REVIEW ARTICLE

The concept of traumatic childbirth and psychopathological consequences

Maja Milosavljevic Markovic[1,2], Nevena V. Radonjic[3,*], Cedo Miljevic[1,2], Olivera Vukovic[1,2,*]

[1]Institute of Mental Health, Belgrade, Serbia
[2]University of Belgrade, Faculty of Medicine, Belgrade, Serbia
[3]SUNY Upstate Medical University, Syracuse, Norton College of Medicine, Department of Psychiatry, NY 13210, USA

*These authors contributed equally to this work

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Correspondence to:
Maja Milosavljevic Markovic
Institute of Mental Health,
3 Milana Kasanina Street, 11000 Belgrade, Serbia
Email: maja.milosavljevic@imh.org.rs

Summary

Childbirth is expected to be a predictable and positive experience in a woman's life. Nevertheless, traumatic experiences related to childbirth have been described for years, which in the most severe cases can result in the onset of postpartum posttraumatic stress disorder. According to current evidence, approximately 4.7% of women in the postpartum period meet the diagnostic criteria for Childbirth-Related Posttraumatic Stress Disorder (CB-PTSD). Unfortunately, little is known about the aspects of traumatic childbirth, the risk factors for the occurrence of this disorder are insufficiently known, and if it progresses to a clinical diagnosis of posttraumatic stress disorder, it is rarely diagnosed and even less often treated. Perceiving childbirth as a traumatic experience may have numerous consequences, including avoidance of subsequent pregnancies, sexual intimacy, or gynecological examinations; withdrawal from newborn care responsibilities; difficulties with breastfeeding and mother–infant bonding; and strain or dysfunction within the partner relationship. Given this, it is extremely important to increase professional and general awareness of this mental disorder, getting to know the risk factors for its occurrence and possibilities for its diagnosis and treatment.

Keywords: traumatic delivery, postpartum posttraumatic stress disorder

INTRODUCTION

There is no unique definition of "healthy childbirth". It is generally accepted that childbirth is a positive experience in a woman's life, planned and predictable. This usually presumes that childbirth is vaginal, full-term, results in a healthy child, and occurs without any additional medical interventions or complications. Special attention should be paid to a woman's views regarding childbirth, and the autonomy of her body, with respectful recognition of her right to make decisions about her health and treatment choices (1).

Pregnancy and parturition constitute a profoundly demanding period, encompassing substantial physiological and psychological changes and challenges. The childbirth experience is shaped by a complex interplay of psychosocial and obstetric determinants, which are conventionally delineated into three temporal phases: antenatal, peripartum, and postpartum (2).

If a woman describes her birth as stressful or traumatic, three different possibilities must be considered. First, if the woman describes giving birth as traumatic, but experiences no psychopathological consequences, it is classified as a traumatic birth (3). Second, when a woman experiences childbirth as traumatic and presents with symptoms of avoidance or intrusion, but their duration or severity does not fulfill the diagnostic criteria for posttraumatic stress disorder, the condition is classified as postnatal traumatic stress rather than PTSD (4). The most clinically significant category is Childbirth-Related Posttraumatic Stress Disorder (CB-PTSD), which followed the change in criterion A in the DSM-IV classification in 1994 (5). According to the DSM-5-TR classification, Criterion A (trauma exposure) encompasses direct personal experience of a traumatic event, witnessing the event, learning that it occurred to a close person, or repeated or extreme exposure to aversive details of such events (6). Essentially, if a woman at any point during childbirth experiences an immediate threat to her life or her baby's life, or a threat to her bodily integrity, she has met the first and fundamental diagnostic criteria for CB-PTSD.

CB-PTSD was first introduced in the late 1990s. In its earliest conceptualizations, the diagnosis was considered contingent upon the presence of obstetric complications during childbirth (1). However, it was quickly demonstrated that CB-PTSD can also occur following a clinically uncomplicated event, resulting in a completely healthy child (7). Since then, intensive research has been conducted to identify possible risk factors that could lead to a woman's assessment of childbirth as traumatic, particularly when no significant clinical complications are present.

