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Article (Unspecified)

Ayers, S, Eagle, A and Waring, H (2006) The effects of childbirth-related post-traumatic stress disorder on women and their relationships: a qualitative study. *Psychology, Health & Medicine*, 11 (4). pp. 389-398. ISSN 1354-8506

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**The effects of childbirth-related post-traumatic stress disorder on women and their
relationships: A qualitative study**

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Running head: Postnatal PTSD

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Abstract

There is converging evidence that 1 to 2% of women develop post-traumatic stress disorder (PTSD) as a result of childbirth. The current study aimed to explore the long-term effects of childbirth-related PTSD on women, their relationship with their partner, and their relationship with their child. Semi-structured interviews were carried out with six women who reported clinically significant PTSD after birth, ranging from 7 months to 18 years beforehand. Interviews were transcribed and analysed using thematic analysis. Childbirth-related PTSD was found to have wide ranging effects on women and their relationships. Women reported changes in physical wellbeing, mood and behaviour, social interaction, and fear of childbirth. Women reported negative effects on their relationship with their partner including sexual dysfunction, disagreements, and blame for events of birth. The mother-baby bond was also seriously affected. Nearly all women reported initial feelings of rejection towards the baby but this changed over time. Long-term, women seemed to have either avoidant or anxious attachments with their child. It is concluded that childbirth-related PTSD can have severe and lasting effects on women and their relationships with their partner and children. Further research is needed to compare this to normal difficulties experienced by women after having children.

Keywords: postnatal, post-traumatic stress disorder, birth, relationship

The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study

Case studies of women with childbirth-related post-traumatic stress disorder (PTSD) have been reported for over twenty years e.g. (Bydlowski & Raoul-Duval, 1978). Studies of the prevalence of postnatal PTSD in Europe (Soderquist, Wijma, & Wijma, 2002); (Wijma, Soderquist, & Wijma, 1997), the UK (Ayers & Pickering, 2001); (Czarnocka & Slade, 2000), North America (Soet, Brack, & Dilorio, 2003) and Australia (Creedy, Shochet, & Horsfall, 2000) suggest approximately 1% to 2% of women will develop clinically significant, chronic PTSD, although there are a few anomalies where only subclinical PTSD has been found (Wenzel, Haugen, Jackson, & Brendle, 2005). This prevalence would result in between 6,000 and 12,000 women developing postnatal PTSD every year in England and Wales alone (National Office of Statistics, 2003). This is especially worrying given the recent Confidential Report into Maternal and Child Health which identified psychiatric illness as the single largest cause of maternal death in the UK (Department of Health, 2004).

To date, most research has concentrated on the prevalence and causes of postnatal PTSD. Diathesis-stress approaches to mental health emphasise that whether a woman develops chronic postnatal PTSD will be influenced to varying degrees by pre-existing vulnerability and beliefs, the events of birth, and postnatal factors such as additional stress, support, and the meaning attached to the events of birth and symptoms of PTSD (Ayers, 2004; Beck, 2004a). Research supports this approach and suggests postnatal PTSD is associated with a previous history of trauma, history of psychological problems, and events during birth such as type of delivery (Ayers, 2004; Olde, van der Hart, Kleber, & Van Son, 2006).

The effects of postnatal PTSD on women and their relationships with their child and partner have not been widely examined but have been subject to speculation (Bailham & Joseph, 2003). Case studies and qualitative research suggest it is likely that postnatal PTSD will affect women's close relationships. For example, in qualitative studies of postnatal PTSD, women report that it affects their sense of self, that they have less patience, feelings of anger, anxiety, depression, find it hard to sympathise with others, feel isolated from their infant, fear future pregnancy, and that it affects social relationships (Allen, 1998; Beck, 2004a). However, these qualitative studies did not assess PTSD using diagnostic criteria. Case studies, in which women do fulfil diagnostic criteria, suggest postnatal PTSD is associated with sexual avoidance (O'Driscoll, 1994) secondary fear of pregnancy and birth (tocophobia; Hofberg & Brockington, 2000), and disordered mother-infant attachment (Ballard, Stanley, & Brockington, 1995). It has been speculated that symptoms of avoidance may lead to the mother not bonding with the infant or, conversely, that hyperarousal and vigilance may lead to an over-anxious or protective attachment (Bailham & Joseph, 2003).

