Journal of Pelvic, Obstetric and Gynaecological Physiotherapy, Spring 2022, **130,** 22–26

POGP CONFERENCE 2021

Understanding birth trauma and physical recovery

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Abstract

The aims of this paper are to: (1) raise awareness of birth trauma and its interplay with associated physical injuries; and (2) suggest how healthcare staff can support women during the recovery period. Many women report that some aspect of their birthing experience was traumatic, and has had negative consequences for them in both the short and longer term. When individuals experience physical birth injuries alongside psychological trauma, this can significantly affect several areas of their lives, including: bonding with their baby; relationships with their partner, family and friends; returning to work; and issues of identity. The struggle to receive the specialist support required to identify, diagnose and treat psychological and physical injuries can be arduous and distressing. Healthcare professionals have an integral role to play in contributing to women's adjustment and recovery by providing accurate information, implementing trauma-informed care and signposting to relevant organizations.

Keywords: birth trauma, education, physical birth injury, psychological injuries, signposting.

Introduction

Unlike other sources of emotional shock, birth-related trauma is relatively unrecognized globally. Currently, up to 30% of women report that some aspect of their birthing experience was traumatizing, with 3–6% receiving a clinical diagnosis of post-traumatic stress disorder (PTSD), a figure that rises to 18% in higher-risk groups (Dikmen-Yildiz *et al.* 2017). Furthermore, in 2016, 5.1 million babies were born in Europe, which means that up to 1.5 million women may have had suboptimal birth experiences, and over 200 000 may have developed PTSD as a result (COST 2019). The symptoms of trauma/PTSD can range from heightened distress to avoidance, hypervigilance, intrusive memories and hallucinations (APA 2013). The response to these symptoms can be physical (e.g. sleep disturbance and hypervigilance/easily startled), emotional (e.g. panic attacks, depression and irritability) or cognitive (e.g. difficulty concentrating and making decisions). It is not necessarily about what actually happened while giving birth; rather, it is about how the woman felt at that time, with some describing their experience as "birth rape" or "obstetric violence" (Harris & Ayers 2012).

Women's subjective interpretation of birth has also been identified as a critical factor for trauma (Garthus-Niegel *et al.* 2013). A traumatic birth can have far-reaching negative consequences on mother–infant attachment, child development and a couple's relationship (Parfitt *et al.* 2013; Fenech & Thomson 2014). Furthermore, maternal postpartum PTSD 8 weeks after birth has been associated with poor social and emotional development for the child at 2 years of age (Garthus-Niegel *et al.* 2017). In a systematic review, Cook *et al.* (2018) reported an association between maternal PTSD after childbirth, lower rates of breastfeeding, and low infant birth rates.

Grekin & O'Hara (2014) suggested that a history of psychological problems, prior trauma, obstetric procedures, negative staff–mother interactions, loss of control, lack of partner support and physical birth injuries are key risk factors for PTSD following childbirth. Given the transgenerational association transmitted between a mother's psychological trauma and her offspring, addressing this is crucial.

A physical birth injury can be psychologically traumatic. Some of the more easily diagnosed examples are major levator trauma, avulsion

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and obstetric anal sphincter injuries (OASIs). Approximately 20% of women will experience an avulsion during their first vaginal childbirth (Cassadó *et al.* 2020). Several risk factors have been identified, including: instrumental delivery (i.e. assisted birth), with forceps presenting a higher risk than a vacuum cup; second-stage labour lasting longer than 2 h; older age at a vaginal birth; having sustained a grade 4 perineal tear; and a baby weighing over 4 kg. Decreased vaginal sensation and prolapse are commonly reported symptoms. Women who had a levator ani avulsion after a forceps-assisted delivery reported decreases in sexual arousal, natural vaginal lubricant, orgasms and sexual satisfaction at 6 months postpartum (García-Mejido *et al.* 2020). Unsurprisingly, this has a significant impact on a women's sexual experiences and levels of discomfort during intercourse. In order to manage these symptoms, she might avoid sexual interactions with her partner, which can negatively affect their relationship in the longer term.