The potential sequelae of traumatic childbirth are extensive, encompassing complications affecting the mother and infant, disruptions in maternal–infant attachment, and adverse impacts on partner relationships, family dynamics, and broader societal functioning. For the woman, consequences may include avoiding subsequent pregnancies and gynecological examinations, insisting on cesarean delivery for future childbirths, and difficulty caring for the baby or breastfeeding (8). Partner relationships may suffer from interpersonal discord, perceived lack of understanding from the partner, and avoidance of sexual intimacy as a strategy to prevent subsequent pregnancy. At the societal level, consequences include reduced work productivity, extended work absences due to illness, and increased medical costs. Despite these significant impacts, women with traumatic birth experience often remain unrecognized or undiagnosed, even if they meet criteria for CB-PTSD. Precise data on the number of undiagnosed cases of CB-PTSD are lacking. Currently, diagnosing CB-PTSD and initiating the treatment remain the exception rather than the rule, contrary to what should be standard practice.

Recent data indicate that the prevalence of CB-PTSD is around 4.7% (9). However, a substantial proportion (around 30%) of women experience post-birth traumatic stress that partially meets CB-PTSD criteria (1,8,10,11). The first CB-PTSD study in Serbia, conducted in 2012 at the Institute of Mental Health, found that 2.4% of participants had CB-PTSD one month after delivery, consistent with global data, while 11.9% experienced partial CB-PTSD (1,10). This was the first study on CB-PTSD in the Balkans, a particularly valuable contribution given that most traumatic stress research focuses on high-income countries (12).

These findings underscore the aim of this review and the critical importance of educating both healthcare professionals and the public about this significant disorder, which remains insufficiently recognized, diagnosed, and treated.

METHODS

This narrative review examines the literature on traumatic birth and childbirth-related posttraumatic stress disorder (CB-PTSD). A comprehensive search was conducted using PubMed and Google Scholar to identify relevant publications from 2008 onward. The search strategy employed combinations of the following key terms: "traumatic birth," "childbirth-related posttraumatic stress disorder," "CB-PTSD," and "risk factors."

The search focused on peer-reviewed articles, systematic reviews, and empirical studies that investigated traumatic childbirth experiences and the development of posttraumatic stress symptoms following delivery. Additional sources were identified through citation tracking of key articles and review papers to ensure coverage of influential studies in the field.

As a narrative review, this synthesis does not claim to retrieve all available literature exhaustively but rather

provides a comprehensive overview of major themes, findings, and debates regarding traumatic birth and CB-PTSD. The review integrates research across diverse methodologies and populations to examine the prevalence, risk factors, clinical presentation, and implications of childbirth-related trauma. This approach allows for critical discussion of the evolving conceptualization of traumatic birth and identification of gaps in current understanding that warrant further investigation.

THE HISTORY OF CHILDBIRTH-RELATED POSTTRAUMATIC STRESS DISORDER

In 1875, Savage described disturbing dreams that preceded melancholic stupor after childbirth (13). For an extended period thereafter, postpartum psychopathology received minimal attention and was infrequently documented in the professional literature. Toward the end of the 20th century, papers began describing small numbers of women who, following painful or prolonged childbirth, developed symptoms such as nightmares with content related to childbirth (intrusion symptoms), dissociation, and anxiety (1,8). These women typically lacked satisfactory support during and after childbirth, and these psychopathological phenomena primarily affected mother-baby attachment (14). Following changes in the diagnostic criteria of the DSM classification, CB - PTSD was first introduced in 1995. Only a year later, CB-PTSD was identified in women who had experienced clinically uncomplicated births. Unlike peripartum depression, which has a specific timeframe in DSM-5-TR (occurs during pregnancy or within the first 4 weeks postpartum), CB-PTSD has no birth-specific time limit but follows general PTSD diagnostic criteria: symptoms must persist for more than one month following the traumatic experience (5). Despite childbirth being a complex event that poses notable risks of illness and death for women, professional research and expert analysis on CB-PTSD have only been available for approximately the past three decades.

RISK FACTORS FOR CHILDBIRTH-RELATED PTSD

Early work on traumatic birth and CB-PTSD focused primarily on births with significant obstetric complications, premature delivery, or perinatal loss. When it was discovered in the late 20th century that CB-PTSD can occur even after clinically normal births, numerous studies began attempting to identify risk factors for developing this disorder (1). Early identification of these risk factors enables more effective birth planning, targeted support for women at elevated risk, and implementation of comprehensive preventative measures.

Childbirth itself carries specific risks for the development of PTSD (1,8,10,15). Childbirth typically occurs in a hospital setting, in the presence of healthcare workers and sometimes a partner or other support person. Significant hormonal changes following childbirth can also affect the mental health and well-being of the birthing person. During labor, medications such as meperidine, epidural analgesics, diazepam, and oxytocin are used for pain relief and labor stimulation. These pharmacological agents modulate pain perception, induce varying degrees of sedation, and alter cortisol secretion, collectively contributing to an increased risk of developing CB-PTSD (1).

