

1 **Perinatal Trauma with and without loss experiences**

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15 **Objective:** The present study explored differences in mental health between women
16 who experienced a trauma which involved a loss of foetal or infant life compared to
17 women whose trauma did not involve a loss (difficult childbirth). **Method:** The sample
18 consisted of 144 women (Mean age = 31.13) from the UK, US/Canada, Europe,
19 Australia/ New Zealand, who had experienced either stillbirth, neonatal loss, ectopic
20 pregnancy, or traumatic birth with a living infant in the last 4 years. **Results:** The
21 trauma without loss group reported significantly higher mental health problems than
22 the trauma with loss group ($F(1,117) = 4.807$ $p=.03$). This difference was observed in
23 the subtypes of OCD, panic, PTSD and GAD but not for major depression, agoraphobia
24 and social phobia. However, once previous mental health diagnoses were taken into
25 account, differences between trauma groups in terms of mental health scores
26 disappeared, with the exception of PTSD symptoms. Trauma groups also differed in
27 terms of perceived emotional support from significant others. **Conclusion:** The
28 findings illustrate the need for a change in the focus of support for women's birth
29 experiences and highlighted previous mental health problems as a risk factor for mental
30 health problems during the perinatal period.

31 Key words: Perinatal trauma, perinatal loss, difficult childbirth

32 **Introduction**

33 Prenatal/postnatal loss and difficult childbirth experiences, (for parsimony, called 'perinatal
34 traumas' in this study), have been identified as predictors of postnatal mental health (Soet,
35 Brack, & Dilorio, 2003). It has been reported that 15% to 25% of women who experience
36 perinatal loss suffer from adjustment problems and may seek professional help for their
37 mental health problems (Hughes, Turton, Hopper, & Evans, 2002).

38 Most common perinatal traumas include miscarriage, stillbirth, ectopic pregnancy, neonatal
39 death and difficult childbirth (Brockington, 1996). Unlike other perinatal traumas, miscarriage
40 has not been recognised as a risk factor for perinatal mental health problems until recently.
41 One earlier qualitative study showed that miscarriage signified a major life event that changed
42 the way in which women viewed their lives in the present, and affected the way in which they

43 planned for the future (Bansen & Stevens, 1992). Later studies also associated miscarriage with
44 anxiety symptoms (Cumming et al., 2007). A recent longitudinal study also emphasised the
45 risks for persistent psychopathology, particularly for vulnerable women, one year post
46 miscarriage (Lok, Yip, Lee, Sahota, & Chung, 2010).

47 Women's experience of stillbirth has been a neglected area, but has started receiving more
48 interest since the study carried out by Hughes and colleagues, which showed that PTSD
49 symptoms were common during the next pregnancy following stillbirth at 1 year post –
50 partum (Hughes, Turton, & Evans, 1999). Furthermore, in a consecutive study, Hughes and
51 colleagues found that contact with the stillborn infant (seeing / holding) was associated with
52 increased post-traumatic stress disorder (PTSD) and that next born infants were more likely
53 to show disorganised attachment behaviour. The authors' findings, in a 7 year follow up
54 study, also indicated significantly higher and enduring symptoms of PTSD following a
55 stillbirth experience (Hughes et al., 2002).

56 Most studies class ectopic pregnancy as a prenatal loss, and examine the effect of such
57 experiences within the prenatal loss construct (Beck & Driscoll, 2006; Ney, Fung, Wickett, &
58 Beaman-Dodd, 1994). Similarly neonatal death has also been studied with other perinatal
59 traumas e.g. stillbirth. Boyle et al., (1996) showed that mothers who experienced stillbirth,
60 neonatal or sudden infant death syndrome (SIDS) remained more likely than controls to
61 display high levels of both anxiety (14%) and depression (7%) more than 2 years after their
62 loss (Boyle, Vance, Najman, & Thearle, 1996).