Obstetric anal sphincter injuries are classified as third- and fourth-degree perineal tears (RCOG 2015), and the prevalence of these lesions has increased over the past 2 decades. This is primarily because of an increase in awareness of the risk factors, the introduction of a new classification system, reduced rates of unrecognized injuries and improved imaging methods for the detection of OASIs postpartum (Košec *et al.* 2019). These injuries can have a life-changing and long-lasting impact on an individual's physical, emotional, social and psychological well-being.

In discussing levator ani avulsion and OASIs, it is important not to negate the long-term adverse repercussions of other injuries; for example, first- and second-degree tears, or those that are not as easily diagnosed, such as damage to the fascial structures of the nerves. These issues can also have a significant impact on several areas of an individual's life.

Psychological impact of physical birth-related issues

Giving birth can be psychologically traumatic for some women, even if they have not suffered from any physical injuries. Others will experience both psychological and physical trauma, which will differ in severity. When an individual psychologically experiences a traumatic birth, this is often classed as the core incident. In the process of seeking help, and adjusting to living with the effects of birth-related injuries and any sequelae, the symptoms of trauma associated with the core incident can be intensified or, in some cases, retraumatizing.

As discussed above, many first-time mothers suffer from physical birth injuries. Birth trauma can have an impact on a woman's relationship with her baby. She may experience heightened levels of anxiety (i.e. hypervigilance), intrusive thoughts and nightmares about her birthing experience. As the woman recovers from the initial impact of the birth, she may or may not begin to realize that her physical symptoms are not resolving as these should. The psychological symptoms of the birth trauma can lie dormant. The necessary adjustment to living with the physical birth injuries, can potentially trigger and/or compound these birth-related symptoms.

Some evidence suggests that women with physical injuries feel "irreparably damaged" and that their lives have been ruined. Psychologically, their injuries affect their body image. When experiencing urinary and/or faecal incontinence, some are repulsed by their vagina, and have frequent feelings of disgust and embarrassment (Mirskaya *et al.* 2019). Many experience heightened levels of anxiety, shame and a sense of being unclean, which lowers their sense of confidence and self-esteem (Keighley *et al.* 2016).

Asian women have the highest risk of third- and fourth-degree perineal injuries (RCOG 2015). Some evidence suggests that African women are at a nearly four times greater risk of anal sphincter tear during vacuum extraction deliveries than those born in Sweden (Ryman *et al.* 2015). Therefore, the range of narratives about birth-related injuries across different cultures and ethnicities could have an impact on the ability of some individuals to seek support.

Social support can prevent PTSD following childbirth (Ford *et al.* 2010). There is some evidence that emotionally support from friends is strongly correlated with trauma adjustment, as opposed to receiving support from family members and mental health professionals (Filipas & Ullman 2001). Given the interpersonal nature of birth-related trauma, social support could be a significant protective factor postnatally. An increase in postnatal depression 6 months postpartum has been reported in some women who suffer from incontinence (Nam *et al.* 2021). Feeling anxious about needing to make frequent trips to the bathroom, the shame associated with the symptoms, or being self-conscious about the possibility of leaking or creating an odour mean that many women withdraw from socializing with friends,

going out into the community or returning to work. Therefore, they are most likely to isolate at the time when they need increased support.

These feelings, coupled with physical pain or discomfort during sexual interactions, also adversely affect relationships with partners. Again, the transition to parenthood can often be a time of adjustment in roles, and the added layer of psychological trauma and physical injuries can place significant strain on relationships. Many women can feel that their birth-related symptoms have overshadowed this transition at a time when they should have been embracing motherhood.

Grief can be experienced by individuals with physical and psychological birth trauma. This may be attributed to many aspects of their lives; for example, the loss associated with not feeling able to have future pregnancies, not being the person they were before giving birth, and not being able to pursue hobbies or activities that they once did (Mirskaya *et al.* 2019). These feelings of grief might present as low mood, anger, sadness and/or a loss of hope about the future. It may be that similar feelings are triggered or resurface at significant points in their lives, such as losing a loved one or transitioning through the menopause.

