DUBLIN BUSINESS SCHOOL

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"AT LEAST YOU HAVE A HEALTHY BABY"

AN OVERVIEW OF PERINATAL TRAUMA AND POSTPARTUM POSTTRAUMATIC STRESS

THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE HIGHER DIPLOMA IN COUNSELLING AND PSYCHOTHERAPY.

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CONTENTS

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ABSTRACT

Childbirth is a complex, multidimensional, and subjective experience that effects the individual, their family unit and society. This study explores the nature of birth trauma and postnatal posttraumatic stress symptoms and analyses evidence for preventative and treatment interventions.

It highlights the importance of good diagnostic practice and specialized tools, precise and rigorous research methods, and understanding the risk factors associated with birth trauma. It underlines the role of prevention, early intervention, and access to services.

The results of this investigation show that while the recommended treatment methods of postpartum PTSD are predominantly Trauma-Focused Cognitive Behaviour Therapy and Eye Movement Desensitisation Reprocessing, there are multiple other methods with less supporting evidence that have great potential. It identifies a lack of inclusion of empirical findings and knowledge from the field of psychotherapy in clinical guidelines regarding PTSD and suggests that more research is needed to establish a deeper understanding of postpartum PTSD.

Chapter 1 – INTRODUCTION

Childbirth is considered a happy, fulfilling, transformative life experience, and while it often is, some people – including the birthing person[1] and their partner - experience psychological distress or develop mental health disorders following the birth of their child due to traumatic experiences during pregnancy, childbirth or the postpartum period (Dekel, Stuebe, & Dishy, 2017; Grekin & O'Hara, 2014). These life events are complex, multidimensional, and subjective, and how one perceives and responds to them effects the individual, their family unit and indirectly society.

Experiencing birth trauma and postnatal mental health problems can impact one's physical and mental health, interpersonal relationships, beliefs and thinking, it may impair attachment and indirectly have adverse effects on infant health (Svanberg, 2019; Williams, Patricia Taylor, & Schwannauer, 2016). On the other hand, societal, cultural and intrapersonal expectations and taboos make it difficult for parents to seek help or talk openly about their struggles, and shame, guilt or being seen as a 'bad mother' can silence them even further: the conversation around postnatal mental health issues is yet to lose the stigma that surrounds it, with the added threat of social services being involved if a parent seems incapable of taking care of their children (Button, Thornton, Lee, Shakespeare, & Ayers, 2017; Williams *et al.*, 2016).

Perinatal mental health related research has been predominantly concerned with postpartum depression in the past, which eventually resulted in a well-founded scientific understanding of the phenomenon (O'Hara & McCabe, 2013). The discussion around it eventually reached the public and created awareness, and routine screening was implemented in many countries. The last two decades have seen a considerable literature emerging around the theme of birth trauma and related disorders, as the need arose for a better

[1] *Although most people giving birth are women, not all of them identify as such, therefore in this study inclusive language is used.*

understanding of perinatal mental health disorders outside of depression, including postpartum posttraumatic stress disorder (PP-PTSD) (Svanberg, 2019).

Experiences such as feeling invisible and out of control, receiving inhumane and degrading treatment, re-experiencing the traumatic event, being affected by "a rollercoaster of emotions" and developing disrupted relationships with their babies and partners are often reported themes among people affected by birth trauma (Elmir, Schmied, Wilkes & Jackson, 2010). PP-PTSD is associated with multiple negative outcomes, such as a high rate of comorbid psychological disorders, dysfunctional coping, ruptures in bonding and early attachment, lower breastfeeding success rates, problems in the partner relationship, sexual dysfunctions, secondary tokophobia and a tendency of having less children following the traumatic event, to name a few (Sjömark, Parling, Jonsson, Larsson, & Skoog Svanberg, 2018; Williams *et al.*, 2016). Partners can also experience and be strongly impacted by vicarious traumatisation (Svanberg, 2019). These outcomes, along with the relatively high prevalence rates make this segment of human experience a worthwhile focus of research, so that crucial interventions can be implemented in terms of prevention and treatment.

