Childbirth and Narratives: How Do Mothers Deal with Their Child's Birth?

Author: Blasio, Paola Di; Ionio, Chiara

Publication info: Journal of Prenatal & Perinatal Psychology & Health 17. 2 (Winter 2002): 143-151.

Abstract: None available.

Full Text: Headnote ABSTRACT: This research focuses on post traumatic stress disorders which arise after childbirth and adds to the literature on psychological post partum diseases. The hypothesis of this study was that psychological expression of negative emotions could reduce the occurrence of stress symptoms after labour and delivery. A group of 64 women with a healthy pregnancy was examined. Half of them were asked to express their emotion experienced during labour and delivery through a written account. The results indicated a significant difference in the number of post traumatic stress symptoms between the two groups, underlining the positive effect of the emotional disclosure. KEY WORDS: childbirth, PTSD, post partum disorder, written emotional expression. INTRODUCTION This study investigated whether written accounts of mothers' experience of their child's birth would reduce the effects of stress that emerge after labour and delivery. Several studies have underlined that childbirth, although it is a natural and positive experience, may be also a very stressful event, causing different kinds of symptoms (more or less serious, short or long term). The disorders described are essentially: 1. "Mood disorders" or "baby blues" (or "maternity blues" or "post partum dysphoria") which usually onset in the first week after childbirth and can last from few hours to several days. Their incidence ranges from 39% to 85% (Stein, 1982; Prezza, Di Mauro, Giudici, Violani, Vaccari &Faustini, 1984; O'Hara, Zekoski, Phillipps &Wrigth, 1990). 2. Post partum depression, which has an incidence fluctuating between 10% and 28%, onset after a few days, weeks or even months from the childbirth and last up to one year (Campbell &Cohon, 1991; Gotlib, Whiffen, Wallace &Mount, 1991; Rossi, Bassi, &Delfino, 1992; Appleby, Gregoire, Platz, Prince &Kumar, 1994; Areias, Kumar, Barros &Figureido, 1996). 3. Puerperal psychosis, which frequently assumes depressive or maniacal clinical characteristics and has an incidence of 1 out of 1000 (O'Hara, 1987; Kruckman &Smith, 1998). Among possible disorders, little is known about the onset of posttraumatic stress disorders (PTSD) as an effect of labour and delivery. Studies on this theme have shown that this disorder arises when labour is long, difficult or when traumatic events, such as complications in the child's state of health, take place (Affleck, Tennen &Rowe, 1991; Manage, 1993; Ballard, Stanley &Brockington, 1995; De Mier, Hynan, Harris, Manniello, 1996; Fones, 1996; Reynolds, 1997). In particular, mothers of high-risk infants who, immediately after their birth must be admitted to neo-natal intensive care units, show many symptoms of post traumatic stress disorders, even months after the discharge of the child (Bydlowsky &Raul-Duval, 1978; De Mier et al., 1996; Hynan, 1998). However, it is worthwhile highlighting that-as Wijma, Wijma and Soderquist (1997) have noted-even in a case of a regular delivery, a negative cognitive processing of the event may lead to the onset of stress symptoms. In the absence of medical and physical complications, the emotion of fear associated with the perception of not being able to cope with the event, may constitute a risk condition in producing a set of stress symptoms (Wijma, Wijma &Zar, 1998). The above considerations led us to consider that mothers' experience of their children's birth, given that it is highly charged with anxiety, the fear of physical pain and worry about the child, may be considered a potentially traumatic condition (and not only when associated with condition of risks for the child's health). When an event becomes traumatic, a series of stress symptoms may occur, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994). These symptoms are essentially of three kinds for Post Traumatic Stress Disorder (PTSD): symptoms which lead to the reexperiencing of the traumatic event (Criterion B), symptoms of avoidance and decreasing of general reactivity (Criterion C), symptoms of increased arousal (Criterion D). The psychological underpinnings of these symptoms altogether lead to a re-experience of the trauma into one's mind (Di Blasio, 2001). Further, they lead