63 Difficult/traumatic childbirth has also been associated with postpartum mental health
64 problems, particularly anxiety disorders, and has been identified as an extremely traumatic
65 stressor (Beck, 2004). It has been reported that 1% - 2% of women develop post-traumatic
66 stress disorder as a result of difficult childbirth (Ayers, Eagle, & Waring, 2006; Bailham &
67 Joseph, 2003). Alcorn et al. in a prospective longitudinal study of the prevalence of PTSD

68 following childbirth, found that PTSD can result from a traumatic birth experience after
69 controlling for pre-childbirth PTSD, depression and anxiety symptoms (Alcorn, O'Donovan,
70 Patrick, Creed, & Devilly, 2010). In addition, predisposing factors such as anxiety in late
71 pregnancy along with other psychiatric symptoms in late pregnancy, critical life events and
72 the experience of delivery was found to be an important predictor of PTSD symptoms (Zaers,
73 Waschke, & Ehlert, 2008). Since the recognition of individual vulnerability in response to
74 adversity in DSM-IV (American Psychiatric Association, 2000), PTSD symptoms following
75 a difficult childbirth have attracted lot of research interest and the current literature suggests a
76 link between PTSD symptoms and traumatic / difficult childbirth (Ayers & Pickering, 2001;
77 Wijma, Söderquist, & Wijma, 1997). However, no other study has examined difficult
78 childbirth in relation to other anxiety symptoms in the postnatal period.

79 Although some women who experience loss or traumatic childbirth trauma adjust well to
80 the loss or trauma, other women will continue to suffer (Badenhorst & Hughes, 2007). Boyle
81 et al., (Boyle et al., 1996) also suggested that although bereaved mothers reported higher rates
82 of psychological distress, not all bereaved mothers suffered from mental health problems
83 following a perinatal trauma. Their findings suggested that women who were psychologically
84 distressed soon after the loss were likely to still be distressed 8 months later and likely to
85 remain so subsequently.

86 It has been argued that perinatal trauma may act as a trigger, turning vulnerability for
87 mental health problems into actual disorders. Côté-Arsenault et al. suggested that it is not the
88 gestational timing of the perinatal loss (miscarriage, stillbirth or neonatal) but the personal
89 meaning of each loss that is important for adjustment to loss (Côté-Arsenault, Bidlack, &
90 Humm, 2001). For example, it has been shown that women who experienced a perinatal loss
91 may begin to question their ability to conceive and to be able to give birth to a living child
92 like any other woman (Nansel, Doyle, Frederick, & Zhang, 2005), or they may suffer from

93 anxiety symptoms following a difficult childbirth and blame themselves for failing to have a
94 successful birth and not being able to bond with their living infant (Czarnocka & Slade,
95 2000).

96 However, whilst PTSD and OCD in perinatal loss (Bailham & Joseph, 2003;
97 McGuinness, Blissett, & Jones, 2011) have received considerable research interest, there is
98 less research into perinatal panic disorder (Rambelli et al., 2010), agoraphobia, social phobia
99 (Murray, Cooper, Creswell, Schofield, & Sack, 2007), and generalised anxiety disorder
100 (GAD) (Lim et al., 2005).

101 Perinatal mental health complications coincide with the very crucial period where
102 bonding to the infant takes place for the mother, and for the infant, attachment to his/her
103 mother. The parenting behaviour of women with anxiety disorders features reduced
104 emotional involvement, impaired communication, and the women are less responsive to their
105 children (Field, Healy, Goldstein, & Guthertz, 1990). It is possible that anxiety disorders and
106 their symptoms could also have a detrimental effect on the early relationship between a
107 woman and her baby. For example, mothers with OCD and panic disorder were observed to
108 be less warm and promoting of psychological autonomy than control group mothers
109 (Challacombe & Salkovskis, 2009). Mothers with PTSD symptoms may have difficulties in
110 breastfeeding and bonding with their baby (Reynolds, 1997). Also, parental behaviour low in
111 warmth has been documented in families with anxiety disordered parents (DiBartolo & Helt,
112 2007). Mothers may experience difficulty in bonding with their infant following a difficult
113 childbirth due to their increased PTSD symptoms (Beck & Watson, 2008) or if the traumatic
114 birth is associated with the baby, mothers may have difficulties in their relationships with
115 their infants (Ayers et al., 2006).