Risk factors can be divided into antenatal, peripartum, and postnatal/postpartum in relation to childbirth (1,2,8,10,15). Antenatal factors include psychosocial factors (lower socioeconomic status, lower educational attainment), parity (first-time mothers are at higher risk), social support, previous psychiatric treatment, history of sexual abuse (particularly childhood abuse) (16), tokophobia, unpleasant or traumatic experiences in previous pregnancies or births, and certain personality traits such as neuroticism. Tokophobia in pregnant women warrants particular clinical vigilance, as some patients experience this fear with functionally disabling severity.

Among peripartum risk factors, the subjective experience of childbirth has emerged as the most significant determinant in recent studies (15). Women form attitudes about childbirth based on their mothers' experiences, friends' accounts, and information from media and social networks – sources that are often unreliable and untrustworthy. Underlying assumptions and personal experiential factors shape these attitudes. When expectations do not align with experience, childbirth can easily be perceived as traumatic, leading to symptoms of traumatic stress or PTSD. Other significant peripartum risks include the delivery method, the intensity of the pain experienced, and the perceived presence or absence of adequate support from partners, significant others, and healthcare professionals. Instrumental vaginal delivery (forceps or vacuum extraction) and emergency, unplanned cesarean section are the most stressful delivery methods (9), alongside other possible obstetric complications. Although subjective pain experience can influence whether childbirth is perceived as traumatic, current evidence indicates that even effective analgesic interventions have not reduced the overall incidence of traumatic birth experiences (1). Here again, the discrepancy between expected and experienced pain can play a key role as subjective assessment is a major factor.

Postpartum risk factors include inadequate social support and having a baby in the NICU, etc. (15).

Support from partners, family, friends, and healthcare professionals is among the most significant protective factors influencing both the development of postpartum PTSD and the likelihood of perceiving childbirth as traumatic. This factor is equally important during pregnancy (prenatal), childbirth itself (peripartum), and after birth (postpartum). Healthcare professionals are expected

not only to provide guidance but also to demonstrate empathy and patience, offering relevant, evidence-based advice and psychoeducation. In the Republic of Serbia, good clinical practice guidelines on "Health Care for Women During Pregnancy" and "Physiological Vaginal Delivery" are currently under development, and will include, for the first time, provisions for routine screening for mental disorders, with a primary focus on postpartum depression (17,18).

THE NEUROBIOLOGY OF CB-PTSD

Endocrine factors constitute a special group of risk factors that remain poorly understood (1). The hypothalamic–pituitary–adrenal (HPA) axis and the female gonadal axis are interconnected through bidirectional regulatory pathways. Pregnancy involves significant hormonal changes, including increased corticotropin-releasing hormone (CRH) secretion, placental CRH secretion, elevated levels of estrogen and progesterone, and both positive and negative feedback regulation by cortisol (19). However, current knowledge remains insufficient to fully explain the endocrine mechanisms that influence psychological processes underlying traumatic experiences.

CRH inhibits the female gonadal axis during pregnancy, with levels in the last trimester increasing approximately 100-fold compared to the pre-pregnancy values. Conversely, estrogen stimulates the HPA axis. Consequently, transient hypercortisolemia is a physiological state expected during pregnancy. In recent years, research has focused on assessing cortisol levels during childbirth and their potential impact on maternal mental health (19,20). Findings have been heterogeneous, with some studies reporting elevated d cortisol levels during childbirth among women who subsequently developed PTSD symptoms, while others reported reduced levels. If future research demonstrates that reduced cortisol levels during labor constitute a risk factor for CB-PTSD, this would imply the possibility of preventive intervention during the immediate postpartum "golden hours"—for example, within the first 2 hours after birth. Such intervention could potentially involve targeted hydrocortisone administration to mitigate subsequent CB-PTSD development.

EPIDEMIOLOGY OF CB-PTSD

The estimated prevalence of CB-PTSD in the literature varies from 0.8 to 6.9%, with a recent meta-analysis estimating the prevalence at 4.7% (10,15). Additionally, between 1.5% and 33.1% of parturients exhibit subthreshold symptoms - symptoms that do not meet full diagnostic criteria in terms of intensity or duration. Reported prevalence rates vary considerably across studies, largely depending on the timing of assessment. CB-PTSD can be diagnosed after one month of childbirth, and the incidence of this disorder is higher when assessment is conducted closer to delivery (after the first month) (1,10).