In spite of recent developments in the field, it appears that the prevalence of these phenomena is still not fully understood, partially due to significant latency, educational and societal factors in Western societies and predominantly the lack of clearly defined and well-designed research in the area (Bastos, Furuta, Small, McKenzie-McHarg, & Bick, 2015).

This study sets out to provide an overview of perinatal trauma and postpartum PTSD and explore the evidence for preventative and treatment interventions.

Chapter 2 is concerned with the definition of PP-PTSD and its diagnostic requirements. After that, by exploring the risk factors contributing to perinatal trauma, PP stress symptoms and PP-PTSD, and the reasons behind conflicting data around the prevalence, the chapter seeks to underline the relevance and significance of research in the field to support positive changes in the health care system and in the society.

Drawing upon previous research and international guidelines from the fields of gynaecology, midwifery and nursing, public health, neuroscience, psychology and psychotherapy, Chapter 3 aims to uncover whether postnatal interventions are effective in preventing posttraumatic stress symptoms, trauma and PP-PTSD, or if other methods might offer a better alternative. It addresses evidence-based treatment options for PP-PTSD and explores alternative modalities and methods within the framework of psychology and psychotherapy, as well as in related fields.

Chapter 2 – THE COMPLEX NATURE OF BIRTH TRAUMA

2.1 Definitions and Diagnosis

Birth trauma[2] – or perinatal trauma – refers to a traumatic experience related to actual or potentially impending injury or death of the birthing person or their baby, that affects people postpartum. Some recover from it, but some report significant adverse consequences following such an experience. If someone's distress and symptoms are severe and meet the diagnostic criteria, they might be diagnosed with Posttraumatic Stress Disorder – a diagnosis that has only recently become potentially associated with perinatal trauma (Svanberg, 2019). Postpartum PTSD, however, is not a separate diagnostic entity, it is a subset of PTSD. Based on the changes in our understanding of trauma, a new category was introduced in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), titled Trauma- and Stressor-Related Disorders, which means that PTSD is no longer considered an anxiety disorder. Further changes included the removal of criteria about reacting to the traumatic stressor with intense fear, helplessness or horror (former A2 criterion of the DSM-IV), and emotional numbing (APA, 2013). The four diagnostic clusters of behavioural symptoms that are required for the diagnosis of PTSD are now re-experiencing, avoidance, negative conditions and mood (a new cluster of symptoms added in DSM-5), and hyperarousal, and these symptoms need to be present for at least a month. Some postpartum people, however, might experience certain symptoms and subsyndromal elements, without meeting the diagnostic criteria for PTSD, and as a result they can easily fall through the gaps of services, albeit they would most likely benefit from psychological interventions, were they available to them. Awareness of this cluster is important when looking at and interpreting research data, as it can

[2] *The expression 'birth trauma' can also refer to another phenomenon in pre- and perinatal psychotherapy, in which case the focus is on the unborn child - their ability to sense their surroundings and remember experiences from the womb and from their birth, being a conscious, unique human being - suffering a shocking or traumatic event prior to or during birth. This research focuses on the mother's experience of giving birth, instead.*

significantly affect prevalence rates, and might account for the vast differences in rates reported by different researchers, as shown in the next subsection.

Diagnosis usually relies on clinical interviews and assessment using questionnaires or other diagnostic tools. As birth trauma and PP-PTSD are still a relatively new area of research, tools of assessment are not advanced, and screening of the potentially affected population is not routinely done. Due to the lack of validated and specific diagnostic tools, many researchers and clinicians either used scales developed for assessing trauma related to experiences that were not specific to the unique life situation of postpartum parents, such as The Impact of Events Scale, or scales developed for perinatal PTSD that were not validated diagnostic measures following the DSM-5, such as the Traumatic Event Scale and the Perinatal PTSD Questionnaire (Ayers, Wright, & Thornton, 2018; Svanberg, 2019). The first scale that was developed and validated to measure birth-related PTSD in alignment with DSM-5 criteria was the City Birth Trauma Scale (Ayers *et al.*, 2018), and it is still the only one published to date.