116 The degree or perception of social support a woman experiences during and after the
117 trauma is an important predictor of outcome. Recently the ‘importance of maternity staff and

118 care pathways' and high risk populations including women who have preterm or stillborn
119 infants has been identified as a research focus on PTSD following childbirth (McKenzie-
120 McHarg et al., 2015).

121 Social support is conceptualised as a multidimensional construct (House & Kahn, 1985).
122 There are four identified attributes which are, emotional, informational, tangible, and
123 appraisal support (Cohen & Wills, 1985). Research confirms the importance of social
124 support, particularly emotional support, for better adjustment following perinatal trauma
125 (Cacciatore, Schnebly, & Froen, 2009; Leon, 1986). For the perinatal period, for example, in
126 a phenomenological study following a perinatal loss, parents defined their emotional
127 support needs as physical presence; being listened to and being allowed to express their
128 feelings; acceptance of their feelings and being given sympathy by health professionals
129 (Kavanaugh, Trier, & Korzec, 2004). Another study focused on emotional needs and
130 perinatal loss highlighted the need for acknowledging and validating the feelings of parents
131 (Davis, Stewart, & Harmon, 1988).

132 Even though studies have examined a range of perinatal trauma experiences in relation to
133 mental health problems, currently no study has yet examined the mental health outcomes of
134 perinatal trauma for those women who experience loss and those women who have a
135 surviving infant. Furthermore, the perceived emotional support from significant others,
136 during and after perinatal trauma has not been compared between groups with and without
137 loss. It is reasonable to expect that survival of the infant may reduce the experience of mental
138 health symptoms in comparison to women who lost their infants before or after childbirth. It
139 may also be that the mother's perception of support from significant others moderates the
140 extent to which mental health symptoms are experienced.

141 In light of the above literature, the present study investigated whether trauma with or
142 without loss of the infant resulted in greater psychological distress, with particular focus on

143 symptoms of anxiety disorders including panic, obsessive compulsive symptoms, post-
144 traumatic stress and generalised anxiety symptoms. It also examined the perceived emotional
145 support from a partner, close family members and health practitioners between trauma
146 groups.

147 **Method**

148 *Sample*

149 A total of 144 women (Mean age = 31.13) from UK, US/Canada, Europe, Australia/ New
150 Zealand took part in this study. Women who experienced a single perinatal trauma within the
151 last 4 years were included in this study (miscarriage (52), neonatal death (4), stillbirth (17),
152 ectopic pregnancy (4) or difficult childbirth (77)). A total of 67 women who experienced a
153 single perinatal trauma with loss (miscarriage, neonatal death, stillbirth and ectopic
154 pregnancy) constituted the ‘trauma with loss’ group, while 77 women who experienced
155 difficult childbirth with a surviving healthy baby constituted the ‘trauma without loss’ group.

156 *Procedure*

157 Participants were provided with an information sheet about the study which fully explained
158 the content of the questionnaires and informed consent to participate in the study was
159 provided by all participants. Each participant completed a set of web-based questionnaires
160 and submitted their answers anonymously online. The study was advertised on social
161 websites and the websites of some national and international organisations (Birth Trauma
162 Association UK; Share US, Australia/New Zealand (Sands AU); Magic Mums). At the end
163 of the study, participants were presented with a debriefing form signposting them to sources
164 of support and information in case taking part in the study had distressed them in any way.

165

166

167 *Measures*

168 *The Psychiatric Diagnostic Screening Questionnaire (PDSQ)*: The PDSQ (Zimmerman &
169 Mattia, 2001) is a self-report scale designed to screen for the most common disorders in the
170 Diagnostic Statistical Manual of Mental Disorders (American Psychiatric Association, 2000).
171 The measure has good to excellent levels of internal consistency, test-retest reliability, and
172 discriminant, convergent, and concurrent validity (Zimmerman & Mattia, 2001). In this
173 study, the bulimia, abuse/dependence, somatisation, hypochondriasis and psychosis subscales
174 were not used.

