Perspectives on barriers and facilitators to mental health support after a traumatic birth among a sample of primarily White and privately insured patients

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Objectives: To elicit the perspectives of individuals with a traumatic birth experience on barriers and facilitators to receiving mental health support in the postpartum period.

Methods: Individuals who experienced a traumatic birth within the last three years (n = 32) completed semi-structured phone interviews about their birth and postpartum experience. The Post-traumatic Stress Disorder Checklist for DSM-V (PCL-5), Patient Health Questionnaire (PHQ-8), and Generalized Anxiety Disorder scale (GAD-7) were administered. Qualitative data was analyzed using a modified grounded theory by three independent coders.

Results: Among participants, 34.4% screened positive for PTSD, 18.8% for depression, and 34.4% for anxiety. Participants described multi-level barriers that prevented clinicians from recognizing and supporting patients' postpartum mental health needs; those involved lack of communication, education, and resources. Recommendations from participants included that 1) obstetric professionals should acknowledge birth-related trauma experienced by any individual, 2) providers of multiple disciplines need to be integrated into postpartum care, and 3) mental health support may be needed before the ambulatory postpartum visit.

Conclusions: There are multi-level barriers towards detecting and responding to individuals' mental health needs after a traumatic birth. Obstetric professionals need to use a trauma-informed approach and proactively assess mental health throughout the postpartum period.

1. Introduction

Birth trauma has traditionally been associated with medical interventions, medical emergencies, or severe maternal events for the birthing individual or baby [1–4]. More recently, it has been recognized that trauma may not always be apparent to the clinician [5]. Between 34 and 45% of perinatal individuals experience childbirth as traumatic, regardless of need for medical intervention [6,7]. Individuals who have experienced a traumatic birth are at increased risk for developing mental health conditions such as postpartum depression, anxiety, and post-traumatic stress disorder (PTSD) [8–10].

To mitigate these effects, early detection of traumatic experiences and mental health conditions is needed. However, mental health conditions are historically under-detected and under-treated due to inadequate screening protocols, lack of mental health training for obstetric professionals, and insufficient community resources [11–15]. The postpartum visit is an opportunity for a mental health assessment, but obstetric professionals do not see more than a third of patients at the follow-up visit, likely due to numerous factors related to health inequities such as lack of transportation or difficulty communicating with

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providers [16–18]. These circumstances present challenges for providing mental health support for individuals who may have additionally experienced a traumatic birth.

The American College of Obstetricians and Gynecologists’ (ACOG) postpartum toolkit currently does not provide guidance specific to traumatic births or its potential downstream effects like PTSD [16,19]. There is also a paucity of evidence on the appropriate postpartum mental health support that should be provided to persons who perceive that they have had a traumatic birth. It is therefore necessary to hear from individuals who have experienced a traumatic birth regarding what they need to better support their mental health in the obstetric setting.

The objective of this study was to elicit the perspectives of individuals who self-identify as having experienced a traumatic birth to elucidate (1) what support they did or did not receive in the obstetric setting and (2) what mental health support they would have wanted to receive. These findings can then inform interventions in obstetric settings to support individuals who have experienced a traumatic birth.

2. Methods

2.1. Study participants and settings

We recruited individuals who had an obstetric delivery that they perceived to be “difficult or traumatic” within three years prior to study enrollment and that affected their emotional health. This was done through purposive sampling with a snowball approach. Participants were recruited through social media and national perinatal mental health-specific support networks such as Postpartum Support International. Four rounds of recruitment were conducted between August 2018 and November 2020 inviting participation in a semi-structured phone interview. Individuals with interest in participating answered a study inclusion criteria questionnaire in REDCap, an encrypted and secure online survey platform [20]. Those who met inclusion criteria viewed the study fact sheet and gave informed consent by submitting their contact information. The lead investigator then contacted the interested participants by phone. After three attempts, those who did not respond were no longer actively recruited. This study was approved by the Institutional Review Board of the University of Massachusetts Medical School.