2.2 Prevalence

Previously published studies on the prevalence of birth trauma and PP-PTSD have not been consistent, the range was far too wide to be useful, between 1 and 30% (Dekel *et al.*, 2017). There are a few possible explanations for the inconsistency in the findings of not only individual papers but also systematic reviews. These could be as simple as different research designs, methodological factors, or cultural context. Clinical samples consisting of high-risk pregnancies have higher rates of interventions and negative birth experiences, which leads to higher prevalence of birth trauma and PP-PTSD compared to community samples. Self-assessment questionnaires using symptom severity scores also lead to higher prevalence rates than clinical assessments that require the full diagnostic criteria (Yildiz, Ayers, & Phillips, 2017).

So far very little attention has been paid to the importance of time regarding the prevalence, more specifically, the time frame in which symptoms emerge and develop, despite its potential to account for a

significant percentage of the variation. Due to the nature of PTSD, symptoms often do not arise immediately after the event that caused them, they can stay dormant, therefore it is crucial to take into consideration the time when the assessment was conducted. Different results could emerge from the same sample if the data was taken at different times, even if incidence and prevalence rates are distinguished. To resolve this, a 2017 systematic review (Dekel *et al.*, 2017) following the DSM-IV subcategories chose to differentiate between assessments carried out 0-1 month postpartum (PP-PTS), 1-3 months (acute PP-PTSD) and 3-6 months (chronic PP-PTSD) postpartum. Bearing in mind the possible late onset of clinical symptoms, this approach would categorize someone whose symptoms started showing past the 3 months postpartum mark as suffering from chronic PP-PTSD, even if their symptoms haven't been persistent for months, therefore the differentiation between them cannot be accurate (however, the overall PP-PTS and PP-PTSD rates are unaffected by this). This raises the next methodological issue: most of the research into prevalence to date has failed to separate point prevalence and period prevalence (Yildiz *et al.*, 2017). The former can be beneficial at determining when screening and treatment can be most effective, and the latter provides statistical data that can be used to inform research and policies.

Surprisingly, the role of time in relation to classification systems has not been discussed in reviews either. If data is included from before and after 2013, when the new diagnostic criteria of DSM-5 were published, cases classified pre- and post-2013 would be measured against somewhat different criteria, creating bias. Given the limited number of systemic reviews published since then, this will likely become a factor to be conscious of in the coming years when more data has accumulated based on DSM-5 criteria.

As results vary between studies to such an extent, without re-evaluating these findings and summarizing the data a consensus or agreed upon estimate is impossible to reach. The most relevant and reliable systematic review targeting quantitative studies from the period between 1980 and 2016 reports prevalence rates of clinically significant PP PTSD symptoms in up to 17% of women (Dekel *et al.*, 2017), and suggests that 3-16% of all women meet the diagnostic criteria of PTSD after childbirth, where the lower rates are associated with community samples and the higher ones to high-risk samples (Grekin & O'Hara, 2014;

Dekel *et al.*, 2017). As the difference between groups associated with different risk levels are so significant, the next subsection sets out to explore them in detail.

2.3 Risk Factors

Data suggests that negative subjective birth experiences are the strongest predictors of developing postpartum stress symptoms along with previous psychological problems including pre- and perinatal depression, trait anxiety and previous traumatic experiences (including but not limited to childhood sexual abuse or interpersonal violence), poor health or complications during pregnancy, fear of childbirth for themselves and/or the baby, delivery mode, obstetric interventions and emergencies, dissociation, distressing parent-staff interactions, perceived loss or low internal locus of control, lack of social support (by family members, the partner or staff), infant complications and poor coping strategies (Andersen, Melvaer, Videbech, Lamont, & Joergensen, 2012; Ayers, Bond, Bertullies, & Wijma, 2016; Dekel *et al.*, 2017; Grekin & O'Hara, 2014; Olde, van der Hart, Kleber & van Son, 2006; Thomson & Downe, 2013).