175 *Edinburgh Postnatal Depression Scale (EPDS)*: The EPDS (Cox, Holden, & Sagovsky,
176 1987) was used to measure depressed mood in the postnatal period. This scale consists of a
177 10 item self-report scale to assess depression. It was developed and validated specifically for
178 postnatal use and is used worldwide.

179

180 *Background/demographic questionnaire*: Participants also provided details of their
181 reproductive history, perinatal trauma, demographics and past history of mental health
182 problems prior to their perinatal trauma.

183 *Perinatal Experience and Support Questionnaire*: This questionnaire was designed to collect
184 information on women's experience of perinatal trauma(s) and their perceived emotional
185 support from significant others (partner/ husband, family, and health practitioners). It
186 consisted of five separate sections for each trauma experience. It is comprised of questions
187 regarding the details of the trauma experiences (e.g. '*type of trauma*', '*when was the*
188 *perinatal trauma experience*') and questions regarding the participant's satisfaction with the
189 emotional support received from significant others ('*Please rate the emotional support that*

190 *you have received from Health Practitioners regarding your stillbirth experience*') on a 1-5
191 likert type scale (1= not at all satisfied, 5 = extremely satisfied).

192

193 This study was reviewed and approved by University of Birmingham Research Ethics
194 Committee (ERN_10-0698).

195 **Results**

196 A preliminary analysis revealed that there were no significant differences between the two
197 trauma groups in terms of relationship, education, ethnicity, job status and age. However, the
198 two groups differed in past mental health history. A higher rate of previous mental health
199 problems was observed in the trauma without loss group. The results are presented in Table
200 1. (A pairwise execution was used for the analysis thus the number of participants varied in
201 analyses, as indicated in the tables).

202 Following to the preliminary analysis a series of one-way ANOVAs were conducted to
203 examine mean differences between trauma groups in the PDSQ total and PDSQ subscales.
204 The findings are presented in Table 2 and Figure 1. There was a statistically significant
205 difference in women's PDSQ total scores between the trauma groups. The trauma without
206 loss group reported more psychological distress than the women who experienced trauma
207 with loss. Despite reaching statistical significance, the actual difference in mean scores
208 between the groups was small.

209 *PDSQ sub-scores and EPDS by trauma groups*

210 Similarly, this difference in psychopathology remained in symptoms of OCD, Panic, PTSD
211 and GAD. Homogeneity of variance assumptions was only violated for the trauma group's
212 OCD scores. However the trauma group's OCD scores were significantly different at a
213 stringent significance level ($p=.01$). The differences between groups in Major Depression,

214 Agoraphobia and Social Phobia were not statistically significant. Furthermore there was no
215 statistically significant difference for the EPDS scores between groups (see Table 2 and
216 Figure 1).

217 *Current mental health symptoms of trauma groups by previous mental health problems*

218 It was noted that the groups differed in terms of previous mental health problems. In order to
219 understand whether the differences in the mental health scores for the trauma with and
220 without loss groups comes from higher pre-existing problems in these women, the above
221 ANOVA analysis was re-run examining only the mental health scores of the women (n=107)
222 in each group who did not report any previous mental health problems prior to their trauma
223 experience (Table 3).

224 As presented in Table 3 none of the general and specific mental health scores other than
225 PTSD scores differed between trauma with loss and without loss groups. Women with no
226 prior history of mental health problems, but who experience a perinatal trauma, are more
227 likely to report higher PTSD symptoms if their trauma involves a surviving infant than a loss.

228 *Perceived emotional support by trauma groups*

229 A series of one-way ANOVAs were conducted to examine mean differences between trauma
230 groups in perceived emotional support from significant others. The findings revealed a
231 significant difference in perceived emotional support from Health Practitioners and Partner
232 between the two trauma groups. For the trauma with loss group, perceived emotional
233 support from Health Practitioners and Partner was significantly higher than perceptions of
234 support reported by those without loss (Table 4).

