



Identifying Patient-Centered Psychological and Social Support Needs After Traumatic Birth: A Qualitative Study

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INTRODUCTION

Emergency deliveries increase maternal risk for postpartum depression (PPD) and post-traumatic stress disorder (PTSD).^{1,2,3} Nearly one in three women describe their birth experience as traumatic,⁴ and PPD and PTSD rates (14% and 4%, respectively) are higher in these cohorts.^{1,4,5} Patient-centered, post-birth support is limited in patients who identified as having had a traumatic birth. We conducted a qualitative study of women with traumatic birth experiences to identify patient-centered priorities to optimize postpartum medical and psychosocial support.

METHODOLOGY

Participants who delivered at Magee Women’s Hospital from March 2022 to May 2022 were screened for eligibility from the “Condition Obstetrics” list and met the following criteria:

- “Condition Obstetrics” called resulting in an emergent delivery
- 18 years or older

Pre-interview screening included:

- Women self-identified as having a traumatic birth experience
- Stanford Acute Stress Reaction Questionnaire (SASRQ)
- Posttraumatic Stress Disorder Checklist (PLC-C)

In depth interviews (IDIs)

- Included open-ended and semi-structured questions
- Developed to examine traumatic birthing experiences
- Interviews were transcribed for qualitative coding analysis
- Initial coding analysis included two independent coders who assigned codes to each patient interview
- Independent coders met to compare coding and designed a universal code book of extracted themes

RESULTS

Eight women completed pre-interview questionnaires and the IDIs. Women were 19 to 34 years of age (M=27.6 years, SD=5.5), all with previous pregnancies (range from 1-6) and live births (range from 1-3). Half of the women had a previous traumatic birth experience. Three women had a previous mental health illness and 75% had at least one chronic health condition. Patient demographics and labor & delivery outcomes are listed in Table 1.

Table 1. Patient Demographics and Obstetric, Labor & Delivery Outcomes		
	Mean	SD
	N = 8	Percentage (%)
Race		
White/Caucasian	6	(75)
Black/African American	2	(25)
Past Medical History		
Prior Mental Health Illness	3	(37.5)
Chronic medical conditions*	6	(75)
Smoking/tobacco use	1	(12.5)
Past Pregnancy History		
Gestational Diabetes	1	(12.5)
Preeclampsia	2	(25)
Previous Traumatic Births	4	(50)
Mode of Delivery		
Assisted Vaginal	3	(37)
Cesarean	5	(62)
Reason for Emergent Delivery		
Non-reassuring fetal heart tracing	7	(87.5)
Large for Gestational Age	1	(12.5)
Induction of Labor Required		
Epidural Labor Analgesia Used	7	(87.5)

*Chronic Medical Conditions Included: hypertension, diabetes mellitus, asthma, & obesity

MATERNAL ANXIETY, DEPRESSION, AND PTSD

Women exhibited anxiety and PTSD symptoms in pre-interview questionnaires and in the IDIs.

- 75% of women reported signs of anxiety, depression or PTSD during the IDIs.
- 62.5% of women expressed moderate to high severity of PTSD symptoms [i.e., PCL-C >30] M=44, SD=18.02 (range 23 to 63)

5/8 Women reported moderate to high levels of acute stress [i.e., SASRQ > 40; Figure 1.]

- SASRQ Scores ranged from 9-111 (M=63.5, SD=41.23)
- 5/8 Women reported feeling these symptoms of distress for more than four days

Figure 1. Stanford Acute Stress Reaction Questionnaire – “How Disturbing was this event to you?”