2.2. Semi-structured telephone interview

In-depth, hour-long semi-structured phone interviews were completed between August 2018 and December 2020 by the lead investigator. All participants reconfirmed their eligibility and gave verbal consent prior to the start of the interview. They answered seven demographic questions and six questions about their obstetric history. Participants responded to probes (Supplemental Table 1) regarding (1) the traumatic birth experience, (2) barriers and facilitators to mitigating its impact, (3) interactions with the clinical team, and (4) mental health support received after the traumatic experience. Those who gave birth within a year of the emergence of COVID-19 in the United States (March 2020) were also asked how the pandemic may have affected their experience. The interviews were audio-recorded for analysis. Participants were compensated with $20 gift cards after completion of the interview. Participants were also screened for PTSD, depression, and anxiety during the interview. PTSD was screened with the Post-traumatic Stress Disorder Checklist (PCL-5) [21]. Symptom severity in the last month were rated on a scale from 0 to 4, with 0 being “not at all” and 4 being “extremely.” Individuals are considered to have a provisional diagnosis of PTSD if they score at least a 2 (“moderately”) on at least: one item corresponding with intrusive symptoms (questions 1–5), one item corresponding with avoidance (questions 6–7), two items corresponding with negative alterations in cognition and mood (questions 8–14), and two items corresponding with alterations in arousal and reactivity (questions 15–20) [21].

The eight-item Patient Health Questionnaire depression scale (PHQ-8) was used to screen for depression [22]. It has high concordance with the nine-item Patient Health Questionnaire depression scale (PHQ-9) [23]. The PHQ-8 does not include the ninth item in the PHQ-9, which asks about suicidal ideation. The PHQ-8 is commonly used to assess for depression in settings where it is not feasible to offer the immediate assessment that is indicated when suicidal ideation is endorsed [24]. Symptoms from the previous two weeks were rated on a scale from 0 to 3, with 0 being “not at all” and 3 being “nearly every day.” We used a cutoff score of 10 as screening positive for current depression symptoms [22].

The Generalized Anxiety Disorder scale (GAD-7) was used to screen for symptoms of generalized anxiety disorder. Symptoms from the previous two weeks were rated on a scale from 0 to 3, with 0 being “not at all” and 3 being “nearly every day.” We used a cutoff score of 10 as screening positive for moderate anxiety symptoms [25]. These measures are commonly used in prior studies with postpartum individuals [26–28].

2.3. Data analysis

Quantitative data was collected at the start of the phone interview. Descriptive analyses, including frequencies and score calculations of the PCL-5, PHQ-8, and GAD-7, were conducted. Analysis of categorical variables was conducted using chi-square. A p-value of <0.05 was considered significant.

Qualitative data was organized theoretically, using a modified grounded theory approach known as “Coding consensus, Co-occurrence, and Comparison.” [29,30] The first author independently created an initial coding schema through open coding after conducting the interviews and reviewing all the transcripts. The coding schema was created using themes that emerged from the interviews and was partially structured within an a priori framework based upon study aims and extant literature [31,32]. The first three authors then independently reviewed five interviews using the initial coding schema, adding codes as necessary. These interviews and discrepancies were discussed. Additional codes were added to create a semi-final codebook, with operational definitions for each code. The semi-final codebook was then used to independently code all the interviews. Reflexivity was conducted throughout with shared comments on transcripts and discussion between all authors. Areas of discordance were further discussed and resolved among the team with adjustments to the codebook as needed. The final codebook was then used to code all interviews and entered into Dedoose version 8.2.14 (Los Angeles, California) for analysis. The coders consisted of a MD/MSCI student, a MD/PhD student, and a PhD student, all with formal training in qualitative analysis. Coders spent cumulatively 20–25 h per week over eight weeks on the coding.

