

TREATING CHILDBIRTH TRAUMA WITH EMDR - A CASE REPORT

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INTRODUCTION

We often hear childbirth described as a unique and wonderful experience. On the other hand, giving birth is often also traumatic for women. Even in high-resource settings, childbirth can be a horrifying experience (Ballard et al. 1995). Women can be a victim of abuse or other trauma before or during pregnancy, which if not treated, can have a negative impact on pregnancy, childbirth, motherhood and ultimately, on newborns. Post-traumatic stress disorder (PTSD) affects about two percent of childbearing women in developing countries (Stramrood et al. 2012). In addition, around 40 percent of women have some PTSD symptoms without meeting all the criteria for the disorder (Stramrood et al. 2012). Some studies report that 28% of women have PTSD following pregnancy, and these women often complain of symptoms such as nightmares, anger, anxiety and fear of the next pregnancy (Abedian et al. 2013). Lack of support, an unplanned caesarean section and various complications during birth are only some of the factors contributing to trauma during childbirth (Hollander et al. 2017). According to Diaz-Tello (2016), women experience significant pressure and loss of control and autonomy in maternity care, and almost a quarter of new mothers who had induced labours or caesarean sections felt pressure to do so. Women attribute their birth trauma primarily to the lack of control over the situation, lack of communication between doctors and patients and lack of emotional support (Hollander et al. 2017). During the #BreaktheSilence social media campaign led by consumer advocate group "Improving Birth", hundreds of women shared their experiences of bullying, coercion, and even unconsented procedures such as episiotomies and vaginal examinations during birth (Diaz-Tello 2016). The childbirth experience is dehumanised due to hospital protocols and the lack of a humanistic approach from medical workers. Being exposed to trauma during childbirth has a wide range of negative effects on future reproductive choices and women and their relationships with their partner and infant (Ayers 2014). These findings suggest the importance of proper medical care and proper treatment of women in labour.

PTSD and depression are also very common in women who have had a stillborn baby. One in a hundred

and ten pregnancies result in a stillborn child, as a result of a natural intrauterine death of the baby after the 20th gestational week, and worldwide data report about four million sudden intrauterine deaths every year (Cacciatore et al. 2009). When exposed to risk factors such as conceiving one year after the loss and lack of social support during the loss, 21% of women match the criteria for PTSD during the next pregnancy (Turton et al. 2001). There is a major concern for the mental health of pregnant women who have had a stillborn child, because pregnancy itself is stressful, and the stress becomes greater after the loss of a baby.

Various complications surrounding childbirth can contribute to trauma. One of the complications during pregnancy is preeclampsia, which can have an extremely negative effect, not only on the physical wellbeing of both mother and child, but also, on the psychological wellbeing of the mother. Preeclampsia (PE) is a pregnancy specific, heterogeneous, multi-system disorder, which has the classic clinical features of pregnancy - induced hypertension and proteinuria, and it may lead to eclampsia (E) (East et al. 2011). Preeclampsia can also be associated with haemolysis, elevated liver enzymes, and thrombocytopenia (Haram et al. 2009). These symptoms together create the HELLP (H – haemolysis, EL – elevated liver enzymes, LP – low platelets) syndrome, which now stands for a serious complication as a severe form of preeclampsia (Haram et al. 2009). It is reported that about 18% of women seek psychological help after being diagnosed with preeclampsia and having a child (East et al. 2011). Women with atypical forms of preeclampsia, such as HELLP syndrome, often experience delayed diagnosis (East et al. 2011), which leads to more stress and therefore more severe PTSD symptoms. Antenatal hospitalization due to the symptoms of HELLP syndrome has also been suggested to lead to various emotional, cognitive and behavioral changes of mother (East et al. 2011).