Two relevant studies have been carried out in this area. A recent qualitative study examined postnatal PTSD in couples where one or both of the couple had postnatal PTSD. By definition, this study only included couples that remained together after birth, so were arguably managing well. Despite this, the results found postnatal PTSD had a wide-ranging and negative effect on relationships and resulted in sexual dysfunction, decreased intimacy, negative emotions, and poorer communication between partners. Women reported feeling abandoned by their husbands and men reported feeling rejected by their wives. Women also reported either a rejecting or over-anxious attachment with their baby (Nicholls & Ayers, in press). In contrast, a quantitative study looking at symptoms of PTSD in couples found that, although 5% of men and

women reported severe PTSD symptoms nine weeks after birth, these symptoms were not related to the quality of the marital relationship or to a basic measure of the parent-baby bond (Ayers, Wright, & Wells, in press).

This inconsistency may be due to the different focus of qualitative and quantitative studies. Whereas case studies and qualitative research tend to focus on individuals with clinically significant PTSD, quantitative research tends to look at the range of PTSD symptoms in a normal population of women or couples following birth. Thus quantitative studies may be identifying factors associated with general stress responses and adaptation to birth, whereas qualitative studies may be identifying the repercussions of traumatic births that are more likely to fulfil diagnostic criteria for a traumatic stressor (DSM-IV; American_Psychiatric_Association, 1994).

There is therefore considerable scope to extend knowledge regarding the aetiology of postnatal PTSD, the effect on women, their partners, and parent-infant attachment. The effects of childbirth-related PTSD on the marital relationship and mother-baby bond have not been widely explored and the research that has been done has either not used diagnostic measures of PTSD (Allen, 1998; Beck, 2004b), has focused on symptoms rather than clinically significant PTSD (Ayers, Wright et al., in press), or has focused on couples (Nicholls & Ayers, in press).

This study sought to address this gap in the literature by carrying out a qualitative investigation of the long-term impact of a traumatic birth and postnatal PTSD on women who had clinically significant PTSD after birth. Participants were interviewed about (1) the effects on themselves, (2) the effects on their relationship with their partner, and (3) the effects on their relationships with their child.

Method

Design

This was a qualitative interview study of the effect of a traumatic birth on women, their relationship with their child, and their relationship with their partner.

Participants

Women were eligible for the study if they were aged over 18 years, able to read and speak English fluently, and reported having psychological problems as a result of a traumatic birth experience. Six women participated in the study. Women were aged between 22 and 37 years when they gave birth. Time since the traumatic birth experience ranged from 7 months to 18 years: at 7 months, 20 months, 30 months, 9 years, 11 years and 18 years respectively. In all cases the traumatic birth was their first birth. Three women had vaginal deliveries and three women had emergency caesarean sections. Four women had only one child and two women had two children. Five women were married and living with their husband and children, one woman was divorced and living alone. All women were unemployed. All women retrospectively reported clinically significant PTSD in the first year after birth as assessed by the PTSD Diagnostic Scale (see Measures section). Median symptom scores were 38 out of a potential 51 (range = 25 to 48). At the time of interview, two women still had clinically significant PTSD symptoms, three women had residual symptoms of PTSD and one woman had resolved her PTSD.

Materials

A semi-structured interview schedule was developed to look at the effects of birth on women, their relationship with their partners, and their relationship with their child.

Childbirth-related PTSD was measured using an adapted version of the PTSD Diagnostic Scale (PDS; (Foa, Cashman, Jaycox, & Perry, 1997), a self-report questionnaire that provides a categorical diagnosis of PTSD and a continuous measure of symptom severity. The PDS has 17 items corresponding to the 17 PTSD symptoms listed in the DSM-IV and further items measuring impairment of functioning, perceived threat to life, symptom duration, time of onset of symptoms, and a checklist of prior trauma history. The PDS has established reliability and when used as a diagnostic measure it has a specificity of .75, a sensitivity of .89, and an 82% agreement with structured clinical interviews (Foa et al., 1997). For this study all symptoms were measured in relation to birth and women were asked to retrospectively report their symptoms for a typical month in the first year after birth.