235 **Discussion**

236 This study aimed firstly to explore differences in mental health scores between women who
237 experienced perinatal trauma with and without loss. Contrary to the expectations, analysis

238 revealed that the trauma without loss group reported significantly higher mental health
239 problems than the trauma with loss group. This difference remained in the anxiety specific
240 mental health problems OCD, Panic disorder, PTSD and GAD but not in major depression,
241 agoraphobia or social phobia. It appears that women who experienced a perinatal trauma
242 without an infant loss, suffered from more anxiety symptoms than women who experienced
243 an infant loss. However, once the previous mental health history was taken into account, this
244 difference disappeared for the general and specific mental health scores. However, there
245 remained a significant difference in PTSD scores, with women who experienced trauma
246 without loss reporting greater PTSD symptomology. This finding supports other literature
247 suggesting a link between increased PTSD and difficult childbirth (trauma without loss)
248 (Ayers & Pickering, 2001; Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008).

249 The women who experienced perinatal loss appeared to have fewer mental health problems in
250 comparison to the trauma group with a living infant; however, they still suffered from general
251 and specific mental health problems (Figure 1). It would therefore be inaccurate to conclude
252 that women who experienced perinatal trauma without an infant loss are ‘worse off’ than the
253 women who experienced perinatal trauma with loss. This study actually underlines the
254 importance of understanding the trauma and individual vulnerabilities in relation to perinatal
255 mental health. It appears that although women survive the perinatal trauma with a living
256 infant, their view of their trauma experience appears to count more than the outcome of the
257 trauma – a living infant vs. a deceased infant.

258 Findings from this study also suggested a significant difference between the trauma groups’
259 perceived emotional support. It appears that mothers who experience a trauma without loss
260 perceive less emotional support from their partners and health practitioners. In other studies
261 mothers reported a lack of validation for their experiences (Ustundag - Budak, Larkin, Harris

262 & Blissett, 2015) particularly from health care staff (Beck, 2011) as the outcome of the birth
263 was a live birth and the mothers perhaps felt that their experiences as whole were not
264 acknowledged. Social support, particularly emotional support from health care providers, has
265 been identified as an important factor for better adjustment following perinatal traumas
266 (Cacciatore et al., 2009; Iles & Pote, 2015). In addition, Beck, in a recent metaethnography
267 analysis of traumatic childbirth, discussed the multiple, recurring, reinforcing, intensifying
268 causal loops, encompassing feedback behaviour and how such loops, in a domino effect,
269 influence the mothers' experiences after trauma. Beck stressed the importance of feedback in
270 order to tackle the reinforcing causal loops (Beck, 2011). The findings of the current study
271 thus highlight the importance of validation of mothers' experiences and the need for
272 compassionate care (Cornwell & Goodrich, 2009) for women who suffered perinatal trauma
273 without loss. Health care staff and partners may show more compassion towards women who
274 experienced a perinatal trauma with loss (e.g. stillbirth or neonatal death) in comparison with
275 women who survived the trauma with a living infant because their focus is on the outcome of
276 the experience. It is plausible to speculate that this invalidation of experiences and feelings
277 could be detrimental to mental health, particularly in symptoms of PTSD. It has been argued
278 that validation, including empathy and accurate reflection of individuals' experiences, is
279 quintessential to both healthy development and treatment of psychological problems (Rogers,
280 1951). This may require further research in terms of perinatal trauma and also may have
281 implications for therapeutic interventions and their need to focus on the validation of
282 experiences. A current review of post-traumatic stress disorder following childbirth
283 (McKenzie-McHarg et al., 2015) highlights current issues around the failure of diagnoses of
284 PTSD symptoms where there has not been tangible trauma, for example a third-degree tear or
285 internal bleeding. The review also underlines the importance of acknowledging sub-threshold
286 symptomology. Women may suffer from a variety of symptoms of PTSD but not meet the

287 criteria for PTSD diagnoses. Women are also less likely to receive emotional support and
288 validation from health care professionals where their trauma experiences are not
289 acknowledged. It is possible that the participants of this study may have perceived the lack of
290 emotional support due to their unrecognised trauma experiences.

