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Traumatic Childbearing Experiences in Macedonian Women

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Abstract

The psychological trauma related to childbearing is a universal phenomenon in women. The influences could extend in a wide range, which includes the mothers' health, mother-infant relationship or partner relationship. The purpose of this research was to evaluate collected data from several obstetric clinics in Macedonia, as well as for primary pediatric settings related to 'Birth Trauma' to review especially women with symptoms of post-traumatic stress disorder (PTSD) following childbirth.

The used psychological instrument is named Intersect Questionnaire, and it is composed of 59 questions grouped in VIII parts. The questionnaire is obtained from the Centre for Maternal and Child Health Research 'City', University of London. This questionnaire was translated into the two mains languages– Macedonian and Albanian. The results confirmed that birth trauma is not rare phenomena in our country, as well. Symptoms correlated with PTSD were present as unpleasant memories, anxiety, traying not remember delivery, self-accusation, negative emotions, alienation, irritation/aggression, self-destruction, impulsiveness, problems with concentration, and sleeping problems. These results alarm that a better understanding of this vulnerable period of women's life is necessary and some response measures are needed.

Keywords: Birth; Trauma; PTSD; Mother; Stress

Introduction

To give life to a baby is perceived as the most important and happiest event in a woman's life. It is a unique feminine privilege in all the living world. However, this event could be the trigger for traumatic experiences for the mother herself. These conditions have been ignored for a long time, but in contemporary medicine, they are increasingly coming into focus, especially in the field of obstetrics and public health. Birth trauma is defined as an event occurring during the labor and delivery process that involves actual or threatened serious injury or even death of the mother or her infant.

A traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or even psychotic behavior. The individual may feel emotionally, cognitively, and physically overwhelmed. In our previous related research, we found that postpartum depression in our country is minimally present in 68% of women after delivery and as mild form in 25%. This was evaluated with the Beck Depression Questionnaire. It was shown that the level of education was negatively correlated with depression scores, and younger women happened to be more susceptible to depressive reactions. It was pointed out that there is a need for early recognition, follow-up and treatment of postpartum depression. This not only provides mothers but also provides for better child development [1].

Traumatic memories related to childbirth arise as an international public health problem. It is supposed that currently up to 45% of new mothers have reported such experiences. International rates of PTSD due to birth trauma range between 1.5 and 9 percent of all births [2]. We all use the word "trauma" in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person's ability to cope. There is no clear distinction between stress, trauma, and adaptation. Psychological trauma is the unique individual experience of an event or enduring conditions, in which the individual's ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity. The possible factors related to postpartum trauma are presented in Table 1. The purpose of this research was to evaluate

collected data from several obstetric clinics in Macedonia, as well as for primary pediatric settings (till 3 months after birth) to select women with symptoms of some form of post-traumatic stress disorder (PTSD) following childbirth.

Table 1: Demographic data for evaluated women.

Main age	30,00± 4,96 years	Minimum 17 Maximum 49
Ethnicity	Macedonian 60%	Minorities (Albanian, Turk, Roma) 14%
Place of living	Cities 82%	Villages 12%
Educational level	Secondary school 41,71%	High school 52,29%
Income	Average 78,71%	Higher 13,75%
Marriage status	Married 87,60%	Living with a partner 5,66%
Number of born children	One 92,72%	Two 4,85%
Delivery mode	Vaginal 50,13%	Caesarea 49,87%
Gestation	37,62 weeks (± 3,73)	min. 30- max.42 weeks

Methodology and sample

The research was prospective (from January 2021 to December 2022). The evaluated sample comprises 371 women. The Questionnaire is dispersed to all available obstetric settings in the country, as well as to primary pediatricians. All included women fulfilled the writing consent for participation, the condition was the age over 16 years and the childbearing before three months. Fulfilled papers were returned to me for evaluation. The calculation of the results was done by platform specially performed for this research.

The used psychological instrument is named Intersect Questionnaire, and it is composed of 59 questions grouped in VIII parts: I - general information and agreement for the participation, II - questions related to the childbirth and the baby, III - emotional balance of the mother, IV- questions related to the delivery itself, V - questions related especially to the emotions, VI - previous traumatic events, VII - related to the whole health issues, VIII - related to some personal characteristics of examinees. The questionnaire is obtained from the Centre for Maternal and Child Health Research 'City', University of London. This questionnaire was translated into the two mains languages used in North Macedonia – Macedonian and Albanian. A descriptive phenomenological approach was adopted as a main.

Results

We obtained 371 valid fulfilled questionnaires from different part of our country. All examined women were aged over 16 years. The consent for participation was obtained in written form. Main demographic data are presented on Table 1. Mother confirmed having complications as minor in 22,10% and as major in 2,70% of the examinees. Complications for babies were confirmed as minor in 22,10% and major in 2,70% of cases.