As various results show, there is a significant prevalence of PTSD and depressive disorders after childbirth (Ballard et al. 1995, Cooper et al. 2003, Meltzer-Brody 2011). In his case studies, Ballard (1995) finds that women develop PTSD symptoms after deliveries of an unhealthy baby, lack of pain control during childbirth, or due to maltreatment by hospital staff. It is

crucial to address these issues, improve the medical health care system and provide proper medical and psychological care for mothers worldwide. In order to assess satisfaction with maternal care, it is necessary to have valid measures for this ongoing problem (Sawyer et al. 2013). Literature reviews show no data on satisfaction with medical and maternal care in Bosnia and Herzegovina. Another problem in B&H society is that postpartum depression is a taboo subject. It is believed that a woman should not feel bad after having a child. Becoming a mother in B&H culture is glorified, and a common belief is that every woman should want to become a mother, to feel happy about it and to put all of her needs aside in order to raise a child. This is one of the reasons why Bosnian women often fail to seek help and psychological support following childbirth.

The Opti-MUM Study (Baas et al. 2017) is an ongoing study on the effects of EMDR therapy in pregnant women with childbirth trauma. Another study on the effect of EMDR treatment in pregnant and non-pregnant women with childbirth trauma shows stress reduction after the treatment (Stramrood et al. 2012). After one to three years following treatment, the benefits of EMDR still remain (Sandstöröm et al. 2008). EMDR treatment provides stress reduction and improves coping abilities regarding childbirth trauma due to the preeclampsia (Poel et al. 2009). This case study also aims to show the benefits of EMDR therapy in treating childbirth trauma, especially one caused by HELLP syndrome and hospital maltreatment, and to give suggestions for further studies.

CASE REPORT

Ana is a 31-year-old female and an only child coming from a very supportive and loving family. She lives with her partner, and has good social support. Together they have an eight-month-old son. She denies any earlier psychological issues except that after the baby was born she felt like she was having postpartum depression or PTSD. Ana describes herself as a very strong and resilient young woman. She is currently waiting for a fresh start in a new job.

She had her first pregnancy, and it was a very healthy one, up until the eight month of pregnancy when her gynecologist in private practice observed the deterioration of her placenta and a lack of amniotic fluid and referred her to the Clinical Centre. The doctors at the Clinical Centre said everything was fine and sent her home. That same night she felt a lot of pain in the lower part of her stomach and started bleeding. She went back to the hospital. Ana stayed at the hospital bleeding for five days, but doctors simply neglected her. She kept telling the doctors that she is bleeding constantly and tried to get some help. The doctors only asked to see her sanitary napkins, but there was not so much blood on them because she had to change them constantly. Consequently, the doctors did not trust what she was telling them (she did not keep the used ones as proof).

The medical staff failed to check her laboratory results, in which they would find the symptoms of HELLP syndrome, as she later found out. One night, the doctor on call examined her and rushed her to the operation room in panic. She had an emergency C-section. She did not see nor hold her baby for a few days after the delivery. She only got to see her newborn once, and she saw him having a tremor while he was in an incubator, which was very traumatic for her. At the end, as Ana was preparing to go home with her baby, the nurse told her that they could not discharge the baby yet, because his laboratory results were not good. A few hours later they brought out her son saying they made a mistake by switching the lab tests, and her baby was fine and healthy.

Presenting Problem

For the first three months after the delivery, she could not feel the joy of having a baby; she felt depressed and unhappy. She still has nightmares and flashbacks regarding her hospital experience. Now she feels she is overprotective of her baby, and she is in constant fear for the baby's life. She analyses every sound that he makes, as well as his sleeping habits, and therefore sees motherhood as an overwhelming experience. She also feels like she did not deliver the baby. During the pregnancy she was preparing herself and her body for the delivery, and now after the caesarian section, she feels like she just fell asleep, woke up and someone gave her the baby. She has some trouble in seeing her son as her own. Ana regrets not being with the baby during his first few days. She cannot trust anyone for taking care of her baby, although she will soon have to find a babysitter while she is at work. Furthermore, she is in dispute with her close friend who is pregnant and plans that the doctor who misdiagnosed Ana will deliver her baby because he is a well known doctor in town. She feels like she cannot be there for her and she is losing her friend.