3. Results

Of 198 individuals who clicked on the recruitment link, 85 individuals met inclusion criteria and submitted their contact information. Thirty-four individuals responded to the investigator's follow-up phone calls to set up an interview for the study, and 32 completed the interview. One participant was located in Canada, and the others were located throughout the United States. Participants lived in 14 different states at time of interview and covered all 8 major geographical regions of the United States. Most participants were White, married, and had at least a bachelor's degree and private health insurance (Table 1). Only three patients gave birth within a year of the emergence of COVID-19 in the United States. No new COVID-19-specific themes emerged from their interviews.
Table 1
Participant characteristics (n = 32). Results listed as n (%) unless otherwise noted.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean, SD)</td>
<td>33.3</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Non-Hispanic White race1</td>
<td>26</td>
<td>(81.3)</td>
</tr>
<tr>
<td>Hispanic or Latino/a/x ethnicity</td>
<td>1</td>
<td>(3.1)</td>
</tr>
<tr>
<td>Relationship status - Married</td>
<td>29</td>
<td>(90.6)</td>
</tr>
<tr>
<td>Highest level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters or doctoral degree</td>
<td>14</td>
<td>(43.8)</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>11</td>
<td>(34.4)</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>(21.9)</td>
</tr>
<tr>
<td>Household income more than $60,000</td>
<td>28</td>
<td>(87.5)</td>
</tr>
<tr>
<td>Private health insurance</td>
<td>29</td>
<td>(90.6)</td>
</tr>
<tr>
<td>Time of birth from time of interview &lt; 1 year</td>
<td>14</td>
<td>(43.8)</td>
</tr>
<tr>
<td>Gravity (mean, SD)</td>
<td>2.4</td>
<td>(1.7)</td>
</tr>
<tr>
<td>Parity (mean, SD)</td>
<td>1.7</td>
<td>(0.9)</td>
</tr>
<tr>
<td>Method of delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency cesarean delivery</td>
<td>16</td>
<td>(50.0)</td>
</tr>
<tr>
<td>Planned cesarean delivery</td>
<td>4</td>
<td>(12.5)</td>
</tr>
<tr>
<td>Unassisted vaginal</td>
<td>8</td>
<td>(25.0)</td>
</tr>
<tr>
<td>Operative vaginal</td>
<td>2</td>
<td>(6.0)</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>(6.0)</td>
</tr>
<tr>
<td>Mental health diagnoses since delivery as per participant report2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum depression</td>
<td>9</td>
<td>(28.1)</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>4</td>
<td>(12.5)</td>
</tr>
<tr>
<td>Postpartum anxiety</td>
<td>6</td>
<td>(18.8)</td>
</tr>
</tbody>
</table>

1 Other respondents include Black or African-American (n = 3), White Hispanic (n = 1), Other (n = 2).
2 Other levels of education include some college or technical/trade school (n = 2), Associate degree (n = 2).
3 Other methods of delivery include Vaginal Birth After Cesarean (VBAC) (n = 1), Dilation and Evacuation (D&E) (n = 1).
4 Self-reported diagnoses in time period between birth experience and enrollment in study.

3.1. Screening results

Screening results from the phone interview are reported in Table 2. More than a third of participants screened positive for PTSD on the PCL-5 and for anxiety on the GAD-7. Although the screening tools inquire about symptoms within the prior 2–4 weeks, there was no significant difference between positive screens for participants who were interviewed within one year of their delivery compared to those interviewed more than a year after their delivery (data not shown).

3.2. Qualitative themes

Below, we present patient perceptions of patient-, provider- and systems-level barriers and facilitators to mental health support after a traumatic birth. These themes and additional illustrative quotes are provided in Table 3.

3.2.1. Patient-level barriers

A variety of psychosocial factors prevented patients from communicating their mental health needs to obstetric professionals after a traumatic birth. Many participants reported that they did not feel comfortable discussing mental health symptoms because of personal stigma towards needing mental health care (Table 3, Ref 3.1).

“I didn’t feel like I would have been accepted, just by saying ‘Yeah I’m completely anxious and out of my frickin mind right now but I don’t want to go on a pill and I don’t want to see a counselor, I just want some support from you.’ But I, I feel like it would, it would have, gone that way like ‘Oh anxious, go to a mental health’ and I don’t even know. I never even tried to say it” (Participant 48).

Some participants wanted to discuss their emotions around the traumatic delivery with obstetric professionals but were afraid that obstetric professionals would automatically see any mental health discussion as something that needed to be treated. Other participants needed time to adjust to unexpected outcomes or events and did not feel they had the mental capacity to discuss their own mental health or listen to education about mental health resources right after delivery.

After patients went home, PTSD symptoms from the traumatic birth experience were also a barrier to patient-provider communication (Table 3, Ref 3.2). Some participants felt that either a particular obstetric professional or the hospital itself was an emotional trigger for them, and they tried to avoid going back.