Procedure

Ethical approval was obtained from the Local NHS Research Ethics Committee. Women were recruited via the Birth Crisis Network (3 women); (ii) responses to media articles (2 women); and (iii) word of mouth (1 woman). Women who were interested in participating were sent an information sheet and given the opportunity to ask questions about the study. If a woman agreed to participate an appointment was made to interview her at a convenient time and place. Informed consent was obtained prior to carrying out the interview. The questionnaire was completed at the end of the interview. All data collected in the study were stored anonymously with identifying details removed. Pseudonyms have been used in this article.

Analysis

Qualitative analysis of interview transcripts was carried out using inductive thematic analysis where dominant themes were identified through careful examination of data (see Boyatzis, 1998, for more detailed information on this approach to qualitative analysis).

Interviews were transcribed and entered into WinMax software, which allows interview data to be coded and managed. WinMax also enables segments of interview text for each coding category to be examined for reliability and consistency of segments in each category. Data analysis was carried out through a series of iterative stages where two researchers read the transcripts independently to identify emergent themes. A coding system was constructed during the first reading of transcripts and agreed by the two researchers. Following this, all transcripts were re-coded using the final agreed coding system. Once all transcripts were coded further reliability checks were carried out with the two researchers checking the consistency and reliability of coded segments for each theme.

Results

Results are reported according to the aims of the study namely the effect of postnatal PTSD on (i) women, (ii) their relationship with their partner, and (iii) their relationship with their children.

(i) Effects on women

Thematic analysis of interview transcripts for the effect of traumatic birth on women yielded four major themes. These were (1) physical effects of birth; (2) changes in mood and behaviour; (3) fear of childbirth & sexual dysfunction, and (4) social interaction and trust. The content of each of these themes are described below and illustrated using quotes from participants.

Physical effects of birth

This theme includes long-term physical effects of the birth and women's feelings about these physical consequences. Four women suffered long-term physical consequences from their birth, such as severe pain from episiotomies and the need for reconstructive surgery. Anna attributed all of her distress to the physical outcome of her birth *'the result that has left me absolutely feeling terrible is the fact that my vagina was just so mutilated... its like a picture of someone that has been battered you know really sort of horrible'*. She described her vagina as *'totally swollen, wonky, cut like brutalised'* and said *'I couldn't get any sensation from my vagina whatsoever...so I thought I was dead, you know, I thought my vagina's dead'*. These physical problems then triggered psychological difficulties related to them. Anna reported distorted memories and beliefs about these physical problems saying *'I've questioned my anatomy, I've got as mad as to think 'was I born with normal anatomy?' because of the rips and the cuts'*, and *'I've gone so far as to think that when the pus, when they pulled it out it was like, it looked like a big fat maggot'* so she worried that she was being eaten from the inside. Anna was so distressed

about damage she sustained to her vagina that she put Detol on herself and started pulling out her pubic hairs.

Two women said that their birth left them feeling physically drained for months afterwards. Kate said she felt '*extreme exhaustion, no energy, drained from the pain*'. Mary said '*the fact that I was so physically depressed afterwards, that coloured everything else*'. Together these indicate how long-term physical consequences can contribute to the difficulties women face and make it harder to cope adaptively.

Changes in mood & behaviour

The effects of birth on women included prevalent moods in the long term after the traumatic birth and the way women felt about themselves on a day-to-day basis. All six women reported changes in their feelings after their birth, which included depression, anger, and changes in how they felt about themselves. Four women said they were seriously depressed, two of whom reported being suicidal. For example, Jane said '*I was hugely depressed I mean I was suicidal, literally suicidal. I used to think how can I kill myself*'. Anna said '*I spiralled into dark depression you know with all these horrible things that I was having to live with and too terrified to speak to anyone about for fear that they would take [the baby] away*'. This illustrates how depression can be comorbid with PTSD and also why women suffering with childbirth-related PTSD may suppress their feelings or avoid seeking help. Two women reported frequent anger. Mary said '*I was angry for years, angry. I was angry that I couldn't get out and do things. I was angry, it would have been so easy to take out the anger to have literally lost control and taken out the anger. I was severely frustrated and severely angry. I was angry at the entire world*'.