291 Parallel with previous literature, the findings of the present study may suggest that previous
292 vulnerability to mental health problems is an important risk factor for poorer mental health
293 scores following a perinatal trauma experience (Milgrom et al., 2008). Pre-pregnancy
294 mental health history has been identified as a risk factor particularly for PTSD symptoms
295 following difficult childbirth (Ayers et al., 2009; Wijma et al., 1997; Zaers et al., 2008).
296 However, the findings also indicated a remaining significant difference between the PTSD
297 scores of the trauma groups with and without loss, who did not have previous mental health
298 problems. This suggests that women who experienced difficult childbirth maybe at risk for
299 PTSD even in the absence of vulnerability caused by previous mental health problems and
300 that this effect may be stronger in those women who have a living infant.

301 The subjective experience of adverse experiences underlines the importance of individual
302 variability in response to a trauma experience. Beck drew attention to the fact that what a
303 mother perceives as birth trauma may be seen quite differently through the eyes of health
304 professionals, who may focus on the live birth following traumatic birth experience (Beck,
305 2004). It has been recently highlighted that the experience of difficult childbirth, suggests a
306 near death experience for both mother and child, unlike other trauma experiences (McKenzie-
307 McHarg et al., 2015). It is plausible that when women experienced a threat to the survival of
308 themselves and/or their infant, their infant then may be a constant reminder of their trauma
309 experience while they struggle to adjust (Ayers et al., 2006). They may also be dealing with
310 difficulties in bonding and negative feelings such as failing to love or look after their infant

311 well enough (Czarnocka & Slade, 2000; Elmir, Schmied, Wilkes, & Jackson, 2010). These
312 may contribute to the worsening mental health symptoms in this group.
313 This study has shown that mental health problems may be experienced by women who have
314 experienced both a live birth after a traumatic event as well as mothers who have experienced
315 an infant death. Mental health problems are more likely to be observed in those mothers who
316 had a previous history of mental health problems, but post-traumatic stress responses may
317 well be observed where there has been no such previous history. Examining and
318 understanding the influence of such factors is important in order to support women
319 accordingly.

320 *Limitations*

321 A possible improvement for this study would have been to record the time that had passed
322 since the traumatic event. In this way, we could have examined the time since the trauma in
323 relation to experience of mental health symptoms. However, mothers were only eligible for
324 the study if they had experienced their trauma within a 4 year period and so all traumatic and
325 loss experiences were relatively recent events.

326 *Implications and Further Research*

327 This study has implications for current provision of perinatal support. The findings
328 emphasise the need for emotional support for mothers who have experienced a difficult
329 childbirth with a living infant. In addition, there is an emerging need for a shift from
330 outcome based focus (the survival of infant), to an individual based focus for women's birth
331 experiences. In particular, the awareness of health professionals involved in childbirth and
332 the perinatal period, about how such traumas may have an effect on the mothers, regardless
333 of their healthy infant's survival, may improve the care provided to women who experienced
334 a traumatic birth. Psychological support may also be necessary for those women with

335 previous mental health problems who experienced perinatal trauma. Health practitioners
336 should be informed of the emotional support needs of mothers who experience perinatal
337 trauma and there is a need for a greater awareness of the potential impact of trauma without
338 loss on later adjustment. Specific training for health practitioners about how to validate
339 women's experiences should be considered. Similarly, the need for support after traumatic
340 perinatal trauma could also be disseminated to women's partners. These findings call for a
341 significant shift of emphasis in the prioritisation of care to include support for women who
342 have experienced difficult births as well as mothers who have suffered a pregnancy loss.
343 The research implications of this study are twofold. Firstly, it is very important to understand
344 the underlying factors that influence the women's view of their own trauma experiences in
345 order to support women perinatally. Further research is needed to understand the factors
346 which may influence women's view of their traumatic experiences and perceived social
347 support. Secondly, there is a need to investigate whether health professionals may behave
348 more sympathetically towards women who have given birth to a deceased infant and yet
349 failed to validate experiences of women who had a difficult childbirth with a living infant.
350 These hypotheses require further research.