There is a relatively small body of literature that is concerned with how minority groups are affected by birth trauma and PTSD, but Svanberg (2019) excellently addresses issues of minority ethnic communities, people with lower socioeconomic status, people with physical or learning disabilities and members of the LGBTQ+ community (suggesting that there is a heteronormative bias within the maternity systems across the world). She suggests these groups experience increased difficulties, but these issues appear to be invisible to the system.

Ayers's (2016) interpretation of the stress diathesis model in relation to PP-PTSD brings many of these risk factors together, pointing out that the aetiology is multifactorial: pre-existing factors create vulnerability, a fertile ground for negative birth-related and postpartum experiences to adversely affect a person.

The overview of these risk factors raises important questions. It is undeniable that some of the contributing factors are determined by social status, genetic predisposition, history of mental health issues and medical

emergencies, but it is very clear that many of them are not: they are interpersonal or systemic issues, that are possible to change or influence. In alignment with the multifactorial aetiology model of PP-PTSD this observation supports the idea that risk factors could be targeted on both micro and macro levels to improve outcomes: if the birthing person feel safe, supported, informed and in control, and interventions are kept at a minimum, the experience of families could be significantly improved, and PP-PTSD rates positively affected.

Chapter 3 – EARLY INTERVENTION AND TREATMENT

Although the risk factors detailed are linked to higher rates of PP-PTSD, trauma theory and research emphasizes that trauma is different for everyone, as the causes, the presentation and the road to recovery are unique to each person.

Efficacy of psychological treatment of birth related stress symptoms and PP-PTSD has not been studied expansively (Sjömark *et al.*, 2018), therefore this chapter discusses general PTSD research, guidelines and PP-PTSD specific literature and smaller studies that indicate the most effective treatment modalities, along with psychological and alternative treatments. Early intervention and treatment are discussed separately in alignment with clinical guidelines, although the differentiation between the two is not straightforward. There are two main approaches in previous research. The approach followed by NICE guidelines uses inclusion criteria and/or baseline mean symptom scores: in the presence of a psychiatric diagnosis it is categorised as treatment, without it as prevention. Most studies and reviews on the other hand, differentiate based on symptomatology, considering that PTSD is a significantly underreported phenomenon (NICE, 2014).

3.1 Prevention and Early Intervention

Some researchers argue that prevention should be the initial focus starting with reviewing obstetric procedures, laying down foundations by educating women on physiological birth as well as possible complications to set realistic expectations, empowering and supporting women in labour so they will feel in control, and making sure social support is in place for the postpartum period (NICE, 2014; Reynolds, 1997; Vesel & Nickasch, 2015). These suggestions are based on the idea that by aiming to eliminate or reduce the risk factors, it is possible to limit the development or recurrence of mental health issues and to reduce its adverse effects on both the parents and the child (NICE, 2014).

Once a potentially traumatic event has happened and consequently, acute stress symptoms, such as re-experiencing, avoidance or hyperarousal appear in the first month following the incident, affecting the person's everyday life and functioning, the latest WHO (2013) and NICE guidelines (2018) recommend early interventions, specifically Trauma-Focused Cognitive Behaviour Therapy[3] (TFCBT) as a first line of treatment. NICE guidelines emphasize the role of active monitoring (analogous to 'watchful waiting') in this first month, and follow-up contact to be organized afterwards to monitor those who are at risk of developing more severe symptoms. Drug treatment - especially benzodiazepines and antidepressants - is not recommended as a preventive measure, considering that many people recover spontaneously in the first weeks (NICE, 2018; WHO, 2013).

