

Case Report

Traumatic Birth and Postnatal Nursing Approaches: A Case Study

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Abstract

It is now recognized that a proportion of women may perceive birth as stressful and traumatic. Traumatic birth experience occurs when a woman perceives an actual threat to her own life or her baby during delivery. This article aims to enhance nurses' understanding in order to deal with woman and her family members who witnessed the birth especially in the post-natal nursing follow-up. This article critically discusses the nursing care and management of people who have traumatic birth experience. A prospective case study design was used to follow one woman who has traumatic birth experience and her family. It followed up pregnancy, postnatal 1st day, 3rd day, 3rd months, 6th months and 10th months. In addition, it is presented information about the consulting model based on cognitive behavioural therapy model has used as a nursing approach at the traumatic birth experience.

Keywords

- Traumatic birth
- Woman
- Family
- Nursing

INTRODUCTION

It is now recognized that a proportion of women may perceive birth as stressful and traumatic [1,2]. Traumatic birth experience occurs when a woman perceives an actual threat to her own life or her baby during delivery [3]. Loss of control, feeling trapped and vivid memories of the event has also been noted as experiences and perceptions of traumatized women following childbirth [4-7]. Women who are traumatised by the act of giving birth generally are reluctant to remember the act and consider the moment of birth as a moment that is unnecessary [8].

Women's perception of the birth process, the interprets and the meanings may be different from each other [8]. A negative birth experience may be defined as traumatic by some women, but perceived as normal by others [4,6]. Factors that lead to the perception of the birth as being traumatic may include a birth experience different from expectations, anxiety for one's own wellbeing and that of the baby, interventions during the birth, emergency C-sections or complications that may develop during or after the birth [9-13]. While a traumatic birth may weaken the women, it may be an event that causes negative psychological or emotional responses [4,14]. The traumatic birth experience may also cause feelings of disappointment, anger, irritation or loss for the woman. The traumatic birth experience will affect not only the woman, but her baby and family. These experiences and feelings may be altered by the woman assuming a motherhood role. As some women become excessively protective and sensitive towards their babies with feelings of guilt due for putting the baby through a negative birth experience, others may want to get

away from their babies due to the anxieties caused by the birth experience [15]. The traumatic birth experience may affect the interpersonal relationships of the woman with those around her. Some women complain that their partners do not understand them and experience physical or sexual withdrawal, while others even consider leaving their partners [4,15,16]. Partners and family members of women who experience a traumatic birth may also be negatively affected by the birth and the following process. Husbands of women who experience traumatic births may also withdraw from sexual activity considering the possibility that the woman may become pregnant and suffer a similar experience again. Some husbands have reported that they are unable to understand exactly what women who have had a traumatic birth experience want and feel helpless as they are unable to support their wives [16].

The aim of this study was to examine the postpartum process with a women and her family who had a traumatic birth experience. This article utilised the descriptive case study approach. This type of case study is used to describe an intervention or phenomenon and the real-life content in which it occurred. A single case was used due to the rarity of the situation [17].

CASE STUDY

FA was 24 years old, a high school graduate, married for 16 months, has been first and planned pregnancy. FA had no health issues before her pregnancy. At the start of the pregnancy she had light morning sickness, which did not reoccur after the 11th week of gestation. FA's pregnancy was normal. FA went to pregnancy

