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Traumatic Birth and Childbirth-Related Post-Traumatic Stress Disorder: Improving Mental Health Care in Maternity Services in Malawi

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Executive summary: The Policy brief on childbirth-related post-traumatic stress disorder (CB-PTSD), examines into critical issue of perinatal mental health, focusing on traumatic birth. Traumatic birth experiences and subsequent CB-PTSD symptoms can cause substantial suffering and have major long-term health implications with extremely distressing mental disorder for women, their infants, and families (Ayers et al., 2024; Horsch et al., 2024). This research sheds light on CB-PTSD which refers to the psychological symptoms that develop after or a direct consequence of having had a traumatic birth.

The Policy brief highlights the requirement for improved mental healthcare services, recognizing the lack of mental health screening and little evidence on how to best assess, prevent, and treat CB-PTSD (Horsch et al., 2024). It emphasizes the role of addressing the risk factors for CB-PTSD by incorporating strategies to promote continuity of care, good support and communication during pregnancy, continuous one-to-one support during labor into practice (Horsch et al., 2024; Thomson et al., 2021). The policy brief promotes respect to women's rights to autonomy before, during, after birth, and responsive care. The Policy brief underscores the importance of collaborative efforts, research-driven interventions, and policy guidance on the prevention, care, and treatment initiatives to address traumatic birth and CB-PTSD.

Introduction: Although the birth of a baby is viewed positively in nearly all cultures, research suggests between 20 and 40% of women find childbirth psychologically traumatic with some of these women go on to develop CB-PTSD as a result (Ayers et al., 2016), and 4% of women who give birth develop CB-PTSD (Ayers et al., 2024), with clinically significant PTSD symptoms observed in up to 16.8% of women (Dekel et al., 2017). Traumatic birth experiences and subsequent CB-PTSD symptoms can cause substantial suffering and have major long-term health implications for women, their infants, and families. However, traumatic childbirth experience and CB-PTSD remain largely unrecognized in maternity services and are not routinely screened for during pregnancy and the postpartum period.

Birth events and CB-PTSD provide an opportunities to prevent traumatic childbirths and CB-PTSD from occurring (Ertan et al., 2021; Horsch et al., 2024). This could be done through recognition of past traumas, continuity of care, good support and communication during pregnancy, continuous one-to-one support during labor, asking about people's birth experiences, can be incorporated into practice and need to be emphasized in the context of preventing and reducing psychological birth trauma and CB-PTSD (Ayers et al., 2024; Horsch et al., 2024).

Methodology: This research overview is based on the authors' study on traumatic birth and CB-PTSD conducted among 6-12 weeks postpartum mothers. The methodology incorporates data from recent literature related to CB-PTSD. Databases were searched to identify peer-reviewed publications related to CB-PTSD. The literature reviewed included scientific papers and consensus recommendations for practice, policy and research papers on CB-PTSD. Therefore, this overview is the result of study findings which aims to provide actionable insights for practicing healthcare professionals to improve mental health care in maternity services.

During birth, risk factors most strongly associated with CB-PTSD were negative subjective birth experiences. Communication during birth was a protective factor in the occurrence of CB-PTSD in the authors' study. Poor communication is a birth risk factor, which is associated with poorer birth outcomes and a greater risk for CB-PTSD, as is mistreatment during child birth (Garthus-Niegel et al., 2020). Lack of communication from staff, specifically experiencing verbal obstetric violence being the most likely to affect the development of PTSD (Martinez-Vázquez et al. 2021). This may reflect the specific behaviors and characteristics of medical staff that will always cause negative reactions among mothers. Reported in van Dinter-Douma et al. (2020), appropriate verbal treatment, providing concrete and understandable information, and ensuring informed consent were most frequently used to reduce fear or the likelihood of a traumatic birth experience. According to the findings reported by Chabbert et al. (2021), a good relationship with healthcare professionals and feeling the professionalism of midwives are also predictors of positive childbirth experiences.