to an emotive arousal, which is caused by an unexpected occurrence of images, thoughts, perceptions, dreams, unpleasant feelings and flashback episodes. Individuals may also avoid stimuli associated with trauma to control the level of anxiety connected to the re-emergence of negative feelings and thoughts. Avoidance and the re-emergence of negative thoughts combine to increase arousal and cause a hyper-stimulation, which leads to sleep disorders, irritability and episodes of anger, lack of concentration and high arousal. Just after delivery, the affective state of the mother, which is connected with the birth, may co-exist with negative emotions such as the memory of physical pain, the feelings of loneliness, the fear and anxiety evoked by the labour and delivery. Considering the positive valence that the birth of a child may bring alone, negative emotions linked to childbirth may be pushed back by conscious cognitive processing and framed into a wordless and unelaborated realm of experience. On the whole, it is known that a lack of elaboration of negative experiences brings about avoidance mechanisms, inhibition of thoughts and feelings which are linked to the stressful event. These mechanisms lead to "rumination" as a result of the accumulation of stress (Pennebaker, 1985). Furthermore, inhibited thoughts and feelings provoke intrusive re-evocations with further stress and reinforcement of avoidance (Wegne, Schneider, Carter &White, 1987). Some scientific works on previous non-elaborated traumatic experiences offer particularly interesting ideas which emphasise the meaning of the narrative and show its positive effects on health (Pennebaker, 1985; Pennebaker &Beall, 1986; Pennebaker, Kielcolt-Glaser &Glaser, 1988; Pennebaker, 1989; Pennebaker, 1999). Narrative accounts, if considered as a means of elaborating on negative experiences by producing a written account (Pennebaker, 1999), may improve individuals' health. This is due to the fact that narrative accounts promote a mental exploration and a metacognitive monitoring of one's emotions. The aim of this work was to investigate whether unelaborated painful and stressful events would lead to symptoms of PTSD. The underlying hypothesis was that the elaboration through written accounts of negative emotions connected to labour and delivery-a method first used by Pennebaker et al., (1986)-may reduce stress symptoms. METHOD Participants A typical population of 65 pregnant women with a stable affective relationship was selected. The sample was construed as to exclude women with pregnancy-related problems and/or diagnosed psychopathology, as such personality disorders (MMPI-2 assessment). The number included in the sample thus decreased to 64. For most women this was their first pregnancy (59.4%) and all had a healthy pregnancy (the average weeks of gestation was 40 and the standard deviation, 0.8). The ages of women included in the sample ranged from 21 to 40 (average = 32.7). Most of them were well-educated (32.8% with high school certificates, 7% with degrees, and 3.1% with Ph.D.s). Instruments The instruments used in the research could be divided into three groups: 1. Instruments to assess whether mothers interviewed were representative of a typical population. The MMPI-2 in its Italian adaptation by P. Pancherie, S. Sirigatti (1995), booklet form (first 370 items), was used to asses the presence/absence of personality disorders. 2. Instruments for measuring stress symptoms. The P.P.Q. (Perinatal PTSD Questionnaire) set up by De Mier et al. (1996) and validated by Quinell and Hynan (1999) was used. The PPQ is a 14-items, dichotomously scored questionnaire; the first three items describe symptoms of unwanted intrusions (Criterion B), the next six describe symptoms of avoidance or numbing of responsiveness (Criterion C) and the last five items describe symptoms of arousal (Criterion D). The questionnaire was first given two days after delivery and then two months later to find out about the persistence of post traumatic stress symptoms. In accordance with the indications of DeMier et al. (1996) and of Quinell et al. (1999), we did not carry out an evaluation of the answers in a clinical-diagnostic way, related to the DSM-IV criteria to reveal the stress symptoms. So we performed a count of the number of symptoms. In fact the questionnaire proved to be "a valid measure of emotional distress ... but not proper to a differential diagnosis of PTSD" (c.f. De Mier et al, 1996, p. 279). Procedure The study was conducted in two phases at the Obstetric Department of Mangiagalli Clinic in Milan (Italy). 1. A week before delivery. The patient's consent was obtained and the MMPI-2 was administered. 2. Two days after delivery. After having verified the absence of complications connected to labour and established the good health of the mother and child, 50% of the sample was asked to write a brief account of their childbirth experience, according to the indications of