CLINICAL ASPECTS OF TRAUMATIC BIRTH

As previously noted, in cases of traumatic childbirth without subsequent psychopathology, a woman may describe the birth as traumatic without measurable consequences for her mental health or daily functioning. Traumatic stress, or partial PTSD, refers to the presence of posttraumatic stress symptoms that do not meet the full diagnostic criteria for PTSD with respect to their intensity or duration. Therefore, the parturient will describe childbirth as traumatic and experience some intrusive symptoms, avoidance, and/or hyperarousal. Clinical assessments must take into account physiological postpartum symptoms, such as insomnia, pronounced fatigue, irritability, and emotional hypersensitivity, that may naturally occur during this period.

CB-PTSD is a form of PTSD and is characterized by the same symptoms. According to the DSM-5-TR criteria for PTSD symptoms are trauma exposure (A criteria) and then experiencing symptoms from four clusters for over a month: intrusion (flashbacks, nightmares), avoidance (places, people, thoughts), negative cognitions/mood (blame, negative beliefs, loss of interest), and arousal/reactivity (hypervigilance, irritability, startle response). These symptoms must cause significant distress or impairment in daily life and not be from substances or another medical condition (6). Criteria A is a mandatory one and is described as exposure to actual or threatened death, serious injury, or sexual violence. In 1994 (DSM 4), the change in diagnostic criteria and the introduction of Criterion A as mandatory for the diagnosis of PTSD actually made it possible to make this diagnosis after childbirth (5). The specificity of Criterion A in the context of childbirth lies in its concern with an event that is expected and predictable. In clinical practice, however, women often report perceiving their own or their baby's life as being in danger, fearing that childbirth will result in lasting physical consequences, or believing that one of them may not survive.

All symptoms of CB-PTSD correspond to those observed in PTSD arising from other causes; however, the avoidance symptoms are uniquely shaped by the postpartum context. These may include difficulties related to breastfeeding or infant care, avoidance of gynecological examinations, avoidance of sexual intercourse due to fear of becoming pregnant again, and avoidance of future pregnancies to prevent another childbirth experience (8). Even stories about childbirth, watching movies, series, or any information related to childbirth can trigger anxiety, and that is the reason for avoidance. At the same time,

these can also be the consequences of this disorder that relates to both childbirth and the newborn, but also to the relationship between partners.

CB-PTSD can often be associated with depressive disorder (postpartum depression), anxiety disorders, or altogether perinatal mood & anxiety disorders (PMADs) or substance abuse (8, 21).

SCREENING FOR CB-PTSD

There is no standardized screening for CB-PTSD (22). To enable timely diagnosis and appropriate intervention, it is essential to conduct PTSD screening among individuals at elevated risk for developing the disorder. Enhanced education of both healthcare professionals and the general public regarding the potential for traumatic childbirth is essential, as limited awareness remains a significant barrier to effective screening. Additionally, maternal reluctance to disclose emotional experiences due to shame and stigma complicates the identification of those requiring screening (23).

Several scales are currently available for assessing PTSD symptoms, in addition to comprehensive anamnestic data collection. The most widely used self-report scales that are adapted to the DSM-5 diagnostic criteria include the PCL-5 (24), the City BiTS (Birth Trauma Scale) (25), and the Peritraumatic Distress Inventory (PDI) (26). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is a structured clinical interview administered by a trained clinician (27). In addition to the City BiTS scale, the Perinatal PTSD Questionnaire (PPQ) is a widely used, revised tool specific to CB-PTSD (28).

Initial screening should be conducted for all mothers who present with significant risk factors for CB-PTSD, particularly those reporting a traumatic childbirth experience or exhibiting postpartum psychological symptoms such as intrusion, avoidance, or hyperarousal. Any of the aforementioned self-assessment scales may be used for initial screening, and the screening can be administered by any healthcare professional encountering the mother. A positive screening result should raise suspicion of PTSD and prompt referral to mental health professionals. The psychiatrist should then perform a complete clinical examination, possibly including CAPS-5 scale administration, and establish a diagnosis of PTSD. Birth itself must be identified as a traumatic experience (A criterion) before the diagnosis of CB-PTSD can be made. Particular attention should be given to women who do not meet the full diagnostic criteria for CB-PTSD but have experienced a traumatic birth, especially when their functional capacity is diminished.

Since routine postpartum depression screening does not identify cases of CB-PTSD, trauma-focused screening is important to enable specific interventions crucial for enhancing maternal mental health outcomes.