The third option, one that has been commonly used in PTSD prevention - and specifically perinatal trauma - with substantial evidence opposing it, is debriefing. The overall goal of this method is to help prevent postpartum disorders or mitigate their negative effects on the person's psychological well-being after a traumatic event by offering clients the opportunity to talk about their birth experience (Bastos *et al.*, 2015). It was a popular intervention until the early 2000s, when rapidly growing controversy and criticism accumulated around it: most critical reviews reported no evidence on the efficacy of these treatments in reducing postpartum morbidity (Sheen & Slade, 2015). In contrast, it has also been noted that feedback from people who availed of such interventions was positive in that they found it valuable and helpful, especially if it involved active listening, talking through the medical notes, and if their partner could be present (Baxter, McCourt & Jarrett, 2014; Thomson & Downe, 2013). While the latest Cochrane review from 2015 (Bastos *et al.*, 2015) concluded that research in the area has been lacking reliable results and sufficient quality and that there is not enough evidence to support the effects of psychological debriefing, the latest NICE guidelines (2018) took it one step further and categorically advocated against using psychologically focused debriefing for the prevention or treatment of PTSD, arguing that by offering this

[3] The expression is used in alignment with NICE terminology. In some other resources it could refer to a specific CBT protocol for children and adolescents developed by Cohen and colleagues, but it is used in its general sense in this paper.

ineffective or potentially harmful treatment when alternative effective, evidence-based interventions are available is unjustifiable.

The WHO and NICE recommendations have a solid evidence base built mainly upon randomized controlled trials, but questions have been raised about the exclusive use of this method of evaluation, suggesting that other approaches could be effective as well, if assessed correctly and thoroughly (Svanberg, 2019). Previous research might need to be re-examined, as well. The example of debriefing in relation to PP-PTSD will be used to show how inaccurate and ambiguous research designs can hinder the evaluation of a method and how shortcomings in terms of clarity, definitions and differentiation makes replication of individual research settings very difficult and comparisons void. A possible setback and reason for inconsistency in previous findings is that what "debriefing" and "counselling" meant was not clearly specified in the studies, therefore the interventions that were used and referred to were most likely different. The focus of the intervention is another crucial element: some debriefing interventions included explicit focus on re-living the traumatic experience, while some stayed within the realm of supportive counselling (NICE, 2014), and the lack of this essential distinction leaded to biased conclusions. Meta-analysis data shows that the timing and the number of sessions offered also varied between studies (Baxter *et al.*, 2014; Brewin, 2014), and so did the level of qualifications or training the health care provider had: in many studies midwives delivered the interventions, in others trained mental health professionals did. Most criticism in the literature was aimed at midwife-led debriefing, highlighting the importance of specialized training. The advantage of midwives providing this service was partially the continuity of care they could maintain from pregnancy through labour and birth to the postpartum period, and partially that they could answer relevant medical questions, but the disadvantages have been widely proven recently and are outweighing the advantages: midwives and nurses are not trained mental health professionals, therefore they cannot provide effective psychotherapeutic interventions. Svanberg (2019) adds another factor against midwife-led debriefing: it can be especially triggering for those with birth trauma to return to the hospital where the traumatic experience took place or to talk to those who had a part in the events.

3.2 Treatment Methods

Several therapies are available for treating birth trauma and PTSD, but only a few have enough scientific evidence to be recommended by international organizations, despite active research and discussion around other theories and treatment modalities.

According to the most recent NICE guidelines (2018) on PTSD, proactive person-centred strategies are considered best practice, and - due to the limited amount of evidence-based, reliable published research into other approaches - mainly brief, highly structured cognitive methods are recommended, especially Trauma-Focused Cognitive Behaviour Therapy and Eye Movement Desensitisation Reprocessing (EMDR). These aim to reduce trauma-related distress, reinforce constructive beliefs, and integrate the traumatic memory into the long-term memory. WHO guidelines (2013) also support TFCBT and EMDR based on moderate quality of evidence, followed by Group Trauma-Focused Cognitive Behaviour Therapy (GTFCBT) and 'stress management and psychoeducation', based on low quality of evidence. Other widely used psychotherapeutic treatment methods have not been included in guidelines. The next subsections explore the most relevant psychological treatment modalities.