The most significant for this research are answers related to the emotional status of mothers especially some symptoms related to birth trauma or PTSD. The delivery was ranged as traumatic on the scale from 1 to 10. The results are shown in Figure 1.

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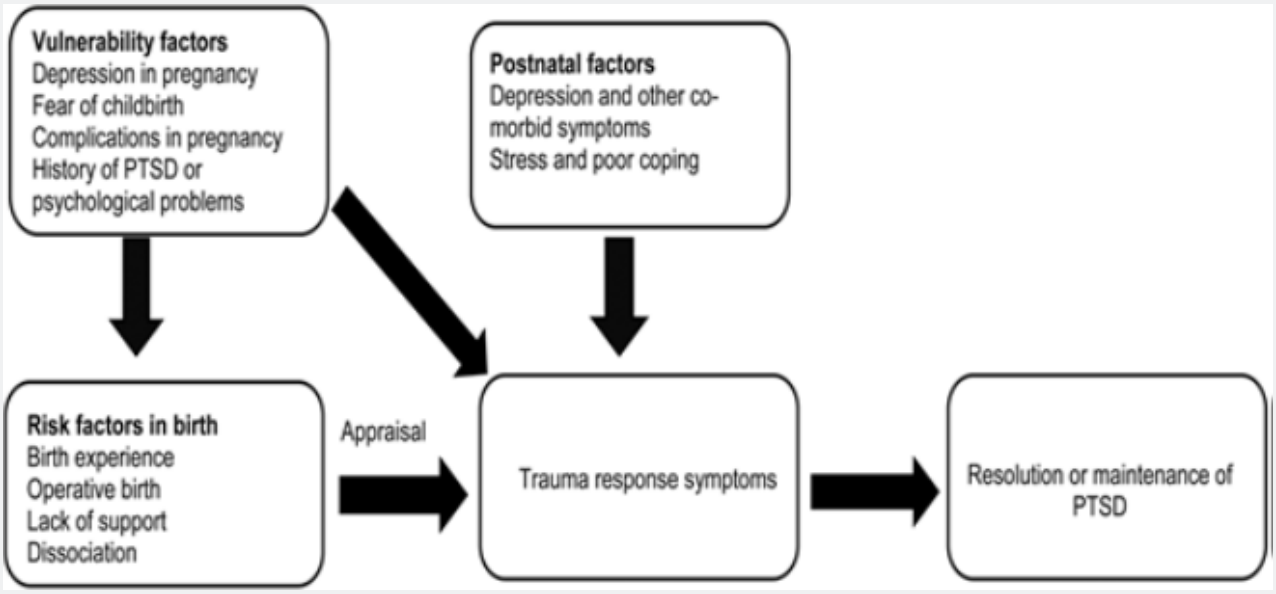

Figure 1: Perceived range of trauma during delivery.

Repeated unpleasant memories for delivery confirmed 11,86% of examinees; Anxiety related to delivery confirmed 11,33%, while 11,59% said that they are trying to not remember delivery. Negative emotions related to delivery (like fear, anger, shame) confirmed 8,09% of women. However, 4,86% accused herself/others for delivery events. Very important data are psychological symptoms after returning home, in quite "normal life". In this context, we registered following problems: No interest for usual activities confirmed 11,86%; Feel alienated for other people 12,67%; Feel irritated/aggressive 7,55%; Self-destructive activities confirmed 5,39%; Impulsiveness 17,25%; Problems with concentration 13,47%; Sleeping problems 13,74% and feeling anxious/nervous 17,79% of examinees.

The question about previous traumatic experiences is very important. In this context previous experiences like serious illness in family member, physical/sexual abuse, natural disasters, accidents confirmed relatively high percentage (45%) of participants. This experience could be related to current emotional problems in women. However, previous psychiatric problems confirmed only 3,23%, but anyone needed medical/pharmacological aid.

Discussion

As is known, pregnancy is a period of psychological and identity reorganization, during which a mother's ambivalent state of mind is as necessary as it is structuring the mind for the child to come. The average duration of gestation in our research was 37.62 (± 3.73) weeks, which is considered normal. It is interesting to note that normal vaginal delivery was present in 50.13%, while Caesarean sections were chosen by the other half of the women.

The Caesarean section was the dominant method for delivery, especially in private obstetric settings. No serious complications for mothers or babies were reported. The perceived range of trauma during delivery was noted as minimal in 32.61% of examinees, but there are some women who rated the delivery as more traumatic (more than range of 5). Results confirmed that birth trauma is a seemingly common event in our women's population. In our study, post-traumatic stress disorder and post-traumatic stress symptoms following birth occur amongst a small proportion of women, but these can still lead to poor maternal mental health, impairment in mother-infant bonding and relationship stress. In this context, follow-up is necessary, and some psychological intervention must be available.