The impact on women also included changes in women's perceptions of themselves. For example, Kate said '*I don't feel a whole person, I just feel so invaded by what's happened*', Mary

said *'I didn't feel particularly good about myself'* and Anna said she still felt *'absolutely inadequate'* eleven years after her birth. Some women reported feeling detached, as would be expected with emotional numbing symptoms of PTSD. For example Claire said *'my feelings were a bit out of synch with everybody else's'*.

Effects on behaviour included changes to women's behaviour that appeared to have roots in the trauma experienced during birth. It does not include coping behaviours. Five women reported effects on their behaviour. Anna said she *'couldn't go out of the house, when it started being that I had to take her to school and things I was just too scared to walk up the road'*. For Ruth, leaving the house became a necessity *'It used to be my goal everyday by half past ten I had to be out of the house. But I did become a bit sort of I suppose regimented'*. Ruth also found that after birth she needed to do everything perfectly, *'suddenly I had stupid standards and it wasn't going to be right. I just had to re-do everything you know, and if anybody did anything for me I had to re-do it to my own standard'*.

Fear of childbirth & sexual dysfunction

Nearly all the women reported fear of childbirth and said their plans to have another child had changed as a result of their birth experience. Ruth said *'I feel quite sick at the thought of having another one, going through that again.'* In addition, most women stated that their birth experience had affected their sex life. For example, Anna said *'I didn't want to have sex after. I didn't have sex for seven years'*. The main reason that sexual function was affected was a fear of getting pregnant. Mary said *'You have to sterilise me, you have to sterilise me...I can't get pregnant, I'm terrified of getting pregnant'* and Kate reported saying to her husband *'I am not having sex with you because there is no contraception...that would convince me that I won't get pregnant'*. One of the effects of feeling unable to have more children was a sense of loss for the

children they originally wanted. For example, Mary said *'I find myself in the middle of the night awake and crying over the years it has developed, it's a sense of loss, the lost children that I didn't have'*. Two women decided to have another child after the traumatic birth, but Claire said *'the minute I got pregnant it just came back, but twice as bad, and I spent most of my second pregnancy not really enjoying it at all'*.

Social interaction & trust

Five women said that their traumatic experience had affected their relationships with friends. Anna said *'I am paranoid actually, I've um broken up with a lot of my friends with things about this'*. Three women said their desire to socialise was reduced and they did not get out a lot. Mary said *'I was just trapped in this tiny little world that I did not seem to be able to get out of'*. Kate explained not wanting to socialise because *'my lack of trust in people before has just been made ten times worse by the experience'*.

(ii) Effects on relationship with Partner

This category explores effects that the experience of birth had on the women's relationship with their partner as well as the impact of the relationship on the experience of women after birth. Two subthemes arose: (1) support and (2) strain on the relationship.

Support

Three women reported a lack of understanding from their partners. For example, Claire said *'when [the baby] was born he didn't see anything was wrong with it, he didn't really; couldn't really empathise and didn't really notice the mess I'd gotten into or tried not to notice it'*. Conversely, two women said their partners gave them practical and emotional support but

this somehow failed to meet their needs. As Kate said, *'He loves me more than ever, he just wants to try and make it better, and no matter what he does he just doesn't make it better'*.