Helping as a healthcare professional

Providing accurate information

Many individuals with birth-related injuries have reported that they were unprepared for the problems that they had to deal with postnatally. There has been a great deal of debate about the content of antenatal education, and many providers do not want to scare women or overwhelm them with information about birth. Individuals are often significantly influenced by informal resources (e.g. social media, books and friends) that help them to prepare for and make decisions about their baby's birth (Sanders & Crozier 2018). These sources of information also affect the discourse and expectations about birth, postnatal recovery and the transition to motherhood. Although the information that they seek may heighten feelings of anxiety or create unrealistic expectations, it can also help women to feel better prepared and more in control. It is essential to acknowledge that women are seeking information, and that providing them with accurate details about what to expect can be helpful in their birth-related and postnatal decision-making. Healthcare professionals (HCPs) can provide guidance and reassurance to prevent them feeling overwhelmed (Lagan *et al.* 2011). Additionally, raising awareness about pelvic health, and its importance before, during and after pregnancy can act as a preventative measure by increasing awareness of the symptoms to look out for in the postnatal period.

The struggle to receive an accurate diagnosis and subsequent treatment can be fraught and distressing. Some women have reported that they did not feel that HCPs believed that they were experiencing the symptoms that they described, or that these were dismissed or normalized as a natural occurrence of a vaginal birth (Mirskaya *et al.* 2019). When a mismatch occurs between an HCP's opinions and a woman's experiences, this can be humiliating and disheartening for the latter. Therefore, it is crucial to be open to a patient's experiences and listen with empathy. This will ensure that a thorough medical history is taken while being alert for red flags that might indicate physical and psychological trauma.

Trauma-informed care

A trauma-informed model of maternity care aims to treat each person as an individual by tailoring their treatment to their needs and goals, respecting their history, and supporting their informed choices. Such a service will promote feelings of psychological safety, control and individual choice. The principles of trauma-informed care broadly include (SAMSHATJSI 2014):

(1) safety;
(2) trustworthiness and transparency;
(3) peer support;
(4) collaboration and mutuality;
(5) empowerment, voice and choice; and
(6) cultural, historical and gender issues.

Following a birth trauma, an individual is likely to: experience triggers that make her feel as if she is reliving some or all of it; have intrusive thoughts; and be overwhelmed by difficult emotions. It is essential to be aware that discussions of the birth, examinations, language used and subsequent treatments could all be potential triggers. It can be helpful to ask women whether there are any words, statements or actions that you should refrain from, and if any are preferred. Also, when individuals disclose their trauma experience(s), it is vital to respond with compassion and empathy, and acknowledge that their feelings are valid and they are not alone.

Signposting

Women can often feel that they are alone in experiencing birth-related difficulties. Therefore,

signposting to organizations that can offer them support and resources can be empowering. Some organizations also provide online support forums, which many individuals find helpful.

Make Birth Better is a unique collective of parents and professionals. They work together to reduce the life-changing impact of birth trauma through education, support, research and campaigning. Their website offers a range of free resources for parents and professionals, and training for HCPs (www.makebirthbetter.org).

The MASIC Foundation is a UK charity that supports women who have suffered OASIs. They have a range of resources for women and professionals online that are free to download (masic.org.uk).

The Birth Trauma Association is a charity that supports women who suffer from this condition (www.birthtraumaassociation.org.uk). They have a team of peer supporters who have also experienced birth trauma, and maintain a private Facebook group for parents (www.facebook.com/groups/TheBTA).

Conclusions

Birth trauma can significantly affect the emotional, psychological and social aspects of a woman's life, and her relationships with her family and friends. It can have long-lasting effects. When psychological trauma is coupled with physical injuries, adjustment to and acceptance of the condition can be complex. Women can feel a deep sense of shame, embarrassment and heightened feelings of anxiety. In an attempt to manage the symptoms of their physical and psychological injuries, they can withdraw from their family and friends, and decide not to return to work.

Women's experiences and symptoms must be validated and believed when they seek support, a diagnosis and treatment. Healthcare professionals have a crucial role to play in providing accurate education and reassurance. When this is delivered within a trauma-informed framework, and the woman is signposted to appropriate services and organizations, it can be immensely helpful in supporting her recovery, which she undoubtedly deserves.

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