follow-up regularly during the pregnancy and no complications were revealed. FA attended for childbirth education class at the 26th-30th week of pregnancy to cope with fear of the childbirth. When she was 35 weeks and 2 days pregnant, she had an intense headache for the whole day. She took painkillers and rested upon her doctor's suggestion, but the headache did not get better. She went into the kitchen to prepare a meal, felt dizzy and grabbed the counter top, after which she remembers nothing. Her husband was in the other room and came to see what the noise was. He found FA on the floor in a pool of blood. FA had hit her head while falling and was bleeding. Her husband called the emergency service. The emergency services immediately took FA to the hospital. When they reached the emergency care unit, FA was unconscious, dilated pupils, blood pressure of 240/110, tachycardic and filiform pulse. The fetus was tested for non-stress test and it was identified that late deceleration had occurred, upon which FA was admitted for an emergency C-section. After the C-section, the baby was admitted to the newborn intensive care unit for respiratory trouble. FA was admitted to postoperative intensive care unit with a preliminary diagnosis of HELLP Syndrome. When FA regained consciousness, she did not understand why she was in intensive care unit. Her family and the staff explained that she was being held in intensive care for observation and baby were fine. Due to the positive developments in her situation on the 3rd day of post-op, she was transferred to the postnatal care unit. During our visit to the hospital on the 3rd day of post-op, it was identified that FA had extensive ecchymosis on her head and right eye, her blood pressure was under control but liver tests showed that function had not returned to normal levels. During our interview with FA, she said that she was sorry that she had not been able to give birth naturally after so much preparations and instead of speaking about her own situation, she was more worried about the babies' health and was asking questions about the baby. While expressing her feelings about the birth experience, she spoke about the birth shortly, without giving any details, as if it was not her experience but someone else's. The baby was kept in the intensive care unit for 3 weeks due to the serious situation and FA was only discharged on the 8th day postpartum. She went to the hospital every day to breastfeeding her baby. At the telephone follow-up, she only told us about her babies' situation. On the postpartum 43rd day, we visited FA at her husband's mother in law's house. Assessing FA's trauma regarding the birth, we saw that she did not consider as the traumatic experience due to she was unconscious when it happened. However, her husband, who experienced the birth in full, was wake up screaming in the night, hugging FA and asking 'you are not dead?' being unable to sleep and coming home regularly from work to check on her. Her husband was very anxious; he reacted more often to insignificant events, had started smoking, was withdrawn from sexual intercourse to protect or prevent harm to his wife, became angry when talking about the birth, wept or changed the subject. FA said that she was sad and worried for her husband but that she was unable to understand as everything turned out fine. Furthermore, FA said that because of her husband's reluctance to leave her alone, they had moved in with his mother after the birth. During our visit, we were also able to talk to FA's mother in law. She tearfully told us about the birth and the hospital experience. FA said that she tried to console her husband and his mother but she felt guilty from

time to time for making them so sad. However, FA displayed no indications of post-traumatic stress and said that she would like to have another child in a few years. In the postpartum 3rd and 6th month telephone follow-ups, FA said that her husband and mother in law no longer spoke about the birth and that it had been covered up. During the 10th month postpartum FA asked for an appointment saying that she had been feeling bad for the last month psychologically. During our home visit, she appeared to be distracted and forgetful, finding concentrating difficult, saying that she felt more withdrawn every day, that she feared that she and others around her would die, that she had negative thoughts and that these thoughts were growing out of control. She added that because of these negative thoughts, she was having trouble sleeping. FA said that she felt better when she visited her own family, who lived in a different city. The home visit showed that the babies' growth and development was normal, the mother and baby relationship was healthy, that the mother was enjoying taking care of her baby, that they spent quality time together and played games. When asked about her further pregnancy plans, FA reported that she had decided not to have any other children due to her fear of death during pregnancy or birth.

DISCUSSION

Sometimes traumatic events can negatively affect those who observe them rather than the subject of the event. In this case, FA was unable to focus on the birth, as she was unconscious when it occurred, and she focuses on taking care of her baby while being unable to understand why her family was negatively affected by her birth experience. However, nine months after the event, it was identified that she displayed post-traumatic stress symptoms. The difference between the expectations and experience of the birth, the emergency C-section and the complications that she and her baby experienced may have caused the birth to be perceived as traumatic [9-13]. However, this case is noteworthy as the woman did not experience her birth process and did not perceive it as traumatic, while she was influenced by family members who did and displayed post-traumatic stress symptoms. FA started to show post-traumatic stress symptoms after 9 months from the event in this way. Post-traumatic stress generally occurs within three months of the event and if the appropriate support can be provided can be overcome the symptoms in more than half of the cases. Rarely, post-traumatic stress can occur months after the event, which is known as 'Delayed Onset' [18]. In this case, the delayed onset of the trauma may have been effective to not knowing the details in the first two months postpartum, to focus on her babies' health in intensive care unit and to focus on supporting family members who were traumatised by the event. In Turkish culture, the families provide support to the expectant mother and father during the pregnancy, birth and afterwards. From the moment the woman finds that she is pregnant, she is enveloped in this support structure for the following process, birth and after the birth. The baby is accepted and valued not only as a member of the nuclear family consisting of the mother and father, but as the member of an extended family. If the process develops normally, all individuals within this social support network take pleasure from fulfilling their roles. However, in this case the family members were not able to provide the expected support, due to the abnormality of the process. The serious health issues experienced by the mother and baby caused the traumatisation

of family members who witnessed them. The woman was living with the traumatised members of the extended family system and tried to support them in coping with their feelings of guilt for the first part, however later on she was affected and traumatised herself. Partners and family members of women who experience a traumatic birth may also be negatively affected by the birth and the following process [16]. For this reason, it must be dealt with woman and her family members who witnessed the birth especially in the post-natal nursing follow-up.