Symptoms associated with possible PTSD in mothers were: No interest for usual activities (11,86%); Feel alienated for other people (12,67%); Irritation/aggressiveness (7,55%); Self-destructive activities (5,39%); Impulsiveness (17,25%); Problems with concentration (13,47%); Sleeping problems (13,74%) and anxiety/nervousness (17,79%). In majority of women, symptoms started in the first six months after delivery. Women who have suffered birth trauma may be at risk of increased fear and anxiety around their child's health and their parenting abilities. Some women may experience this as feeling less emotional attachment to their infant.

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Women who experience birth trauma should be offered support during early parenting. However, mother-infant relationships often improve after the first year. The recent work of Tom Parkhill (presented at the 36th European College of Neuropsychopharmacology (ECNP) conference, Barcelona) showed that the relation mother/baby could be trained, especially in women with previous postpartum depression. The unique feminine privilege in all the living world is to give life to a baby. Even the happiest, this event could be the trigger for traumatic experiences for the mother herself. Being ignored for a long time these conditions are increasingly coming into focus, especially in the field of obstetrics and public health.

Axioms related to birth trauma are firstly presented by Beck [3-5] and are cited as follows:

i. Traumatic birth can be considered as an extreme traumatic stressor that can lead to PTSD.

ii. Posttraumatic stress symptoms are a result of traumatic childbirth and can vary in intensity and duration.

iii. Traumatic childbirth can have long-term, chronic consequences.

iv. Traumatic childbirth can have stinging tentacles that can lash out at obstetrical clinicians and significant others who were present at the birth.

v. Posttraumatic stress symptoms can interfere with mother–infant interaction.

vi. A traumatic birth can negatively affect a mother's breastfeeding experience.

vii. At the anniversary of a traumatic birth, posttraumatic stress symptoms can flair up.

viii. Subsequent childbirth after a previous birth trauma is an anxiety-filled time for mothers.

ix. Not all subsequent childbirths after a previous birth trauma are healing.

As mentioned before, published studies report rates of PTSD after childbirth as varying between 1.5 and 9 percent of all births. Those who have a traumatic delivery but are not diagnosed with PTSD have fewer symptoms of the disorder or the duration of their symptoms is less than a month. These women are referred to variously as having Post-Traumatic Stress Symptoms (PTSS), Post-Traumatic Stress Effects, (PTSE), or Partial Post-Traumatic Stress Disorder (PPTSD) [6]. Trauma during pregnancy is commonly viewed as benign for the newborn when the delivery occurs normally. Our study revisits that point of view: 88,14% of women think that themselves and the baby were not seriously traumatized. The perception of traumatism during delivery ranged on the scale from 0 to 10. Perceived range of trauma during delivery was noted as minimal in 32,61% of examinees, but there are some women who ranged the delivery as more traumatic (more than range of 5/10).

According to graduation of unpleasant symptoms 46,90% of women went through the delivery practically unscathed, but the labor was graduated as too long in 11,32%, and only 10,24% felled out of control during labor. Additionally, majority of women confirmed that medical staff was encouraging for them, and delivery room were hygienic and clean. In this context, follow-up is necessary, and some psychological intervention must be available. In a study of [7] the prevalence of PTSD after child-birth has been estimated to be around 3% for women meeting full diagnostic criteria and up to 9% for sub-threshold symptoms [8] showed that the social and health system could prevent psychological harm during birth and promote maternal health by measures of pain management, thoughtful attention, adequate caring, and prenatal preparation.

In a recent study of [9] it was suggested that childbirth is an independent stressor capable of evoking PTSD in mothers. Analysis reveals the importance of antepartum and birth related risk factors above and beyond child outcomes [10] showed that childbirth-related posttraumatic. Stress disorder occurs in 3-7% of all pregnancies and about 35% of women after preterm birth meet the criteria for acute stress reaction. Known risk factors are trait anxiety and pain intensity, whereas planned delivery mode, medical support, and positive childbirth experience are protective factors. It is interesting that changes to birth experience due to the COVID-19 pandemic have small but persistent effects on depressive and PTSD symptoms [11,12] Prenatal exposure to maternal depression increases the risk for emotional and behavioral disorders in children. In this context [13] confirmed widespread white matter alterations in 2-3-year-old children with prenatal exposure to depression which are consistent with neuroimaging findings in adults with major depression. Further, these novel associations of altered white matter integrity with cognitive development in depression-exposed children are suggesting that these neuroimaging findings may have early functional impact.

Conclusion

The presented results confirmed that birth trauma is not rare phenomena in our country, as well. Symptoms correlated with PTSD were present as unpleasant memories, anxiety, panic, traying not remember delivery, self-accusation, negative emotions, alienation, irritation/aggression, self-destruction, impulsiveness, problems with concentration, and sleeping problems. These results alarm that a better understanding of this vulnerable period of women's life is necessary. Preventive measure is needed.

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