Strain on the relationship

All women said their traumatic birth experience had put strain on their relationship with their partner. One woman had separated from her partner, and a further two women said their difficulties nearly caused them to separate. For example, Kate said *'There have been times when I felt I want to leave and just take [the baby] and not be with him any more, and it's not because I don't love him, It's because I don't feel that I can give to him any more'*. Women mentioned a variety of factors that contributed to strain on the relationship including women's loss of self-esteem as a result of birth, loss of sexual intimacy, disagreements about birth, women blaming men for the events of birth, and women not giving their partners time or attention. For example, Anna said *'I thought he wouldn't, you know, desire me any more'* but that she stayed in the relationship *'because I thought no one else would ever want me'*. Ruth said *'There was no romantic inclination, we were friends'*. Kate was clear she did not want any physical contact with her husband but realised that this affected the way she felt about herself, saying *'I don't feel I'm a proper wife, if you like, because there's no sexual relationship and I don't know if there ever will be again'*. Kate also mentioned problems caused by her anger, saying *'I do tend to be very angry towards him, which he does find very difficult'*. None of the women felt their experience of birth had any positive effects on their relationship.

(iii) Effects on the mother-child bond

This part of the interview explored the relationship women had with their child, how they felt about the child, behaved towards them and interacted with them. Three subthemes arose: (1) differences in attachment, (2) early feelings about the child and (3) later feelings about the child.

Differences in attachment

Women reported either avoidant or overprotective behaviour towards their baby, which suggests avoidant or over-anxious attachments. Anna and Mary described avoidant behaviour towards their baby e.g. *'I could never just cuddle and hold her'* (Anna). Conversely, Kate and Ruth described overprotective behaviour towards their baby *'I have...anxiety about her since she's been born but I'm never apart from her. I wouldn't leave her with anybody'* (Kate). Ruth explained why she felt very protective of her baby saying *'I felt such a failure at actually giving birth that I was determined that I was going to do everything else'*.

Both women who had a second child reported differences in their behaviour towards their two children. Jane felt very protective towards her first child who was born during the traumatic birth. She described a time when her second child was life threateningly ill and she said to the doctor *'Don't think that I'm a bad mother, but I can't stay, I've got to get [first born] out if my baby is going to die. Because he [first born] is so precious'*. Claire, on the other hand, described the reverse pattern, saying *'I have less patience with [first born] and I get angry with him easily, and I hate myself for it because it's not his fault'*.

Early feelings about the child

The majority of the women reported initial feelings of rejection towards their baby, with the exception of Kate who reported feeling *'besotted'* with her baby from the beginning. Ruth said *'I can remember thinking, you horrible thing, you've done this to me, and what you doing here, you evil child'*. Jane reported thinking *"In god's name why are you giving me a baby, you know, I'm dying, why would I want a baby?" I had no connection between...that it was my baby'*. She then felt the baby rejected her, saying *'the baby had one eye open, one closed, and he looked at me and there was this scowl on his face as if to say, where am I and in god's name don't tell*

me you're my mother'. Two women said they constantly wanted to avoid contact with their children. For example, Mary said *'I kept trying to give her away. Anybody who wanted to pick her up, you have her'*. For some women this also included thoughts of harming the baby. For example, Anna said *'I just thought oh, I wanta strangle, you know I didn't want to, it just came into my head, strangle'* although no actual harm appeared to result from this. There was no noticeable association between the type of attachment and whether the mother thought her baby would die during birth.

Later feelings about the child

Feelings towards the child seemed to develop over time and by the time of interview most women no longer had feelings of rejection towards their child. The exceptions to this were Claire and Anna who still reported difficult relationships with their child. These seemed to stem from blaming the child for their traumatic experience. Anna is unable to live with her child saying *'I can't say I've ever felt good with [child]'*. She saw the birth as *'her birth, my sexual death'* and that *'on my own left with her I'm, I'm absolutely petrified'* which she explained was because of feelings of aggression towards her child when the child was a baby.

Other women, such as Ruth and Mary, reported that their relationship with their child improved over time. For Mary this took a number of years, she said *'It was literally, [child] was about five before I could sit on the end of the bed and say would you like me to read you a story and sit there calm and say I can do this'*. Ruth reported a much better relationship with her daughter 20 months after birth, saying that now *'to me [the baby is] everything, I suppose it was so very nearly that one of us wasn't going to make it I suppose in a way I owe her'*.

