# Postpartum haemorrhage and post-traumatic stress disorder

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**'I'm only having this baby if I can have a caesarean section,' was the second sentence the patient said to me at her booking visit. This surprised me as she had a normal vaginal delivery of her first child, albeit complicated by a 1000ml postpartum haemorrhage and manual removal of placenta in theatre.**

She did not require a blood transfusion and I had not regarded the birth as being a particularly traumatic delivery.

However, further questioning revealed that the patient had been experiencing flashbacks and nightmares involving her hearing the sound of her blood dripping from the bed onto the floor and an associated feeling of impending death.

Post-traumatic stress disorder (PTSD) is described in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) as when 'the person has experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury; or a threat to the integrity of self or others and the person's response involved fear, helplessness or horror and that the traumatic event is persistently re-experienced by either:

1. Recurrent and intrusive distressing recollections of the event;
2. Recurrent distressing dreams of the event;
3. Acting or feeling as though the event were recurring; or
4. Intense psychological stress at exposure to events that symbolise or resemble an aspect of the event.'

These symptoms must persist for at least a month after the event.

It would appear that my patient satisfied the diagnostic criteria for PTSD. Although many of us would argue that a 1000ml postpartum haemorrhage is not life-threatening, we must realise that the threat of death or serious injury is from the patient's perspective.

PTSD was initially used to describe symptoms experienced by Vietnam War veterans in the 1970s and was made an official diagnosis in 1980. It was withdrawn from *DSM-II* when there were too many post-war veteran PTSD compensation claims, but reappeared in *DSM-III*. Similar symptoms had previously been called shell shock or battle fatigue.

**Risk factors for PTSD after childbirth**

- Past psychological problems
- Anxiety trait
- Obstetric procedures
- Negative aspects in staff-mother contact
- Feelings of loss of control over situation
- Lack of partner support

Symptoms of PTSD include the previously mentioned flashbacks; an inability to describe the event (psychogenic amnesia); a high state of arousal with hyper vigilance and an exaggerated startle response; avoidance of reminders of the event; intense psychological stress and/or panic attacks on exposure to similar events; and, importantly for caregivers, fantasies of retaliation and a cynicism and distrust of authority figures and institutions. Long-term PTSD may be masked by other conditions such as alcohol and drug use, eating disorders, gambling and depression.

Proven effective treatments are cognitive behaviour therapy, aversion therapy, or rapid eye movement desensitisation therapy, usually by a clinical psychologist. Essentially, treatment involves revisiting the incident and desensitisation through a variety of means. Drug treatments that have been shown to be useful include the selective serotonin reuptake inhibitors (SSRIs) paroxetine and sertraline, as well as carbemezepine, lithium and quitiapine.

Post-traumatic debriefs have not been shown to be beneficial in reducing PTSD or post-natal depression after childbirth and revisiting the event early afterwards may exacerbate psychiatric symptoms. However, as cognitive behavioural therapy involves revisiting the event and involves explanations of misrepresentations of reality through a debrief, I believe that after a traumatic birth, the obstetrician should at least offer the patient the chance to ask any questions about their birth, so that any misconceptions may be rapidly corrected. Exploration of the traumatic birth patient support group websites reveals a thirst for information about their deliveries, which is in contrast to the lack of evidence of benefit for debriefs. The difference may be in the timing of the delivery of the information, with the patient not being ready in the early post-incident period.

One of the recurring themes in PTSD after childbirth is a feeling of a lack of control at the time of the incident and a search for control in the subsequent pregnancy. The controlled environment of an elective caesarean section is frequently sought by PTSD patients. To assist in these feelings of control, I have found it much better to say yes to such requests immediately, rather than be confrontational, and then discuss other options as the pregnancy progresses. With my patient who had experienced the postpartum haemorrhage, by 24 weeks she had decided to have another vaginal birth. She went on to deliver at term with a normal third stage and a 250ml blood loss. Subsequent to this positive experience, she has no further flashbacks or nightmares regarding her first birth.

As a postpartum haemorrhage is a potentially life-threatening event, it may be followed by PTSD. The symptoms of PTSD may be part of a normal reaction to a threatening event for up to four to six weeks after the event. We should, however, be able to recognise the symptoms of PTSD and be able to refer the patients on for further support. There is an excellent website for the New Zealand Trauma and Birth Society (www.tabs.org.nz). Their site includes a list of clinical psychologists specialising in PTSD.

In subsequent pregnancies, it is important to realise that the patient may have a distrust of health professionals and hospitals and be looking for control. I believe that it is important for us to listen to the patient's concerns, give them a choice of birth options (even including a general anaesthetic lower segment caesarean section if required), be non-confrontational and provide full information about the past birth and current pregnancy. This should enable the patient to have a successful subsequent birth, both physically and psychologically.

**References**


1. Olde, *et al.* Post-traumatic stress following childbirth a review. *Clin Psych Rev.* 2006; 26 (1) 1-16.
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3. Psychological debriefing for preventing post-traumatic stress disorder (PTSD): www.cochrane.org/reviews/en/ab000560.html .
4. en.wikipaedia.org/wiki/Post-traumatic_stress_disorder
5. www.tabs.org,nz
6. www.rcpysch.ac.uk/mentalhealthinfoforall/problems/posttraumaticstressdisorder/posttraumaticstressdisorder.aspx



# Asia Pacific Committee

*Involved in a developing country?*
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The APC is keen to be kept informed about activities and involvement of our Fellows in all developing countries, but particularly the Asia Pacific region. From this information we will be able to increase valuable networks and build a more comprehensive picture of the involvement of College Fellows in the region, either under the auspices of the College or via other avenues or personal connections you may have.

Please send one paragraph outlining details of any activities/projects/consultations you have been involved in over the past year or details of activities you will be involved in for the coming year to:

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# Nuchal Translucency Online Learning Program

***Purpose***
**The Nuchal Translucency Online Learning Program (NTOLP) is designed to replace the theoretical course that is conducted for operators who wish to become credentialed to perform Nuchal Translucency scans.**

***Content***
**The NTOLP covers eight topics:**
1. **Principles of screening**
2. **Practicalities of NT measurement**
3. **NT and chromosome abnormality**
4. **Biochemical screening**
5. **12-week anomaly scan**
6. **Screening test results and informed choice**
7. **Screening and multiple pregnancy**
8. **Increased NT and normal chromosomes**

***Features***
**This site uses many elements to engage and interest the learner. Some examples are:**
- **Interactivity – mouse over, prediction tasks and multiple choice questions**
- **Customised images – graphs, detailed diagrams, flash animations and ultrasound scans**
- **Illustrations and text**
- **Discussion Forums**

**The course is now live and costs A$165.00 incl. GST per individual. Please visit www.nuchaltrans.edu.au/ for further details or to enrol. This program is co-located with The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and development has been funded by the Australian Department of Health and Ageing.**