Discussion of policy options

1). Screening for traumatic birth and CB-PTSD

Evidence indicates that childbirth-related trauma and childbirth-related posttraumatic stress disorder and its associated risk factors may be addressed through psychosocial interventions including screening to reduce burden caused on an individual. CB-PTSD is an extremely distressing mental disorder and has a substantial negative impact on those who give birth, fathers or co-parents, and, potentially, the whole family (Horsch et al., 2024). Still, a traumatic childbirth experience and CB-PTSD remain largely unrecognized in maternity services and are not routinely screened for during pregnancy and the postpartum period (Ayers et al., 2018). Adequate prevention, screening, and intervention could alleviate a considerable amount of suffering in affected families (Horsch et al., 2024).

2). Train healthcare professionals in perinatal mental health care to deliver evidence-based services

In Malawi midwives and other professionals working and providing maternity care are frequently the first health professionals who could identify traumatic birth and CB-PTSD, or to whom women with risk for CB-PTSD or any common perinatal mental disorders may go to seek for help. However, the country has low mental health specialists. This shows that pregnant women, women in labor and postpartum women attending maternity services may have limited access to mental health specialists. Despite a gross shortage of mental health specialists in the country, midwives therefore could participate in the prevention and detection of women with traumatic birth and CB-PTSD when providing maternity care (Ayers et al., 2024).

3). Integrate mental health with maternity care services

According to the National mental health policy, (2020), mental health is integrated in general health care system at policy level in Malawi, so that people could have increased access to mental health services. This means that mental health care could also be integrated with maternity care to allow mothers receive mental health care along with the usual antenatal, labor and delivery, and postnatal care as needed. Integrating mental health into maternity care requires midwives to assess and deal with mental health problems affecting women in maternity care settings in Malawi; to enhance early identification, prevention and intervention of traumatic birth and CB-PTSD risk, hence improve and maintain the well-being of mothers and others.

Despite the National mental health policy, Malawi lacks policy guidelines for maternal mental health care to increase awareness of perinatal mental health problems, however, recently a practical guide for maternity healthcare workers has been put in place (Williams & Stewart, 2024). Few countries have policies in place for the prevention of traumatic birth and treatment of CB-PTSD, (Thomson et al., 2021). Lack of clear policy or guidance means many do not access these services (Sperlich et al., 2017). There is need to put in place clinical guidelines, policy needs, training on perinatal mental health problems, and adequate resourcing of services to support healthcare providers to address the problems and prevent traumatising behaviors, such as obstetric violence, traumatic birth and CB-PTSD

Policy recommendations

The following recommendations have been proposed to be suitable for Malawi context:

1. Healthcare professionals must respect women's rights to autonomy i.e., maltreatment and obstetric violence must stop and women must receive responsive care.
2. Healthcare professionals must interact with childbearing women and their families in ways that maximise positive birth experiences and minimise negative experiences for women and their supporting persons.
3. Healthcare professionals must respond to childbirth-related mental health problems with compassion, understanding, and respect. Specialist support services for those who experience

traumatic births are uncommon, this is the same with Malawi.

4. Routine clinical practice should incorporate assessment of birthing mothers' experiences of care and identification of negative birth experiences in order to evaluate and improve care.
5. National guidelines for maternity and mental health care are needed to increase awareness of perinatal mental health problems, including traumatic birth and CB-PTSD, and outline evidence-based, practical strategies for detection, prevention and treatment.
6. Healthcare policies for maternity and mental health services should provide for prevention, detection, and treatment of traumatic birth and CB-PTSD.
7. Maternity care services need to offer routine screening for perinatal mental health and traumatic birth as part of family-centered, integrated care. National policies among others will help to emphasise regular screening for identifying those women and birth companions affected, and establishing formalised care pathways to facilitate access to effective care for women and families.
8. Maternity services need to be resourced to act on feedback around respectful care, including dignity, autonomy, and healthcare providers' communication and interaction with women.

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