AIMS For a better birth...

Post-traumatic stress disorder: AIMS' voice at the RCOG

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by Jean Robinson

Recent evidence shows that suicide was the single largest cause of maternal death during the first year after childbirth. Jean Robinson shares her thoughts on posttraumatic stress disorder.

On the front of the Royal College of Obstetricians and Gynaecologists' latest book on maternal mortality is a photograph of a group of people in the RCOG's elegantly landscaped garden. In the front row, there I am - a small, grey-haired woman squinting into the sun, surrounded by obstetricians. Not my usual territory.

At rather short notice, I was asked to take part in a threeday meeting on maternal mortality and morbidity. It was a small symposium and everyone present was giving a paper. I knew at once what I wanted to talk about: post-traumatic stress disorder. The latest Confidential Enquiry Into Maternal Deaths had at last shown that suicide was the largest single cause of maternal death during the first year after childbirth. But, although depression and postnatal psychosis were mentioned, nothing was said of PTSD.

Yet, among the many women who contact AIMS, the most worrying are those with severe trauma from childbirth, with the classic symptoms of nightmares, flashbacks, depression and personality changes. We find that many are suicidal, their condition has often not been diagnosed and is rarely successfully treated on the NHS and, years later, many have become chronic cases. Now, at last, I had a chance to tell their story and to make sure their voices were heard-and in a place where it might make a difference. Because of all I have learned from them, there should be hundreds of names listed as joint-authors of 'my' paper[1].

I knew the message I was bringing would not be palatable as most postnatal PTSD is avoidable - it is iatrogenic (an illness caused by medical care), mainly due to the way women are treated. I had a lot of material from women, and their families, whom we had listened to over the years, and it was far richer and more varied than what appeared in professional journals. What I tried to do was amalgamate the valuable information they had given us with what the research already showed so that it wouldn't be rejected as a lot of unscientific anecdotes.

My interest in PTSD started long before anyone knew what it was, including me. I was Chair of the Patients Association from 1973-75, when obstetricians had just discovered the oxytocin drip as a means of inducing labour and had really gone overboard. Some hospitals were inducing up to 60 per cent of their

pregnant women, despite the fact that the effect of even a small dose on the uterus could not be predicted. Indeed, it could cause powerful, intense and frequent contractions that became one continuous contraction. It made the body behave in a way that Nature had not designed it to. Oxytocin contracted the uterus, but did not dilate the cervix (we had to wait for prostaglandins for that), so this attempt to squeeze the baby out intensified against the pressure of a tightly closed cervix.

In Oxford, where I live, a woman GP lied about her dates to avoid it, and a midwife who worked at the hospital hid in the lavatory until her labour was too far advanced for any interference. I was receiving letters from all over the country from women who had had children before, but were now having terrible nightmares after their last child was induced. This was before epidurals came in. One woman from Glasgow wrote, "I heard the women screaming and it struck terror into my heart, though I had had three children before". I could only think of what the women described as shell-shock - like the state I had heard about in soldiers after WWI. This proved to be prophetic as it was by studying veterans of the Vietnam War that psychiatrists eventually coined the term 'post- traumatic stress disorder'.

At the meeting, I suggested four reasons why PTSD was not being diagnosed:

1. GPs, health visitors and even psychiatrists do not know there is such a postnatal illness. Childbirth was a 'normal' function and women should be grateful for a healthy baby.
2. When the Edinburgh Depression Scale is used to diagnose postnatal depression, women with PTSD simply show up as depressed, not traumatised.
3. Diagnosing PTSD means listening to the woman's story of trauma-and if you believed her, you would be criticising the professional colleagues who looked after her.
4. There is a shortage of psychiatrists and clinical psychologists who know about and are able to treat it.

From the many accounts received by AIMS, I was able to pinpoint common factors, especially staff behaviour, and emphasise the heightened hormone- induced awareness and sensitivity that women have during labour and shortly after giving birth that makes them vulnerable. I showed how important a public health issue this was by quoting a prospective study, from at St George's Hospital in London, which estimated that 10,000 new cases of PTSD are created every year in the UK. I finished with a list of what women and AIMS wanted:

1. Recognition that mental health outcomes are an essential component of medical care and should be measured;
2. More research on attitudes and procedures that women described as causing their PTSD;
3. Psychological and 'spiritual' training of all staff dealing with labouring women or those who had just given birth;
4. Research on the differences between PTSD as a whole and the sort that can follow childbirth;
5. More specialist maternity psychiatric services, including mother and baby units.

In my presentation, I explained that, after induction rates decreased (in response to consumer protest),

there were fewer traumatised women, but then, augmentation of labour with oxytocin went up along with early rupture of membranes, and so on, and cases came from these interventions also.

However, the common theme in PTSD was not just a procedure or intervention, but the way the woman was treated. In the discussion that followed, Professor James Drife said: "Mrs Robinson said... when induction rates came down, the complaints were about something else. This made me wonder whether there is a normal distribution of people who are very satisfied, and people who complain and, whatever we do, people at one end of that distribution will complain."

I did my best to respond!

Reference

1. Robinson J. Post traumatic disorder-a consumer view. MacLean A, Neilson J. Maternal Morbidity and Mortality. RCOG Press, 2002; pp 313-22

NB: On the last page of the book Maternal Morbidity and Mortality, the last word comes from Dr Gwyneth Lewis, the doctor at the DoH who has edited the last three Confidential Enquiries into Maternal Death and improved them enormously. She writes: "On a personal note, there is something else that I had not thought about until you mentioned the word 'costs'. There are other costs. I am a hard-bitten old civil servant and doctor of many years. I read these reports, and I have to put them all on the database. I can get through five or ten quite easily, for a week, and then one hits me, and another one hits me and I cry - usually at three o'clock in the morning, all alone at home. We underestimate the emotional effects that running an Enquiry can have - particularly one with so much detail. The suicide note made me cry. We ought to be realistic about the cost to ourselves, but it shows at the end of the day that it is real women we are trying to help.