“I actually never ended up going back to my OB...I still like just feel too stressed out to go back there. Like, it just brings back too many memories, so I actually haven’t had any kind of OB visit since my delivery” (Participant 55).

Some participants with PTSD symptoms never returned to see their obstetrician again, while others only returned after the postpartum period.

3.2.2. Provider-level barriers

Most participants wanted someone on the clinical team to check on their mental and emotional health after their traumatic birth, but the majority of participants felt that they did not receive adequate support while they recovered in the hospital after their delivery (Table 3, Ref 3.3). Some said that they were screened for mental health conditions but received no follow-up discussion afterwards, which they did not consider to be adequate support. Others said that obstetric professionals neglected to ask about mental health at all. Several participants noted that their birth complications, their baby’s outcomes and/or how they presented after the birth should have made it clear that they needed mental health support from obstetric professionals.

The lack of recognition of need for mental health support was not limited to obstetric professionals. Almost all participants interacted with pediatric professionals before the postpartum visit, but several participants stated they felt like they were only screened out of protocol. There was no follow-up discussion about the results of the screening test or about mental health (Table 3, Ref 3.4). One participant said she screened positive, but the pediatrician only told her to watch out for certain symptoms and provided no assessment or follow-up. Participants expressed disappointment that the focus seemed to solely be on the baby without support for the mother.

Table 2
Mental health screening results.

<table>
<thead>
<tr>
<th>Timing of traumatic delivery before study interview</th>
<th>PTSD</th>
<th>Depression</th>
<th>Generalized Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCL-5 score (Median, IQR)</td>
<td>PCL-5 positive screening score (%)</td>
<td>PHQ-8 score (Median, IQR)</td>
</tr>
<tr>
<td>&lt;1 year before (n = 14)</td>
<td>26 (10–30.8)</td>
<td>35.7</td>
<td>7.0 (3.0–8.8)</td>
</tr>
<tr>
<td>≥1 year before (n = 18)</td>
<td>18 (8.3–22.8)</td>
<td>33.3</td>
<td>4.0 (2.0–9.0)</td>
</tr>
<tr>
<td>Total n = 32</td>
<td>22 (9.0–33.3)</td>
<td>34.4</td>
<td>4.5 (2.0–9.0)</td>
</tr>
</tbody>
</table>

a Probable diagnosis of PTSD was met by answering a severity of “2” or greater to questions in 4 different symptom categories.

b A score of 10 was used as the threshold score for major depressive disorder.