In this case, the consulting model based on cognitive behavioural therapy model was used as a nursing approach. Nursing approaches based on the model;

- Each family member was listened actively and given the opportunity to express their feelings regarding the experience. Questions were asked allowing them to relate between current thoughts and feelings and traumatic event.

- Negative thoughts that allowed symptoms to continue were replaced with positive ones. The process was facilitated to allow the persons to realise the positive aspects of the experience.

- Individuals were facilitated to discover potential solutions and make new decisions.

- They were supported to plan for the future.

- Consultation services were planned individually or as a group for those affected by the event once a month regularly until the post-traumatic stress symptoms disappear.

In conclusion, in this case the family members witnessing the traumatic birth process were also traumatised and although the woman did not show any signs of trauma at first, she was affected by the family members and traumatised later on. The woman and her family experiencing the traumatic birth process should be treated together in the scope of postnatal care and monitored for an extended duration due to the possibility of delayed onset. Furthermore, there is a need for research regarding the effects of traumatic birth on the family in different cultures.

REFERENCES

- Garthus-Niegel S, von Soest T, Vollrath ME, Eberhard-Gran M. The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study. *Arch Womens Ment Health*. 2013; 16: 1-10.
- Modarres M, Afrasiabi S, Rahnama P, Montazeri A. Prevalence and risk factors of childbirth-related post-traumatic stress symptoms. *BMC Pregnancy Childbirth*. 2012; 12: 88.
- Beck CT, Watson S. Impact of birth trauma on breast-feeding: a tale of two pathways. *Nurs Res*. 2008; 57: 228-236.
- Elmir R, Schmied V, Wilkes L, Jackson D. Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *J Adv Nurs*. 2010; 66: 2142-2153.
- Goldbort JG. Women's lived experience of their unexpected birthing process. *MCN Am J Matern Child Nurs*. 2009; 34: 57-62.
- Ayers S. Delivery as a traumatic event: prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clin Obstet Gynecol*. 2004; 47: 552-567.
- Olde E, van der Hart O, Kleber R, van Son M. Posttraumatic stress following childbirth: a review. *Clin Psychol Rev*. 2006; 26: 1-16.
- Ayers S. Thoughts and emotions during traumatic birth: a qualitative study. *Birth*. 2007; 34: 253-263.
- Ayers S, Jessop D, Pike A, Parfitt Y, Ford E. The role of adult attachment style, birth intervention and support in posttraumatic stress after childbirth: A prospective study. *Journal of Affective Disorders*. 2014; 155: 295-298.
- Boorman RJ, Devilly GJ, Gamble J, Creedy DK, Fenwick J. Childbirth and criteria for traumatic events. *Midwifery*. 2014; 30: 255-261.
- O'Donovan A, Alcorn KL, Patrick JC, Creedy DK, Dawe S, Devilly GJ. Predicting posttraumatic stress disorder after childbirth. *Midwifery*. 2014; 30: 935-941.
- Andersen LB, Melvaer LB, Videbech P, Lamont RF, Joergensen JS. Risk factors for developing post-traumatic stress disorder following childbirth: a systematic review. *Acta Obstet Gynecol Scand*. 2012; 91: 1261-1272.
- Verreault N, Da Costa D, Marchand A, Ireland K, Banack H, Dritsa M, et al. PTSD following childbirth: a prospective study of incidence and risk factors in Canadian women. *J Psychosom Res*. 2012; 73: 257-263.
- Gamble J, Creedy DK. A counselling model for postpartum women after distressing birth experiences. *Midwifery*. 2009; 25: 21-30.
- Ayers S, Eagle A, Waring H. The effects of childbirth -related posttraumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health and Medicine*. 2006; 11: 389-398.
- Nicholls K, Ayers S. Childbirth-related post-traumatic stress disorder in couples: a qualitative study. *Br J Health Psychol*. 2007; 12: 491-509.
- Yin RK. Case study research: design and method (3rd ed). Thousand Oaks, CA: Sage, 2003.
- Andrews B, Brewin CR, Philpott R, Stewart L. Delayed-onset posttraumatic stress disorder: a systematic review of the evidence. *Am J Psychiatry*. 2007; 164: 1319-1326.

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