Ana's main goal is to overcome her negative hospital experience. Also, she wants to prepare herself for going to work and leaving the baby with the babysitter.

Case Conceptualization

In terms of Shapiro's adaptive information processing model (Shapiro, 2001), the impression was that Ana was unable to process her hospital experience due to her extreme and overwhelming emotions during the stay and after the baby was born. Distress during childbirth and indifference from the hospital staff contribute to Ana's current symptoms and negative emotions. Her processing seems to be looping around images from the hospital which was blocking access to positive memory networks, not allowing her to make a healthy attachment with the baby and embrace the role of the mother in a positive way.

Course of Treatment

Session 1

After the first two sessions of the preparation phase, which consisted of history taking and installing the safe place, we started the reprocessing. During the history taking, there were two separate events recognized as targets that disturbed her, and these need to be reprocessed separately.

The first disturbing aspect of the memory was constant bleeding and asking for help (before childbirth). Ana's negative cognition (NC) was "I am helpless" and her positive cognition (PC) was "I am not alone". Validity of Cognition (VoC) for PC was two. It is important to note that while the standard protocol for EMDR requires PC to be in the opposite state of NC, the client felt the chosen PC "I am not alone" was very important to her, as she rationally knew she was supported by the presence of her partner, both in the hospital and on the phone. Her traumatised part was not able to access that fact. Ana's initial Subjective Unit of Distress (SUD) was six. Her emotions were fear and anger with stomach and chest pain and chills in her arms. Ana was instructed to hold the target image, the associated NC, and the emotion and physical sensation, in mind while following my fingers for bilateral eye movement. Desensitization using eye movements elicited a range of physical sensations, such as chest pain and heavy breathing (the same she had in the hospital). During the session, Ana described a feeling of anger towards herself for being too polite with the doctors. As reprocessing continued, she kept reporting various body sensations, from chest pain to stomach pain and a feeling of emptiness in her stomach. She had an image of breastfeeding the baby for the first time, and the fact that she could breastfeed him in all that stress was a miracle to her. She realized her body did everything it could to protect the baby. Towards the end of the session she went back to her safe place and felt calmer.

Session 2

The second session took place after seven days. Ana reports having a lot of nightmares since our first session. During the last seven days, she felt like she was back in the state of the first 2-3 months after the delivery.

We went back to the initial target, and continued with BLS. During the BLS reprocessing, she had an intrusive image of the nurse telling her that her baby had a tremor because she was not with him in his first few days. Towards the end of the session, she started to feel like she was a good mother after all, and that she did everything she could to save the baby. We used that as a resource.

Session 3

The third session took place after eight days. Ana said she had a really good week. She had her first period after the pregnancy, which made her really happy; she felt like her body was normal and healthy again. The

whole week was very positive for her. She dyed her hair again, got a manicure and overall felt good about herself. She also did some lab tests, and they were good, confirming her health.

The reprocessing continued again with the initial target and with the same PC and NC. During the reprocessing, she felt power and accessed the strength to move on. She felt like she was back in the hospital, but this time she felt like she was not alone, like her ancestors were there taking care of her (although she is not a religious person). Ana felt determined to move on to better times in her motherhood. We came to the end of reprocessing; there was no more disturbance and no new images or sensations. The SUD level was two and VoC was six. Ana explained that feeling slightly disturbed by the image is acceptable to her, because she feels like she could never be totally indifferent regarding her experience. Ana wanted to change the PC to "I am strong", and the VoC for new PC was seven. A body scan showed no disturbance, and we did the installation of the PC.

Session 4

The VoC level for the previous PC "I am strong" remained seven, and the SUD level was two, which was acceptable for Ana. The second disturbing aspect of the memory identified at the assessment was targeted.