c A score of 10 was used as the threshold score for moderate anxiety.
Table 3
Barriers and facilitators to comprehensive mental health support for patients after a traumatic birth.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Level</th>
<th>Identified barriers/facilitators</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Patient Barrier</td>
<td>Participants did not feel comfortable discussing mental health symptoms due to stigma against needing mental health treatment</td>
<td>“I didn’t want someone to think that I was like, you know, suicidal or, you know, because I wasn’t- any of those things. So I didn’t want a psych consult because I didn’t think I was in psychosis, but I still had something that happened to me that was kind of rough” (Participant 46).</td>
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<tr>
<td>3.2</td>
<td>Participants may avoid returning to the hospital due to PTSD symptoms from the traumatic experience</td>
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<tr>
<td>3.3</td>
<td>Provider Barrier Obstetric professionals did not recognize the need for mental health evaluation and did not provide adequate support despite risk from traumatic birth experience</td>
<td>“I think I saw my doctor like maybe once after I delivered. And he just kind of like came in, and like, checked on the scar and that was it and he left” (Participant 44).</td>
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<tr>
<td>3.4</td>
<td>Pediatric professionals screened some parents, but did not provide subsequent follow-up, as focus was primarily on child rather than mother</td>
<td>“‘My pediatrician’s office did a follow-up screening and I kind of screened positive there and they said, ‘Oh, you screened positive. Like, watch out for this.’ There was not really any follow-through ever…” (Participant 44).</td>
<td></td>
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<tr>
<td>3.5</td>
<td>Systems Barrier Long intervals between discharge from hospital and postpartum appointment without support from healthcare professionals allow symptoms to develop or worsen</td>
<td>“I wish that I had a follow-up appointment sooner than six weeks because I wish I would have been able to start my medication sooner than that. Because I didn’t- I ended up not starting the medication until about eight weeks postpartum… And I just feel like it was a lot of wasted time that I could have been feeling a lot better” (Participant 14).</td>
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<tr>
<td>3.6</td>
<td>Lack of follow through from hospital staff for patients that experienced a traumatic birth results in patient distrust</td>
<td>“They said they were going to follow up with me, make sure everything was okay and I just sort of felt like I was- that they didn’t care, in a sense, or that I wasn’t important or my feelings weren’t valid because they just kind of dropped the ball on everything both times” (Participant 45).</td>
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</tr>
<tr>
<td>3.7</td>
<td>Patient Facilitator Participants felt more empowered to speak about emotions if obstetric professionals acknowledged their trauma</td>
<td>“‘Like I said, that doctor I felt more supported during that conversation and she was the one that had done the actual surgery and she was the one that said that, you know what I went through was traumatic and that it’s possible I went through some post-traumatic stress. I felt like more supported in that conversation than I had, while I was in the hospital” (Participant 49).</td>
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<tr>
<td>3.8</td>
<td>Some participants felt more comfortable talking to non-physicians about mental health because they were not as afraid of being forced into treatment</td>
<td>“And I know that [the chaplain] was probably like flagged down the ball… but nobody like specifically said like, ‘We’re calling the chaplain for you because you don’t have control of your emotions,’ but I didn’t at all. So they were they were good about doing what needed to be done but not calling attention to it” (Participant 5).</td>
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<tr>
<td>3.9</td>
<td>Provider Facilitator Participants wanted obstetric professionals to recognize that anyone could perceive their birth to be traumatic</td>
<td>“I mentioned it to my OB at my six-week and I told her that it was really… and she just kind of brushed it off like, yeah. Because I delivered vaginally… I would have liked her to maybe say that, you know, they should have listened to you.” (Participant 138).</td>
<td></td>
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<tr>
<td>3.10</td>
<td>If educated, pediatric professionals can be an important ally because the perinatal individual sees them many times before they see the OB</td>
<td>“I think with my son’s, like with the pediatricians, just saying like it’s okay to feel, you know, you don’t have to act tough. You know, it’s understandable to be exhausted. They knew everything that had gone on. … I think them just saying like, you do want to talk about it or do you want us to call your doctor and set something up? Like just an offer to help instead of just ignoring it completely” (Participant 132).</td>
<td></td>
</tr>
<tr>
<td>3.11</td>
<td>Systems Facilitator Proactive mental health professional could be embedded in labor and delivery to automatically see patients after birth</td>
<td>“[The doctors told me there was risk factors. There was nothing that I had done to cause this, but you still like a doctor is not gonna sit there and continually reexplain why it’s not your fault, but like a, like a therapist would, you know” ( Participant 46).</td>
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increasing their comfort with discussing mental health symptoms. Par
3.2.4. Patient-level facilitators
health described by many of our participants.

Several participants expressed difficulty with the interval between hospital discharge and the postpartum visit (Table 3, Ref 3.5). They felt that this was a time when postpartum mental health symptoms developed or escalated, and they did not always have the opportunity to interact with a healthcare professional. One participant’s baby died during this period and she still had no communication with her obstetrician.

“I think checking in on my mental health more often, because even when [my baby] came home, nobody was really checking in on me and I feel like I’m like, pretty prime target for postpartum depression. Even after [my baby] died, I called my OB’s office to tell them what happened, and nobody checked in on me” (Participant 17).

This made the participant upset, and she did not go to her scheduled postpartum visit which meant that no one assessed her mental health state. Some participants with traumatic births were told by hospital staff that they would call them after they were discharged from the hospital. However, several participants reported that they waited for a phone call but received no follow-up communication at all (Table 3, Ref 3.6). This also left them feeling like their obstetric team did not care about them, or that their “feelings weren’t valid”. The loss of trust in the health care system exacerbated the preexisting discomfort about discussing mental health described by many of our participants.