TFCBT is a cognitive behavioural intervention with an educative approach that aims to alleviate psychological distress by challenging and altering unhelpful trauma-related beliefs and thought patterns that would otherwise lead to avoiding behaviours. It uses a combination of techniques such as revisiting the traumatic memories in detail (exposure), determining goals, giving homework, identifying the elements associated with negative meaning and exploring alternatives. Teaching helpful techniques such as differentiating between a certain past event and the present, the ability to create a feeling of safety within oneself, or grounding are also common elements in TFCBT (Svanberg, 2019; WHO, 2013). The more recently published NICE guidelines (2018) also suggest the use of the computerised version of TFCBT, called Supported Trauma-Focused Cognitive Behaviour Therapy as an alternative, which includes interventions such as cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy

and prolonged exposure therapy, and also recommends certain CBT-interventions targeted at specific trauma-related symptoms if TFCBT or EMDR are not possible.

EMDR is a highly structured, standardized technique consisting of eight phases. It simultaneously uses bilateral stimulation and spontaneous associations of trauma-related thoughts, feelings, and bodily sensations (WHO, 2013). It involves setting goals, psychoeducation, building inner resources to keep the client safe, desensitization using dual awareness, integration of positive beliefs and appraisals, monitoring the body for tensions that can signal trauma being locked in the body, offering grounding techniques and closure to the sessions, and a continuous re-evaluation of the effectiveness of the treatment (Svanberg, 2019). As opposed to TFCBT, EMDR does not necessarily involve verbalizing the traumatic memory, direct exposure to it or direct challenging of beliefs (WHO, 2013), so many trauma victims find it easier to engage with it (Svanberg, 2019).

If psychological interventions are not available, or if the person is unresponsive to them or has comorbid depression, SSRIs or TCAs can be considered as the next line of treatment. A significant portion (20-75%) of people suffering from PP-PTSD have comorbid depression as well (Svanberg, 2019), and in complex cases like these, PTSD is targeted first, unless the depression is too severe or there is a risk of self-harm involved (NICE, 2018).

Surprisingly, guidelines do not involve other psychotherapeutic interventions. There is a lack of synthesis between clinical guidelines and psychotherapy literature despite the closeness of the two fields. Several trauma-related holistic paradigms have been created, practised and researched in the past four decades, integrating disciplines such as psychology, neurobiology, psychiatry, behavioural neuroscience, psychobiology or neurolinguistics, tying together traditional psychodynamic, interpersonal, Gestalt and cognitive-behavioural psychotherapy approaches, body-centred paradigms, neurofeedback and spirituality, to mention the most influential ones. Many of these approaches could be hugely beneficial when working with PP-PTSD, as well.

As the recommended therapeutic modalities discussed above are short-term, highly structured interventions with a CBT approach, it would be interesting to explore other, less regimented, somatic approaches that emphasize the role of sensory experiences and bodily sensations in how trauma gets locked in the body and how they play an important role in healing, (Rothschild, 2000, van der Kolk, 2014). They highlight the importance of understanding what happens in one's own body and how top-down and bottom-up regulation utilize the interconnectedness of body and mind (van der Kolk, 2014). One of these approaches is Sensorimotor Psychotherapy, an integrative model with growing popularity and research-base. It is a body-centred talking therapy that uses directed mindfulness and dual awareness to work with cognitions, emotions, bodily sensations, perceptions and movement (Ogden & Fisher, 2015, Fisher, 2019). It works with the autonomic and somatic aspects of trauma that are so central in PTSD and as birth is such a fundamentally physical experience, working with the body - alongside cognitive-behavioural aspects - appears to be a sensible approach. Levine's theory (1997) supports this idea: using the felt sense and somatic experiencing facilitates decompression of the energies of the traumatic memories, experiencing the self, and ultimately, renegotiating trauma. Rothschild (2000) and Ogden (Ogden & Fisher, 2015), pioneers of Sensorimotor Psychotherapy, emphasize the importance of a comprehensive narrative of the traumatic event. This might explain why many women find midwife-led debriefing valuable: they receive a complete version of the missing narrative based on hospital notes, which fills the gaps and gives explanations. Somatic approaches, on the other hand, offer the opportunity for the client to develop their own narrative, based on their feelings and understanding, with increased awareness of the emotional, cognitive, and somatic aspects.