The target was seeing her baby having a tremor in the incubator. Ana chose new cognitions for this target - NC: "I am not a good mother", and PC: "I am a good mother". The VoC for PC was two, and SUD level was eight. The dominant emotion was sadness following unpleasant sensations in her eyes, nose and throat as well as feeling of heaviness in her body. During the BLS Ana started sobbing, a strong abreaction. As she could not follow the fingers for BLS, it was switched to tapping on her knees. Again she felt like being in the hospital and felt the pain in her body along with the image of the nurse telling her that it is her fault the baby has a tremor. Ana kept asking herself why she feels guilty and sad knowing that she did everything she could for her baby. She had a memory of meditating and soothing herself in her hospital bed after her extreme emotional reaction following learning about the baby's tremor. Later on, the nurse told her that her baby is calm and sleeping. She felt strong and proud for managing to calm the baby by calming herself. She realised that she did everything she could for her baby - even before she got pregnant - by preparing her body for pregnancy, which she believes is the reason her son is now a really big and healthy baby. At the end of the session, Ana felt calmer and relaxed in her body, and we finished the session with that.

Sessions 5 & 6

During these two sessions, the client realised that her hospital experience broke all of her boundaries and that she felt depressed due to the extreme exhaustion she went through. Now she sees the event as an act of violence, which reminds her of an incident with her

mother's friend back when she was 15 years old. A friend touched her inappropriately and her mother did not give any importance to that. Ana did not want to reprocess that event with EMDR because she says she processed that with psychotherapy years ago. During the reprocessing, she felt angry at her baby. That anger transferred onto her pregnant friend who was seeing and praising Ana's doctor that misdiagnosed her. We reprocessed that anger and Ana reports that in between the sessions she managed to reconcile with her friend.

During reprocessing she accessed many positive images, which were installed as resources, such as feeling that it is finally over, feeling that she gave her best, and the first picnic she had with her partner and their baby. At the end, her VoC was 6.5. Ana was asked what she needs for the VoC to be seven, and she said: "More experience as a mother". There was still some disturbance regarding the target event.

Session 7

Ana still seemed to be distressed by her traumatic childbirth, although standard EMDR protocol was completely implemented. It was assumed that there are still some parts of the target event that she did not want to disclose. Therefore, the Blind to Therapist (B2T) protocol was used for decreasing the level of disturbance.

The target word was "horror" following emotions of sadness and terror as well as stomach pain. This was processed with BLS until Ana reported no more disturbances. VoC was seven and SUD level was two which was also acceptable for her. Ana says it is something she can handle now. Like the first reprocessed target event, she could never see that picture with no disturbance at all, but she reached her goal of not seeing herself as a bad mother. Ana still felt the blank space between her pregnancy period and the period of having a child. She said she cannot connect those two pictures, and sometimes felt like a child has only been given to her. She focused on that feeling of blank space in between, noticed the body sensation (heaviness) and emotion (confusion), and processed it with BLS. After only two sets, she could connect those two pictures, and was feeling more relaxed and in tune with herself and with the baby.

As Ana stated in the initial session, she was also worried about her baby's future. She kept seeing it as negative. She was asked to visualize her son growing up as if she was watching a videotape. She kept seeing negative outcomes in his life due to the fact that he is born in Bosnia and Herzegovina where there is a lack of opportunities for young people. Towards the end of reprocessing, Ana was able to visualize his life as positive, with lots of obstacles which he will be able to confront because he has a healthy and loving family who will support him. At the end of the session she felt much more relaxed and happy about her motherhood and upcoming challenges with the baby. Then we proceeded to the installation and body scan phases.