Pennebaker (1999). Subjects were given the following instructions: "In about 10-15 minutes please write about the thoughts and feelings you had when experiencing childbirth. Please describe also feelings and thoughts that you would not disclose to others. You may want to include in your account other people, such as hospital professionals or important people in your present, past or future life. Everything you write will be kept strictly confidential". Later the Perinatal PTSD Questionnaire (PPQ) was submitted to all the women. In two months stress symptoms were assessed with the aid of a telephone interview by means of the same questionnaire (PPQ). Results As we have said before, the aim of this research was to assess whether the account of childbirth could be a suitable condition for allowing a cognitive elaboration of the pain and fear connected to childbirth and thus reducing the stressful symptoms. We randomly subdivided the total sample in two subgroups: one group was asked to narrate their childbirth experience by writing about personal thoughts and feelings whereas the other group was not asked to write anything. Twenty-six participants out of 32 performed the writing task, 6 participants decided not to performed the task. Summing up all the above data, the sample was made up of 58 women; 26 women out 32 performed the task, while 32 out of 32 (the control group) performed no written task. The data has shown a significant difference between the averages of the overall number of symptoms after childbirth and the mothers' written account two days later (t-test = 1.921; p <.05) (Table 1). In particular, women who wrote about their experience of child delivery showed a lower number of symptoms (M = 3.5, SD = 2.2) than those who were not asked to narrate their experience (M = 4.9, SD = 2.9).

Table 1
Narrative Accounts and Stress Symptoms Two Days after Delivery

	Narrative (26 subjects)		*Non-narrative (32 subjects)*			
	M	*SD*	*M*	*SD*	*T-test*	*p*
Re-experiencing	1.07	(.68)	1.03	(.69)	−25	n.s.
Avoidance	1.21	(.99)	1.93	(1.2)	2.29	$p < .02$
Hyperarousal	1.23	(.99)	1.93	(1.2)	2.29	$p < .02$
Total symptoms	3.53	(2.2)	4.90	(2.9)	1.92	$p < .05$

A significant difference emerged with regard to the avoidance (t-test = 2.29; d.f. = 56; p <.02) and hyperarousal (t-test = 2.29; d.f. = 56; p <.02) symptoms. However, there was no significant difference with regard to the symptoms of re-experiencing an unpleasant event. Therefore, regarding the symptoms present two days after delivery, some conclusions may be drawn: 1. The presence of unexpected feelings and thoughts connected to child labour and delivery is not affected positively by narrative accounts. 2. Symptoms of avoidance, which promote a lack of cognitive elaboration, the removal of unpleasant thoughts, the estrangement from others and the onset of feelings of loneliness, are reduced with the aid of narrative accounts. 3. Symptoms of high levels of arousal that lead to irritability, hypercontrol, anxiety for forthcoming negative events, are reduced with the aid of narrative accounts. This positive effect of narrative accounts remains consistent over time. In fact, two months later, the average number of all stress symptoms showed a difference between the two subsamples (t-test = 2.859; d.f. = 56; p <.006). Women who wrote about their experience scored lower (M = 4; SD = 1.7) than those who did not write (M = 5.46; SD = 2.0). The total score of symptoms decreased, as well as their distribution among the three categories (Table 2). In fact, two months after childbirth both the symptoms of re-experiencing (t-test = 2.37; d.f. = 56; p <.02) and avoidance (t-test = 2.1; d.f. = 56; p <.03) were reported to be lower among the women who expressed their emotions and worries without denying them or pushing them back.