3.2.4. Patient-level facilitators

The facilitators described by our participants primarily centered on increasing their comfort with discussing mental health symptoms. Participants felt more empowered to speak when they felt that their obstetric professionals cared about them and acknowledged their concerns (Table 3, Ref 3.7).

“[My OB] spent a lot of time with me. She came in on her days off. She just...she came in and she just hold my hand and seeing her emotional was helpful. That made me know that it was okay to be emotional about it” (Participant 132).

Participants said that they wanted to be strong and worried that they were weak for being so affected by their delivery experience. Obstetric professionals helped patients feel that it was okay to be vulnerable by acknowledging that they had a traumatic experience.

Some participants felt more comfortable talking to non-physicians about their experiences and emotions because they were not as afraid of being pushed into mental health treatment (Table 3, Ref 3.8). For example, one participant’s care team asked a chaplain to talk to her when they saw she was getting extremely anxious about unexpectedly needing a cesarean delivery. She appreciated they acknowledged her need for emotional support “but not calling attention to it”. Other participants felt that nurses, therapists, or social workers would be helpful for initiating the conversation.

3.2.5. Provider-level facilitators

Participants wanted obstetric professionals to understand and recognize that anyone could perceive their birth to be traumatic (Table 3, Ref 3.9). Participants felt like their concerns were brushed off if the birth was not obviously traumatic.

“I left kind of feeling like [my OB] minimized [my feelings about my birth]. You know, and I think people need to say, ‘What was that like for you?’” (Participant 118).

Therefore, participants suggested that obstetric professionals proactively ask all patients how they perceived their birth to understand who may be struggling and respond with appropriate supports.

To address the need for mental health support from providers before the postpartum visit, several participants said they wished pediatric professionals could have the opportunity to inquire about the birthing person’s mental health (Table 3, Ref 3.10). Most participants saw pediatric professionals several times before they saw an obstetric professional in the postpartum period, and they thought it could be an opportunity to ask about mental health and receive timelier referral for assessment or treatment if needed.

3.2.6. Systems-level facilitators

Overall, participants emphasized the need to invest in resources to properly integrate mental health care into labor and delivery. Several participants recommended embedding a mental health professional, such as a psychiatrist or therapist, into postpartum care to automatically see all patients with delivery complications in the hospital after delivery (Table 3, Ref 3.11).

“Instead of doing a screening tool with a nurse, let’s do it with a therapist, and they can, you know, be there. Because I’m not like I’m not a person to seek it out but if help is right there in my face, I will accept it” (Participant 46).

Many participants stated that, while they would not have proactively asked to see a mental health professional in the hospital, they would have welcomed the opportunity if it has been offered. This would take the responsibility of recognizing who may need professional mental health support off of obstetric professionals and removes the burden of asking for additional support off of patients.

Participants also recommended that the care team establish a support system for postpartum mental health support before the first postpartum visit (Table 3, Ref 3.12). This could mean educating the birthing partner, family member, or anyone in the household about signs and symptoms of postpartum mental health conditions before the patient is discharged. Participants felt this would be particularly important because patients might not “really know how they’re going to feel about it” or may be “in complete denial”. They also recommended including comprehensive mental health resources in their discharge paperwork so that patients are aware of what mental health symptoms are and what supports are available. Because most participants did not return to the hospital for the postpartum visit for at least several weeks, they additionally recommended having a dedicated staff member check in on patients during this interval and offer mental health screening or mental health resources if needed.

4. Discussion

Recognizing that a traumatic birth depends on the patients’ perception, we use the term traumatic because all the study participants described their experience as such. The experience of a traumatic birth was different for each participant. The factors that made the delivery feel traumatic ranged from fetal complication or demise, poor
communication from staff, to having an unexpected delivery method such as an emergency cesarean delivery. Further details on the factors leading to perception of a traumatic birth and recommendations for mitigating these factors will be forthcoming in a subsequent paper.

Our findings, elicited from a sample of patients that are primarily White and privately insured, suggest that individuals perceive they have had a traumatic birth want obstetric professionals to ask about their birth experience, acknowledge their trauma, and offer support throughout the postpartum period. Patients need timely follow-up and a mental health assessment after a traumatic delivery so that mental health symptoms are addressed and diagnoses are not missed.