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496 **Tables**

497 Table 1. Demographic differences in PDSQ scores of single trauma with or without loss
498 groups (n=144)

499

500 Table 2. Univariate analysis of variance for the differences between trauma without loss and
501 trauma with loss scores on the PDSQ and PDSQ sub scores (n=144)

502

503 Table 3. Univariate variance analysis for the differences between trauma without loss and
504 trauma with loss scores on the PDSQ and PDSQ sub scores of women with no mental health
505 history (n=107)

506

507 Table 4. Univariate analysis of variance for the differences between trauma without loss and
508 trauma with loss scores on perceived emotional support (n=142)

509 **Figures**

510 Figure1. PDSQ total and sub scale scores by trauma group

511

512 Table1. Demographic differences in PDSQ scores of single trauma with or without loss
 513 groups (n=144)

		Trauma without loss		Trauma with loss	
		N	%	N	%
Relationship	Single	1	1.5	3	3.9
	In a Relationship	14	20.9	12	15.6
	Married	52	77.6	62	80.5
$\chi^2 (2, N(144))=1.34, p =.51 (NS)$					
Education	School education	3	4.5	13	16.9
	Post school	18	26.9	21	27.3
	Degree level	32	47.8	18	23.4
	Postgraduate level	13	19.4	22	28.6
$\chi^2 (4, N=140)=12.30, p =.06 (NS)$					
Ethnicity	Black	-	-	-	-
	Asian	2	3	5	6.5
	White	63	94	69	89.6
	Other	2	3	3	3.9
$\chi^2 (2, N=144)=1.07, p =.59 (NS)$					
Job Status	Unemployed	3	4.5	5	6.5
	Unskilled	7	10.4	11	14.3
	Skilled	45	67.2	50	64.9
	Managerial/Professional	12	17.9	8	10.4

$\chi^2 (5, N=141)=3.68, p=.60 (NS)$

Previous

Mental Health	Yes	24	35.8	13	16.9
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Problem

	No	43	64.2	64	83.1
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$\chi^2 (2, N=144)=5.77, p=.02 (S)$

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516 Table 2. Univariate analysis of variance for the differences between trauma without loss and
 517 trauma with loss scores on the PDSQ and PDSQ sub scores (n=144)

	Trauma without			Trauma with			F	Df	p
	Loss			Loss					
	M	SD	N	M	SD	N			
PDSQ Total	29.74	17.49	61	23.14	15.20	58	4.81	1-117	.03*
Obsessive Compulsive Disorder (OCD)	1.02	1.52	66	0.47	0.94	73	6.66	1-137	.01*
Panic Disorder	2.45	2.72	65	1.35	2.05	71	7.07	1-134	.01*
PTSD	7.23	4.23	62	4.65	4.11	63	11.93	1-123	.03*
Major Depression	6.75	5.14	61	6.32	4.42	62	.25	1-121	.62
Agoraphobia	1.82	2.60	62	1.33	2.02	63	1.38	1-123	.24
Social Phobia	4.47	4.13	62	3.63	4.29	59	1.21	1-119	.27
Generalised Anxiety Disorder (GAD)	5.61	3.46	62	4.34	3.44	61	4.16	1-121	.03*
Depression measured by EPDS	14.40	6.99	56	12.90	5.57	52	1.53	1-106	.22

518 * p< 0.5

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524 Table 3. Univariate variance analysis for the differences between trauma without loss and
 525 trauma with loss scores on the PDSQ and PDSQ sub scores of women with no mental health
 526 history ($n=107$)