Table 2
Narrative Accounts and Stress Symptoms Two Months after Delivery

	Narrative (26 subjects)		*Non-narrative (32 subjects)*			
	M	*SD*	*M*	*SD*	*T-test*	*p*
Re-experiencing	.42	(.64)	.844	(.72)	2.37	$p < .02$
Avoidance	1	(.89)	1.65	(1.3)	2.1	$p < .03$
Hyperarousal	2.76	(1.0)	2.96	(.99)	.74	n.s.
Total symptoms	4	(1.7)	5.46	(2.08)	2.85	$p < .006$

There were not, however, differences between the two groups with regard to symptoms of increased arousal. Irritability, alertness, excessive sensitivity, lack of concentration, and problems with sleeping or staying asleep do not vary between the two subsamples (Table 2). DISCUSSION In this work, we have emphasised the stressful nature of childbirth. Starting from the hypothesis that insufficiently elaborated painful and negative experiences can generate stress symptoms, we have analysed the effect that elaboration of contents of anxiety connected to the experience of labour and delivery has on the onset and duration of stress symptoms. Thus, women who were asked to write about their emotions and the positive or negative feelings linked to delivery, showed a lower number of symptoms, in the short term (two days after childbirth). In particular, this was true for the symptoms of "avoidance" which usually provokes estrangement, anxiety and rejection of the stimuli (vis-à-vis the child or the partner) which could recall memories of the event. As well, we analysed whether narrative accounts might lead-even in the short term-to a decrease in arousal and anxiety. Arousal and anxiety led in turn to irritability, hypercontrol and worries about the occurrence of negative events. Two months after the event, the data showed a difference in the number of stress symptoms. It is not possible to fully understand whether these differences are due to environmental factors or to a positive effect of elaboration. The emotive state of the mothers may be affected by different factors: temperament of the child, family environment, couple relationship, social networks, etc. We can only infer that the narrative accounts of the mothers had a positive influence during the two month period following childbirth. In conclusion, it would appear that mothers need to be monitored and supported in elaborating any negative feelings related to childbirth. This is an important factor to be taken into account when considering post-natal care. In so doing, risk factors for the onset of stress may be prevented even in mothers who do not appear to be at risk. References REFERENCES American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th edition). Washington, DC: Author. Affleck G., Tennen H., Rowe J. (1991). Infant in crisis: how parents cope with newborn intensive care and its aftermath. New York: Springer-Verlag. Appleby L., Gregoire A., Platz C., Prince M., Kumar R. (1994). Screening women for high risk of postnatal depression. Journal of Psychosomatic Research, 38, 539-545. Areias M.E.G., Kumar R., Barros H., Figureiedo E. (1996). Correlates of postnatal depression in mothers and fathers. British Journal of Psychiatry, 169, 36-41. Ballard G.G., Stanley A.K., Brockington I.F. (1995). Post Traumatic Stress Disorder (PTSD) after Childbirth. British Journal of Psychiatry, 166, 525-528. Bydlowsky M., Raul-Duval A. (1978). Un avatar psychique méconnu de la puepéralité: la névrose traumatic post-obstétricale. Perspectives Psychiatriques, 4, 321-328. Campbell S.B., Cohon J.F. (1991). Prevalence and correlates of postpartum depression in first time mothers. Journal of Abnormal Psychology, 100(4), 594-599. DeMier R.L., Hynan M.T., Harris H.B., Manniello R.L. (1996). Perinatal Stressors as predictors of symptoms of posttraumatic stress in mother and infants at high-risk. Journal of Perinatology, 16, 276-280. Di Blasio P. (2001). Rievocare e raccontare eventi traumatici,. Maltrattamento e abuso all'infanzia, 3(1), 59-82. Fones C. (1996). Posttraumatic stress disorder occuring after painful childbirth. Journal of Nervous and Mental Disease, 184, 195-196. Gotlib I.H., Whiffen V.E., Wallace P.M., Mount J.H. (1991). Prospective investigation of postpartum depression: factors

