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Commentary on 'Post-traumatic stress following childbirth: a review of the emerging literature and directions for research and practice'

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The study and recognition of post-traumatic stress disorder (PTSD) following childbirth is an area that is rapidly expanding and new research is being generated internationally. To date, however, little of this research has been published and Dawn Bailham and Stephen Joseph are to be commended for trying to pull together most of the published research, and draw conclusions on the basis of the limited evidence available. Equally, it must be recognized that it is difficult at such an early stage to do more than suggest factors that may be important, and some of these suggestions may later be shown to be erroneous. Therefore, it is important that we maintain a cautious and critical approach towards postnatal PTSD. I would like to draw out a few key conceptual and methodological issues I think should be borne in mind when carrying out or interpreting research in this area.

Conceptually, it is important to recognize the distinction between perceiving birth as traumatic (appraisal), a traumatic stress response (initial symptoms of intrusions and avoidance), and clinical PTSD (fulfilling criteria for diagnosis). Although they may be interrelated, these three are not necessarily the same. For example, as Bailham and Joseph mention, although women with instrumental deliveries perceived birth as more distressing, they did not have more symptoms of PTSD. Similarly, research I have carried out shows that although a large proportion of women have symptoms of a traumatic stress response in the first week after birth, only a very small proportion of them will go on to develop clinical PTSD (Ayers & Pickering; unpublished).

In addition to distinguishing between appraisal, traumatic stress responses, and PTSD, it is important to recognize that vulnerability and risk factors may vary for these different outcomes. For example, we could speculate that women with high trait anxiety may be more prone to show a traumatic stress response which then resolves during the first few weeks after birth, whereas women with a history of trauma or psychological problems may be more likely to develop PTSD.

The distinction between appraisal, traumatic stress responses, and PTSD also has a number of implications. First, it is important that we do not end up pathologizing the traumatic stress response, as the majority of women with these symptoms are likely to spontaneously resolve them in the first few weeks after birth. As part of the DSM-IV subcommittee on PTSD, Rothbaum and Foa (1993) recommended 3 months as the best duration for diagnosing chronic PTSD because there is much less spontaneous resolution after this time. Another implication is that when evaluating research it is important to look at the outcome measures used, as well as the time of measurement, to judge whether the research is looking at appraisal, a stress response, or clinical PTSD. Finally, we must be aware that there are many possible responses to highly stressful or traumatic events. These responses are not only restricted to PTSD and can include depression and somatization (see Davidson & Fairbank, 1993 for a discussion of post traumatic depression responses).

In addition to conceptual issues there is a particularly critical methodological issue that research in this area needs to take into account. This is that some women may have PTSD that predates

childbirth. In other words, women may have PTSD in pregnancy, or have a history of PTSD related to another trauma, which may or may not have been resolved. In both these instances it is possible that an event like childbirth may re-trigger PTSD symptoms and/or shift the focus of current symptoms onto birth. It is also possible that causal factors for women with pre-existing PTSD are different from those for new cases of PTSD after birth. This has many implications, one of which is that research looking at the prevalence and incidence of postnatal PTSD must take into account this possibility and screen for current and lifetime PTSD in pregnancy. To date, there is only one published study that has screened for PTSD in pregnancy and this study suggested that, once these women were removed from the sample, a further 2% of women had PTSD 6 months after birth (Ayers & Pickering, 2001). However, this study did not look at lifetime PTSD and therefore could not account for women who had a history of PTSD. Another implication is that research looking at vulnerability and risk factors should examine whether these differ between women with a previous history of PTSD, compared to women with no previous history. So far, no published studies have done this.

With regard to aetiological factors, I would argue that the role of obstetric variables in postnatal PTSD is currently controversial. The intrigue of childbirth is that it has the potential to range from extremely positive to extremely negative. Indeed, for many women birth involves both positive and negative experiences and emotions (Slade et al., 1993). Thus we can study a range of stress responses and look at the differing roles of objective and subjective experience. There are, for example, birth situations that appear objectively traumatic, such as undergoing a caesarean section without effective anaesthetic, which one would expect the majority of women to find traumatic. There are other situations, such as a normal vaginal delivery, where one might expect the majority of women to be fine. However, we must remind ourselves of the diathesis-stress approach, where individual vulnerability interacts with events to determine outcome. Therefore, if a woman has a high level of vulnerability or risk, it is possible that the experience of an obstetrically 'normal' birth is traumatizing because of subjective experience (e.g. high levels of fear, lack of control, etc.). Similarly, a woman with low levels of vulnerability may recover from a more objectively traumatizing experience. This variation in individual vulnerability, objective and subjective birth experience means there is unlikely to be a simple linear relationship between obstetric intervention and psychological outcome. The conflicting evidence regarding the role of obstetric events in PTSD supports this.

Finally, publications in this area often mention the practical implications of this research in terms of providing primary prevention, secondary prevention, or tertiary care. However, there is little research evaluating these kinds of interventions with postnatal PTSD. Studies that have looked at postnatal debriefing have conflicting results (e.g. Lavender & Walkinshaw, 1998; Small et al., 2000). Furthermore, this research has concentrated on postnatal depression or anxiety and has not examined the effect of postnatal debriefing on symptoms of PTSD. In addition, debriefing interventions have tended to be midwife-led and not structured psychological debriefing, such as critical incident stress debriefing (Dyregov, 1989; Mitchell, 1983). Finally, this research has chosen 'at-risk' women on the basis of assumed aetiological factors, such as type of delivery or parity, when there is no consistent evidence that these do actually constitute risk factors. Research examining debriefing in other samples provides little evidence that debriefing is effective for reducing distress or for preventing the development of PTSD (Wessely et al., 2000). Yet, worryingly, there are reports that as much as 36% of hospital trusts in the UK have postnatal 'debriefing' services, and that a

further 28% plan to implement such a service (Small et al., 2000). It is therefore vital that research starts to address this issue and inform the provision of clinical services.

In conclusion, I would like to commend Bailham and Joseph again for their attempt to pull together some of the research at this early stage. I have raised only a few of the conceptual and methodological issues that I think are important to bear in mind at this stage. I hope that Bailham and Joseph's paper, along with this commentary, will guide future research in this area and help us towards a better understanding of factors involved in the development of postnatal PTSD.

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