After the 4-Month Follow-Up

Ana was contacted via e-mail for the purpose of a follow-up. She reported feeling very well and relaxed with the baby, and that she is much better in handling the ups and downs of motherhood. She just started a new job so now she leaves her baby with a babysitter. Although she does not work full time, she uses the benefits of having a babysitter to do other errands and to have a little time for herself. She also has a very good relationship with her friend, and now she is able to be there for her and is even helping her prepare for the hospital. She could not even imagine that she could ever feel better, and now she feels healed.

DISCUSSION

Our case study showed that EMDR might be a good therapy of choice in treating women with childbirth trauma.

Ana reported childbirth trauma, showed symptoms of PTSD and testified that she was maltreated by the medical staff. Nine months after the trauma, EMDR resulted in stress reduction, fewer PTSD symptoms and more confidence toward her motherhood and baby's future. Factors that may have contributed to this positive outcome include Ana's positive and healthy background, supportive social network and her motivation since she was self-administered to therapy and EMDR was her therapy of choice. Another factor that may have contributed to her progress is the fact that she has been to therapy years before (psychodrama), so she is an experienced and cooperative client. She asked for EMDR because she heard it was a specific trauma-focused therapy and she did not want to go through all the analyses and details of her personal history.

It is possible that one of the shortcomings of this case study is the fact that the positive cognition was not in the same cognitive domain as the negative one. In these instances, it is recommended to use clinical judgment (Hensley 2016). Ana could not connect to any other PC that was offered to her as a counterpart to her NC, so we agreed to go with the chosen PC, which Ana could relate to. It seems that EMDR provided a natural healing process (Shapiro 2001), so at the end of reprocessing Ana felt the need to change her PC so it could be in tune with her NC.

There have been a number of studies about childbirth trauma and the factors contributing to it. Most of them are case studies showing women testimonies about their hospital experiences. Among all the factors contributing to the negative experience, the most common factors are delivering stillbirth (Turton et al. 2001, Murray 2012), preeclampsia and HELLP syndrome (Poel et al. 2009, East et al. 2011, Stramrood et al. 2012), emergency caesarian section and lack of (pain) control (Stramrood et al. 2012, Diaz-Tello 2016), and some form of hospital maltreatment or obstetric violence (Diaz-Tello 2016). According to these findings, it

is necessary to provide a proper mental health care to new and future mothers. It is not just the issue of mother's mental health, but also the child's physical and mental health, since a healthy and stable mother is necessary for a newborn's well-being. Some previous studies show that cognitive-behavioral therapy and psychodynamic therapy give good, but short-term, results in treating childbirth trauma (Cooper et al. 2003). EMDR therapy produces reduced stress symptoms after childbirth in the long-term (Sandstöröm et al. 2008). Results presented here somewhat match these previous findings, although long-term follow-up is needed, as well as other studies.

Another important issue needs to be addressed. Postpartum depression is a taboo subject in B&H society, so it is important to address it in a systemic way. It is not enough just to treat women medically and psychologically after their childbirth experiences, but it is important to raise awareness about this issue so that women could feel comfortable even admitting they have a problem. This might be one of the reasons why women often do not talk about their mental health following delivery, and why there is no data on the number of women seeking professional help after their childbirth.

CONCLUSIONS

The result of this case study indicates that EMDR might be a good therapy of choice for women battling childbirth trauma. Positive outcomes of the therapy might also be attributed to the fact that it was the client's first pregnancy, so there was no previous childbirth trauma involved. Earlier childhood trauma was already processed before, and the client was highly motivated and had positive expectations of therapy. This case study represents a good basis for further researches.

More studies are needed, and it is important to include other variables, such as women with previous pregnancies, fear of childbirth, lack of social support, single mothers etc.

Furthermore, it is important to compare outcomes of treating childbirth trauma with EMDR and with other psychotherapies.

B&H society also needs a study of satisfaction with medical care, prevalence of hospital maltreatment and obstetric violence, to encourage all women with childbirth trauma to ask for psychotherapy help.

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Merima Pašalić: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the article and gave final approval of the version to be submitted.

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