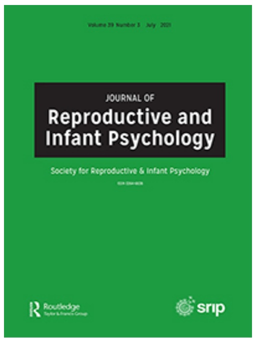

Journal of Reproductive and Infant Psychology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cjri20

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To cite this article: Danny Horesh, Susan Garthus-Niegel & Antje Horsch (2021) Childbirth-related PTSD: is it a unique post-traumatic disorder?, Journal of Reproductive and Infant Psychology, 39:3, 221-224, DOI: 10.1080/02646838.2021.1930739

To link to this article: https://doi.org/10.1080/02646838.2021.1930739

Published online: 24 May 2021.

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JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY
2021, VOL. 39, NO. 3, 221–224
https://doi.org/10.1080/02646838.2021.1930739

EDITORIAL

Childbirth-related PTSD: is it a unique post-traumatic disorder?

Post-traumatic stress disorder (PTSD) is a highly distressing psychiatric disorder, with far-reaching psychological and physiological effects. It consists of four main symptom clusters: re-experiencing of the traumatic event, cognitive and behavioural avoidance, negative alterations in mood and cognitions, and hyperarousal.

In recent years, researchers have gradually identified an increasing number of events that may entail post-traumatic distress, a development that was accompanied by continuous changes and adaptations to the event criterion (criterion A) in the DSM. This eventually resulted in the expansion of PTSD research into events, which previously had not been studied in the context of trauma (e.g., bullying and social stressors). As part of this evolution, the field of childbirth-related PTSD (CB-PTSD) has developed in recent decades, with the realisation that childbirth may also meet DSM criteria for a traumatic stressor. CB-PTSD is a relatively new construct, which has already yielded a considerable amount of research. Studies show that approximately 4% of women undergoing childbirth may develop full-blown CB-PTSD, with many more developing sub-syndromal symptoms (Ayers et al., 2018).

Given that PTSD is a multilayered, widely heterogeneous disorder (Galatzer-Levy & Bryant, 2013), research exploring in more detail the associations between specific traumatic events and their resulting psychopathology is needed (Stein et al., 2016). Unfortunately, this approach still remains the exception rather than the rule in current PTSD research, as the vast majority of studies tend to address a rather 'generic' type of PTSD. Still, recent years have seen efforts to categorise PTSD into specific variants. Thus, studies have identified possible sub-types of the disorder, including a dissociative subtype, which has already been included in DSM-5.

In what follows, we will discuss the specific aetiological, clinical, and sociological characteristics of CB-PTSD and their potential implications on the nosological status of this particular post-traumatic condition. We argue that CB-PTSD is unique in several important ways, possibly to the point of being considered and studied as a separate subtype of PTSD. We outline our argument for this below. Specifically, we wish to argue that CB-PTSD includes:

(1) ***A unique traumatic event***. CB-PTSD is arguably one of the only psychiatric disorders resulting from an event that is socially considered positive. The realisation that seemingly positive life experiences may cause a significant amount of stress was triggered by Holmes and Rahe's (1967) seminal work on Stressful Life Events. However, it is possible that many still view childbirth as a potentially stressful *life event* rather than as a potential trauma (e.g., Vythilingum, 2010), and thus more in line with DSM criteria for adjustment disorder than for PTSD. This may have

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significant implications in terms of women's sense of legitimacy in experiencing and reporting their post-traumatic distress, as well as society's level of acknowledgement and validation of their experiences.

(2) ***Unique clinical characteristics and phenomenology***. Mounting evidence shows that CB-PTSD consists of two symptom clusters: *childbirth-related symptoms* of re-experiencing and avoidance; and *general symptoms* of hyperarousal and negative cognitions and mood (Ayers et al., 2018). Hypotheses have been put forward to explain the predominance of re-experiencing symptoms. Given that childbirth is a powerful physiological and sensory event occuring in one's own body, stronger interoceptive intrusive memories may be created, compared to other traumatic events (Harrison et al., 2021). These intrusive memories may be triggered by internal bodily cues, such as pain and sexual intercourse. Furthermore, the baby, being an integral part of the traumatic event, may act as a constant post-traumatic reminder. Complex patterns of psychiatric comorbidity may also appear following childbirth, including the co-occurrence of post-traumatic symptoms and postpartum depression symptoms (Dekel et al., 2020). Finally, numerous biological and physiological processes may be involved in CB-PTSD (e.g., involving hormones, the blood and cardio systems, and more), and need to be taken into account when researching this unique condition.

(3) ***Unique family implications.*** When considering the clinical characteristics of CB-PTSD, one must take into account the entire family system. Childbirth is *inherently* a familial event. The effects of traumatic childbirth are thus felt throughout the family, including secondary traumatisation among partners, as well as various effects on parent-child bonding and attachment (Cook et al., 2018). These effects require much more research, as they have yet to be fully understood.

(4) ***Unique survivors***. While most traumatic events may afflict both men and women, traumatic childbirth is one of few events where directly-exposed survivors are always biologically female.[1] This fact potentially carries far-reaching implications – clinically, socially, and politically. Gender differences in PTSD, including a higher female-to-male ratio in diagnosis, have been widely documented and were found to be related to various cognitive, emotional, and biological factors, many of which presumably play an important role in women's distress following childbirth. More importantly, however, we argue that the social status of CB-PTSD as a 'real' disorder, worthy of high-quality research and treatment, is interwoven with women's rights and societal status in the broader sense. For example, over-normalising women's role as those who give birth, only to then naturally go on with their daily life, is a simplification of a much more complex reality.

In light of the unique characteristics noted above, we propose that CB-PTSD should be re-considered as not merely a 'generic' PTSD, which happens to result from the index event of childbirth, but rather as a potentially unique sub-type of PTSD. This shift in perspective may require: 1. new and innovative research methods, e.g., conducting latent class and network analysis in an attempt to further elucidate the inner symptomatic structure of this disorder; 2. specific measurement (e.g., City Birth Trauma Scale, Ayers et al., 2018) and diagnostic tools; 3. specifically-adapted interventions, which build upon existing evidence-based treatments for PTSD, while also incorporating therapeutic

elements related to parent-child bonding, hyper-vigilance to bodily cues, shattered expectations related to childbirth, and more.

In summary, CB-PTSD is a relatively young and novel research sub-field within the broader area of trauma, and more research is still needed in this area. However, the significant amount of data that has accumulated so far already indicates that it may require a place of its own within the PTSD scientific and clinical realms, as was the case with postpartum depression before it. In this era of re-constructing and sub-typing PTSD, a more sensitive, accurate, and tailored approach is warranted. Should CB-PTSD receive more widespread acknowledgement as a unique type of PTSD, this is likely to strengthen social acknowledgement of childbirth as a potentially traumatic event. Furthermore, this process could eventually improve healthcare and policy in the field of CB-PTSD, as well as enhance education for medical and mental health professionals.

Note

1. Some may self-identify as male or gender-neutral (e.g., transgender pregnancies)

Disclosure statement

No potential conflict of interest was reported by the author(s).

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