthermore, PTSD is associated with higher health care costs among women, even after controlling for depression and medical illnesses (Walker, Katon, Russo, Ciechanowski, Newman, & Wagner, 2003). Given the deleterious personal, relational, and societal impact of postpartum PTSD, evidence-based mental health care for birthing mothers is critical in terms of prevention.

Not only is childbirth a rite of passage, it becomes part of the fabric of a woman’s identity and a significant chapter in her life story that will be recounted with mirth or woe, as the case may be, for generations to come. Consistent with a growing body of research, a traumatic birth experience can have far-reaching, long-lasting, and grim consequences for women and their families.

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REFERENCES