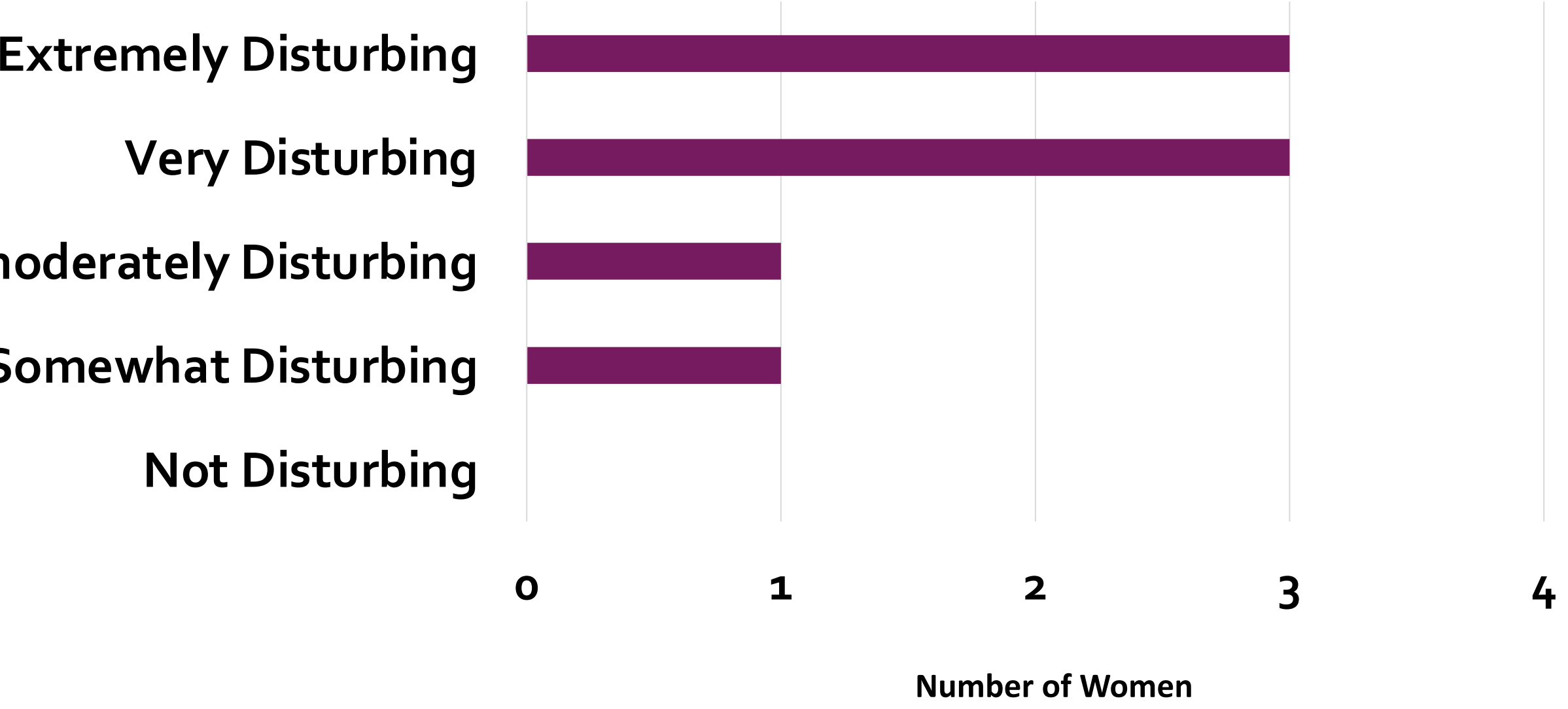


Table 2. PCL-C PTSD Screening*		
	N	(%)
Little to No Severity of PTSD (%)	3	(37.5)
Some PTSD symptoms (%)	0	0
Moderately High Severity of PTSD (%)	1	(12.5)
High Severity of PTSD (%)	4	(50)

*PCL-C PTSD Screening Scale Ranges: 17-29 – little to no PTSD, 28-29 -some PTSD symptoms, 30-44 – moderate to moderately high severity of PTSD, 45-85 -high severity of PTSD symptoms.⁷

INTERVIEW FINDINGS– Qualitative categories

Prenatal & Pregnancy Concerns

- Women expected an uneventful delivery (4/8).
- Women felt there was limited education beyond vaginal delivery expectations (3/8).
- Women reported pre-existing health maternal (5/8) or fetal (5/8) concerns.

Trauma of Emergent Labor and Delivery exacerbated by:

- Perceived Lack of information (4/8) provided by staff
- Negative reactions/responses of staff during the emergency (4/8)

Difficulties during Postpartum Hospital Stay

- Women reported trauma and anxiety prior to discharge (6/8)
- Perceived lack/limitations in emotional support (6/8)
- Received limited information about postpartum depression (4/8)

Psychosocial Support

- Most women expressed acceptability at routine referral for psychosocial support after traumatic birth (5/8).

CONCLUSIONS

Trauma experienced after a complicated delivery may be minimized if precautions are taken in the prenatal, perinatal, and postnatal period. Prenatal visits provide multiple opportunities for conversations to 1.) discuss maternal history of mental health, 2.) examine previous birth experiences, and 3.) develop a breadth of conversations beyond the idealized birth plan to accommodate a wider range of labor and delivery scenarios. ***Screening and Risk assessment may be useful in targeting these patients for psychosocial support referral postpartum.***

Following a traumatic birth, women expect health care providers to comprehend the physical and mental toll of their birthing experience. Intervention is viewed as supportive and necessary. Opportunities to enhance patient-centered care and communication during emergencies were identified as 1.) improving education in the prenatal period for unforeseen or alternative birth plans; 2.) improving patient-clinical staff communication quality during emergent events; 3.) providing psychosocial support following a traumatic birth experience by including PPD and PTSD-relevant conversations within the postpartum hospital stay; and 5.) and providing psychiatric resources for women a with a history of mental health disorders, or traumatic prenatal or birth experiences.

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