3.3 Complementary and Alternative Methods

There are alternative paths in treatment that can complement mainstream therapies. These are interventions and treatments without solid supporting evidence behind them, yet either empirical data or smaller, statistically not significant results indicate their effectiveness and potential. Some of these are treatments that are being used in other disorders, such as repetitive transcranial magnetic stimulation (rTMS) - which is well-known for its effectiveness in relation to depression, but studies show strong evidence in favour of it in PTSD, as well (Wahbeh, Senders, Neuendorf, & Cayton, 2014) -, while others are novel methods.

Taking advantage of technology is an exciting new path. A simple example of it could be a birth trauma related study that reported a brief cognitive intervention - namely playing Tetris for 15 minutes within 6 hours of traumatic emergency C-sections - significantly reducing intrusive memories in the postpartum period (Horsch *et al.*, 2017). Thinking of more complex, individualized, multimodular methods, virtual reality exposure therapy (VRET) is a good example: in an interactive environment populated with their 'hot spots' (specific triggers), the client can move around and interact with their environment, which means avoidance is bypassed, motor functions are involved, and active involvement is facilitated, unlike in the usual sitting across from the therapist arrangement (Nijdam & Vermetten, 2018). It would be interesting to see how this approach works in birth related PTSD: as the hospital environment birth trauma often takes place in has many universal features, it could be more easily recreated in VR, and because often there is a strong element of vulnerability and immobility involved, being able to move around could be very empowering.

Another promising treatment for chronic PTSD is MDMA-assisted therapy (Sessa, Higbed, & Nutt, 2019), which mitigates the overwhelming threat and fear element of trauma, so processing feelings and thoughts around the traumatic event becomes easier, and it has the benefit of not having to be taken long term. Medical MDMA use in psychotherapy is in phase 3 of research in the USA and phase 2 in Europe, so in a few years, it might become one of the recommended treatments. However, methylamphetamine transfers

into breastmilk (Bartu, Dusci & Ilett, 2009), so it is likely that other treatments will still be prioritized over MDMA-assisted psychotherapy in perinatal mental health disorders for breastfeeding parents.

In terms of complementary methods that people might find therapeutic or helpful, acupuncture, hypnotherapy, meditation, and visualization have been proven effective (Wahbeh *et al.*, 2014), and trauma-sensitive yoga and structured expressive writing have some, albeit low and limited evidence (van der Kolk *et al.*, 2014, Cramer, Anheyer, Saha & Dobos, 2018; Nguyen-Feng, Clark, & Butler, 2019). Mainstream therapies can also be supported by methods that facilitate bonding between parents and babies, such as parent-infant psychotherapy or baby massage, or ones that build on social support, such as positive parenting groups, peer and social support groups and helplines (Iribarren, Prolo, Neagos, & Chiappelli, 2005; Sjömark *et al.*, 2018). There are methods that work with the body, such as women's health physiotherapy that might help with physical symptoms or the closing the bones ceremony which brings a spiritual element to aid acceptance and letting go (Svanberg, 2019).

3.4 Universal Bases of Trauma Therapy

Whichever paradigm one follows, it is hard to imagine working with trauma and PTSD without creating a sense of trust and safety in the therapeutic relationship and shaping it in a way that it can become a model for healthy relationships and attachment outside of the therapeutic alliance, once internalized. Rothschild (2000) explains the key components of safe trauma therapy excellently. Firstly, creating and fostering a safe environment for the relationship to develop lays down the foundations for trauma work. As for the defences, instead of working against them or aiming to diminish them, Rothschild suggests they are treated as useful aids and work towards creating a balancing counterpart to them, so that when something triggers their activation, the client has alternative coping mechanisms and can be more flexible. Trauma therapy can be very intense and triggering, yet there are many ways the therapist can keep their client safe during the process: keeping track of the client's arousal and pacing the work according to it, using voice tone or facilitating mindfulness techniques are all helpful tools (Ogden & Fisher, 2015). Part of the safety ideals is,

however, that not only the therapist has the power to regulate the intensity of the work, but the client has the permission and the ability to deescalate it, if necessary, too (Rothschild, 2000).