Discussion

This study illustrates the immediate and long-term effects that clinically significant postnatal PTSD can have on women, their relationship with their child, and their relationship with their partner. In summary, the results suggest traumatic birth affects women physically, emotionally, socially, and leads to fear of childbirth and associated sexual dysfunction. All women reported that birth and its consequences put a strain on their relationship with their partner – with marriage breaking down in one case. Women appeared to differ on how birth affected their relationship with the infant. Most women described rejecting behaviour immediately after birth, but many reported bonding with their baby over time. The length of time it took for women to feel their attachment towards their child improved ranged from approximately one year to five years. In the long-term, however, women appeared to have predominantly avoidant or over-anxious attachments with their infant.

These findings are broadly consistent with previous qualitative research and case studies. For example, Ballard et al (1995) report four cases of women with postnatal PTSD with comorbid depression, one of whom had suicidal ideation. Allen (1998) reports examples from her qualitative research of women feeling angry and saying birth affected them emotionally, behaviourally, and socially. Nicholls and Ayers (in press) report consistent effects of birth trauma on women's sexual function and a fear of childbirth. Fear of birth following a traumatic birth (termed secondary tokophobia) is discussed by Hofberg and Brockington (2000) in their synopsis of 26 cases of tokophobia. Similarly, a number of case studies have noted either rejecting behaviour or over-anxious behaviour of the mother towards the infant (Ballard et al., 1995; Moleman, van der Hart, & van der Kolk, 1992). A qualitative study of couples also found women were avoidant or anxious/over-protective towards their child (Nicholls & Ayers, in

press). However, in this study partners often compensated for problems of attachment between the mother and infant. So it is not clear whether the effect of birth on a woman's relationship with her baby has any significant long-term effects on the child.

There is therefore an increasing amount of evidence from case studies and qualitative research that traumatic birth and postnatal PTSD has wide ranging effects on women and their relationships. However, these findings need to be placed in the context of the effects of normal birth on women. It is likely that giving birth and coping with a new baby puts strain on most women and their relationships. For example, studies of mother-infant attachment types suggest that up to 22% of women have avoidant attachments with their infant (Van Ijzendoorn & Sagi, 1999). Whilst postnatal PTSD might account for some of these avoidant attachments, the prevalence of postnatal PTSD is too low (1% - 2%) to account for all avoidant attachments. Thus future research needs to compare the effects of birth in women with and without postnatal PTSD to determine the extent to which the effects noted in this study are unique to women with postnatal PTSD.

The importance of care during birth raises some interesting issues when considered in light of the diathesis-stress model of postnatal PTSD. Women with postnatal PTSD will vary in the extent to which their previous experiences and beliefs affect how they respond to events in birth. Case studies of postnatal PTSD illustrate that events in women's past such as sexual abuse, previous trauma, or sensitivity to criticism and judgement, make some women more vulnerable to trauma following insensitive or poor care during birth (Ayers, McKenzie-McHarg, & Eagle, in press; Ballard et al., 1995). Similarly, there will be cases where the events of birth are so severe they will be traumatising for women with no pre-morbid vulnerability. Obstetric emergencies are, by their very nature, usually unpredictable, novel, and largely uncontrollable by the woman. In

these situations women need high levels of support and consideration which is sometimes difficult for healthcare professionals whose immediate priority is the physical safety of the woman and baby. Thus, it is clear that healthcare professionals can improve their practices in order to minimise their contribution to a birth experience being traumatic. However, this should be done in conjunction with research to ascertain how best to identify vulnerable women in pregnancy so that care during pregnancy and birth can be tailored to avoid birth being traumatic. The retrospective nature of the current study obviously means we are unable to draw any conclusions about women's premorbid characteristics and how much these influenced their postnatal difficulties.

In summary, the present study adds to the literature on the effects of traumatic birth and suggests that clinically significant postnatal PTSD has both immediate and long-term effects on women, their relationship with their child, and their relationship with their partner. However, further research is needed to compare these effects with the experience of women without postnatal PTSD, and further research is needed to look at the varying role of premorbid vulnerability factors and the events of birth.

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