TREATMENT OF CB-PTSD

In cases of traumatic childbirth without a diagnosable psychiatric disorder, no specific psychiatric treatment is indicated. In most situations, providing emotional support, creating space to be heard, and helping to normalize the experience are sufficient.

Parturients experiencing traumatic stress, or partial PTSD, require an appropriate level of support (potentially including counseling), and should undergo a thorough assessment to ensure that care is tailored to their individual needs. A personalized approach is essential. Given that most partial PTSD symptoms spontaneously resolve over time, it is important not to pathologize the current situation while closely monitoring the mother's mental state.

When a woman is diagnosed with postpartum PTSD, therapeutic protocols should correspond to those for the treatment of PTSD of any other origin (8). Special caution is required when the mother wishes to breastfeed, as any prescribed pharmacotherapy must be carefully evaluated and adjusted to ensure compatibility with lactation.

General therapeutic measures include psychoeducation and normalization of the condition (29). Stigma remains a significant problem that prevents women from seeking help and avoiding psychiatric care. Recognizing that traumatic childbirth experiences do not reflect personal weakness or inferiority, but rather constitute a distinct disorder with specific causes, symptoms, and methods of treatment can bring relief to women. Education of healthcare workers is also a necessary measure in national strategies for the treatment of mental disorders. Greater awareness among health workers would lead to more frequent recognition of at-risk women and those with symptoms, enabling easier and faster access to adequate help.

In general, patients with milder clinical symptoms are treated with psychotherapy (Eye Movement Desensitization and Reprocessing – EMDR or Cognitive Behavioral Therapy - CBT) (29,30), while those with more severe forms of the disorder require an integrative approach, psycho- and pharmacotherapeutic protocols. First-line medications belong to the selective serotonin reuptake inhibitors (SSRIs) class (31).

PREVENTION

Prevention measures should ideally be implemented at all three levels of healthcare, primary, secondary, and tertiary (8). Although definitive prevention guidelines are lacking, current evidence suggests that psychoeducation, brief trauma-focused and non-trauma-focused psychological therapies within 96 hours after birth, support, and improving coping strategies (resilience) may be beneficial (8,32).

CONCLUSION

Although the traumatic potential of childbirth has long been recognized, only in the past two decades has this topic received systematic scientific attention. When childbirth is appraised as traumatic, a range of psychopathological responses may emerge, including traumatic experience, traumatic stress symptoms, and childbirth-related posttraumatic stress disorder (CB-PTSD). These conditions can have far-reaching consequences for the mother, the infant, the partner relationship, and society as a whole. This underscores the need for routine screening, accurate diagnosis, and an integrative, personalized approach to treatment. Strengthening professional education and raising public awareness about traumatic childbirth are essential steps toward supporting women who often endure these experiences in silence.

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KONCEPT TRAUMATSKOG PORODAJA I PSIHOPATOLOŠKE POSLEDICE

Maja Milosavljević Marković[1,2], Nevena V. Radonjić[3], Čedo Miljević[1,2], Olivera Vuković[1,2]

Sažetak

Porođaj bi trebalo da predstavlja očekivano i pozitivno iskustvo u životu žene. Ipak, godinama unazad opisuju se traumatska iskustva povezana sa rađanjem koja u najtežim slučajevima mogu rezultovati nastankom postporođajnog posttraumatskog stresnog poremećaja. Prema današnjim saznanjima, oko 4,7% porodilja će ispunjavati kriterijume za postavljanje ove dijagnoze. Na žalost, o aspektima traumatskog porođaja se i danas malo zna, nedovoljno su poznati faktori rizika za nastanak ovog poremećaja, a ukoliko progredira u kliničku dijagnozu posttraumatskog stresnog poremećaja retko se dijagnostikuje i još ređe leči. Sagledavanje porođaja kao traumatskog iskustva može imati brojne posledice u vidu izbegavanja narednih trudnoća, seksualnih odnosa ili pregleda ginekologa, izbegavanja obaveza oko novorođenčeta, dojenja, dolazi do otežanog povezivanja majke i bebe, a i partnerski odnos može postati disfunkcionalan. S obzirom na navedeno, izuzetno je veliki značaj u povećanju stručne i opšte svesti o ovom mentalnom poremećaju, upoznavanje sa faktorima rizika za njegov nastanak i mogućnostima za njegovo dijagnostikovanje i tretman.

Ključne reči: traumatski porođaj, postpartalni posttraumatski stresni poremećaj

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