	Trauma without Loss			Trauma with Loss			F	df	p
	M	SD	N	M	SD	N			
PDSQ Total	23.74	15.05	38	22.09	14.40	46	0.26	1 82	0.61
OCD	0.69	1.30	42	0.48	0.97	60	0.86	1 100	0.36
Panic	1.69	2.41	42	1.26	1.90	58	1.00	1 98	0.32
PTSD	6.38	4.14	39	4.31	3.94	51	5.84	1 88	.018*
Major Depression	5.26	4.55	38	5.86	4.31	50	0.39	1 86	0.53
Agoraphobia	1.05	1.85	39	1.28	1.95	50	0.32	1 87	0.58
Social	3.62	4.13	39	3.67	4.34	46	0.00	1 83	0.95
GAD	4.46	3.36	39	4.23	3.32	48	0.10	1 85	0.75
EPDS	12.12	6.63	35	12.43	5.36	40	0.50	1 73	.821

527 * $p < .05$

528

529

530

Table 4. Univariate analysis of variance for the differences between trauma without loss and trauma with loss scores on perceived emotional support (n=142)

	Trauma without Loss			Trauma with Loss			F	df	p
	M	SD	N	M	SD	N			
Perceived Emotional Support from Health Practitioner									
Perceived Emotional Support from Health Practitioner	1.92	1.03	66	2.67	1.20	76	15.55	1/140	0.0001*
Perceived Emotional Support from Partner									
Perceived Emotional Support from Partner	3.27	1.44	66	3.91	1.25	76	7.94	1/140	0.01*
Perceived Emotional Support from Family									
Perceived Emotional Support from Family	2.93	1.33	61	3.00	1.24	74	.088	1/133	0.77

* $p < .05$

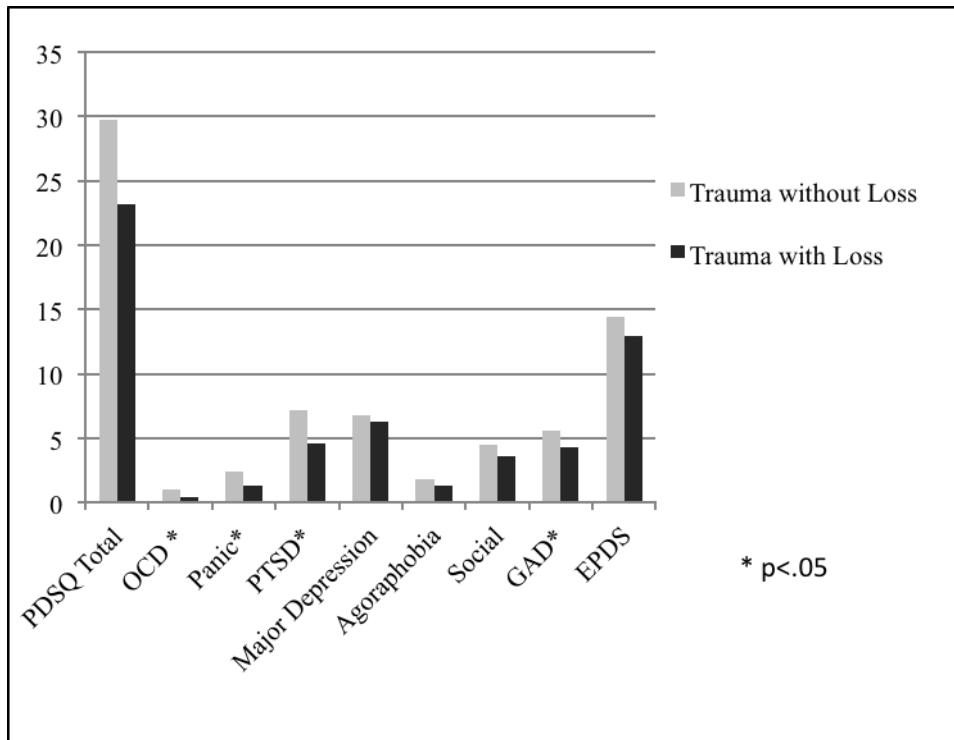


Figure 1. PDSQ total and sub scale scores by trauma group