involved in onset and recovery, Journal of Abnormal Psychology, 100(2): 122-132. Hynan M.T. (1998). The perinatal posttraumatic stress disorder (PTSD) questionnaire (PPQ), in Wood R., Zalaquette C.P. (eds.) Evaluating Stress : A handbook of resources (vol. 2). London: Lanham, Md, The Scarecrow Press, Inc. Kruckman L., Smith S. (1998). An introduction to postpartum illness. Postpartum Support International (www.iup.edu/an/postpartum/momhelp.html). Manage J. (1993). Posttraumatic stress disorders in women who have undergone obstetric and or gunecological procedures: A consecutive series of 30 cases of PTSD. Journal of Reproductive and Infant Psychology, 11, 221-8. O'Hara M.W. (1987). Post-partum "blues", depression, and psychosis: a review. Journal of Psychosomatic Obstetric and Gynaecology, 7, 205-227. O'Hara M.W., Zekoski E.M., Phillipps L.H., Wright E.J., (1990). Controlled prospective study of postpartum mood disorders: comparison of childbearing and nonchilbearing women. Journal of Abnormal Psychology, 99, 3-15. Pancheri P., Sirigatti S. (1995). Minnesota Multiphasic Personality Inventory-2. Firenze: Organizzazioni Speciali. Pennebaker J.W. (1985). Traumatic experience and psychosomatic disease: exploring the roles of behavior, obsession and confiding. Canadian Psychology, 26, 82-95. Pennebaker J.W., Beall S.K. (1986). Confronting a traumatic event: toward and understanding of inhibition and disease. Journal of Abnormal Psychology, 95, 274-281. Pennebaker J.W., Kielcolt-Glaser J.K., Glaser R. (1988). Disclosure of traumas and immune function: health implication for psychotherapy. Journal of Consulting and Clinical Psychology, 64, 239-245. Pennebaker J.W. (1989). Confession, inhibition and disease, in Berkowitz (eds.). Advances in experimental social psychology. New York: Academic Press. Pennebaker J.W. (1999). Traduire in parole le esperienze traumatiche: implicazioni per 1'abuso infantile e per il mantenimento della salute (Tr. it. di Francesco Casatello). Psicologia della Salute, 2, 32-48. Prezza M., Di Mauro D., Giudici M.G., Violani C., Vaccari S., Faustini F. (1984). Studio longitudinale sulla disforia post parto, in Montemagno U., Zichella L. (eds.). Psicosomatica ginecologica ed ostetrica. Bologna: Monduzzi. Quinnel F.A., Hynan M.T. (1999). Convergent and discriminant validity of perinatal PTSD questionnaire (PPQ). Journal of Traumatic Stress, 12(1), 193-199. Reynolds J.L. (1997). Post-traumatic stress disorders after childbirth: the phenomenon of traumatic birth. Canadian Medical Association Journal, 156, 831-835. Rossi N., Bassi L., Delfino M.D. (1992). Atteggiamento psicologico verso la gravidanza ed adattamento emotivo successive al parto. Archivio di Psicologia, Neurologia e Psichiatria, 53(3), 337-355. Stein G., (1982). The Maternity Blues, in Brockington I.F., Kumar R., Motherhood and mental illness. New York: Grune &Stratton. Wegner D., Schneider D., Carter S., White T. (1987). Paradoxical aspects of thought suppression. Journal of Personality and Social Psychology, 53, 5-13. Wijma K., Wijma B., Soderquist M.A. (1997). Posttraumatic Stress Disorders after childbirth: a cross sectional study. Journal of Anxiety Disorders, 11(6), 587-597. Wijma K., Wijma B., Zar, M. (1998). Psychometric aspects of the W-DEQ; a new questionnaire for the measurement of fear of childbirth. Journal of Psychosomatic Obstetric and Gynecologic, 19, 84-97. AuthorAffiliation The authors thank Dott. Eugenic Vignati, Health Master of Istituti Clinici di Perfezionamento in Milan, for his approval and support of this study, and the medical and nursing staff of Clinica Mangiagalli, in particular, Dott.ssa Cristina Maggioni, gynaecologist, for their help and collaboration. Correspondence to: Paola Di Blasio, C.R.T.I., Dipartimento di Psicologia, Universita Cattolica del Sacro Cuore, Largo Gemelli, 1, 20123 Milano, Italy. Email: pdiblasi@mi.unicatt.it

Publication title: Journal of Prenatal&Perinatal Psychology&Health

Volume: 17

Issue: 2

Pages: 143-151

Number of pages: 9

Publication year: 2002

Publication date: Winter 2002

Year: 2002

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: Forestville

Country of publication: United States

Journal subject: Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

ISSN: 10978003

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198693732

Document URL: http://search.proquest.com/docview/198693732?accountid=36557

Last updated: 2010-06-06

Database: ProQuest Public Health