The goals of trauma therapy are unique to each method, but they all include building the client's resource repertoire. These are primarily psychological resources such as dual awareness, mindfulness, relaxation and grounding techniques, self-compassion, curiosity, creativity, authenticity, vulnerability, spirituality or sense of humor, but interpersonal and physical ones are often important and relevant, too (Brown, 2015; Rothschild, 2000). Tools that can be taught to clients are especially effective when time is important, as they do not require the presence and holding environment the therapist provides but can be used independently, and they are easy enough to learn. These self-regulating techniques enhance well-being by reinforcing a sense of safety and calmness, or with the assistance of a professional they can be used to attune to trauma work, as well (Svanberg, 2019).

Chapter 4 – CONCLUSION

The purpose of this study was to provide an overview of what is known about perinatal trauma and PP-PTSD by analysing research and practice from different fields and exploring the treatment methods that are used in relation to them, both evidence based and novel.

This study has concluded that birth trauma and perinatal PTSD are still underreported and insufficiently researched due to the relatively new recognition of PP-PTSD as a distinct subtype of PTSD and consequently its exclusion from classification systems and lack of specific diagnostic assessment tools. Conclusions based on unclear and inadequate research designs need to be re-evaluated, and current data suggest that more definitive research, which take variables such as diagnostic categories, time and risk status into account, will need to be undertaken to establish higher accuracy on the question of prevalence.

The investigation of risk factors revealed that many of them could be eliminated or mitigated on an interpersonal level by improving how people are treated during pregnancy, childbirth and postpartum, and on a systemic level by establishing trauma-informed care as a fundamental paradigm of health care.

A main goal of this study was to offer a review of interventions, and one of its major findings was the limited nature of international guideline recommendations due to the lack of adequate research into non-mainstream therapeutic modalities. The current recommendations are based on guidelines that analysed and evaluated previous research findings, and recommend those with good quality, reliable evidence. The advantage of following such guidelines is that the treatment that is available is more likely to be effective. On the other hand, several treatment methods and interventions that could be beneficial and effective are not recommended due to insufficient evidence[4], which leads to difficulties not only around funding and availability, but also public awareness of alternative therapies.

[4] *Most research papers regarding certain treatment methods in guidelines and meta-analysis found that there is so little evidence on methods - usually one or two papers, under the required threshold population size of 400, with identified risks of bias -, that no conclusion can be drawn from them.*

The search for evidence on the most suitable treatments highlighted another fact of critical importance: although trauma therapy has a very rich and ever-evolving literature in psychotherapy, it is only partially reflected in recommendations on best practice. A possible explanation for this might be that in the field of psychotherapy findings tend to be published and discussed with a focus on theory and practical implications based on individual cases and cumulated clinical experience rather than statistically quantifiable results, and randomized control trials. It appears that the lack of supporting research leads to an unjustifiable partial invisibility of the vast experience psychotherapists have in relation to trauma and PTSD.

Until synthesis of existing knowledge is achieved, focusing on prevention, implementing better birth protocols, and promoting access to services must be the main priority. There must be programs in place to support parents during pregnancy and for an extended period after the birth, so the prevalence of birth trauma and stress can be reduced, and when it does happen, specialized professional support needs to be widely and easily available to the birthing person, their partner and the medical staff. The road to recovery might not be easy or fast, but PTSD is treatable: both psychological treatment and medication are valid options if they are tailored to PP-PTSD, and many complementary methods can support a well-thought out, individualized treatment plan. With the right support trauma can be followed by recovery and posttraumatic growth, and kindness and compassion can weave through the memories.

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