Our qualitative themes identified multi-level barriers towards recognizing and supporting individuals who had a traumatic birth. As anyone can potentially experience their delivery to be traumatic, every perinatal individual should be treated with a trauma-informed approach. Trauma-informed care is an approach where the possibility of trauma is recognized, and efforts are made to provide compassionate care without retraumatizing the patient [33]. In an obstetric setting that utilizes a trauma-informed approach, the clinician-patient relationship is vital for decreasing the influence of trauma by focusing on respect, validation, and empowerment [34]. Obstetric professionals may have limited training in trauma-informed care, but it is an increasingly recognized approach recently recommended by ACOG [35]. This includes educating patients about perinatal mental health in the prenatal period to empower patients to understand their symptoms. Participants suggested that obstetric professionals ask all patients how they perceived their birth, provide support, and administer earlier screening for mental health conditions if needed. It is imperative that screening be accompanied by a systematic approach that ensures that any positive screen is responded to appropriately [15]. If the patient shares that they experienced trauma from the delivery, the obstetric professional should acknowledge those feelings, regardless of the circumstances of the birth. This approach could potentially address several of the patient- and provider-level barriers towards communication that we identified. Additional team members in the practice such as perinatal nurses, midwives, or social workers can further support these recommendations.

While all participants wanted more comprehensive and timely support for their mental health, they experienced traumatic deliveries in different ways and consequently had different mental health needs. Some participants wanted to talk about their mental health with their obstetrician, while others felt more comfortable talking to non-obstetric professionals. Many participants wanted to be educated on mental health resources before they were discharged from the hospital, while others did not recognize their need for mental health support until they were already home. Ultimately, this speaks to the importance of providing patient-centered care and using a multi-pronged approach to accommodate patient needs.

Our proposed patient-centered conceptual framework (Fig. 1) outlines the many avenues by which a patient can be connected to support and followed up with for more mental health screening and assessment if needed. While in the hospital, all members of the care team, including nurses, therapists, social workers, and other professionals, can be trained to check in with the patient and address these needs. These efforts may still not be enough, because many participants did not realize that their symptoms persisted until they were already home. The potentially hectic environment during and after traumatic births and patient avoidance of returning for postpartum care are unique factors that must be considered with birth trauma. Thus, efforts should be made to develop a support system for the patient in the event they need additional support between their discharge from the hospital and their scheduled postpartum visit.

The support system can be strengthened by educating the partner and/or family members on signs of postpartum mental health symptoms and having a social worker or obstetric care professional call to check on the patient at designated intervals before the postpartum visit. This aligns with ACOG’s postpartum guidelines, which recommend obstetricians check in with the patient within 3 weeks of the delivery [16]. Pediatric professionals should be included in the postpartum support system because the postpartum individual may see them multiple times during this high-risk period before they see an obstetric professional. This also aligns with recent recommendations from the American Academy of Pediatrics to integrate postpartum depression surveillance and screening at monthly intervals [36]. Efforts should be made to increase communication and collaboration between pediatric and obstetric practices in response to a positive screen. It is particularly important for obstetric professionals to check in with individuals with a fetal demise during this period as they may be disconnected from both obstetric and pediatric settings due to the loss. Obstetric professionals can additionally consider using telehealth for postpartum visits to overcome barriers related to healthcare inequalities or triggering stimuli from the traumatic experience [37]. This multi-pronged system can provide support for all patients after delivery, nurture the patient-provider relationship, empower patients to discuss their mental health, and identify those who may need additional assessment and treatment for mental health conditions.

In our study, the numbers of individuals who screened positive for PTSD and anxiety at the time of the interview were higher than in the general population [38,39]. As our study instruments assessed symptoms that were at times years after the traumatic event, this suggests that traumatic births can have lasting mental health consequences. This further emphasizes the importance of providing comprehensive mental health assessment and support after a traumatic birth.

The study strengths include a large and geographically diverse sample for a qualitative study with an in-depth focus on patient experiences with postpartum mental health care after traumatic births and recommendations that can inform health care system interventions. A major limitation is that our sample was primarily White individuals with private health insurance, likely due to our virtual recruitment strategies which included social media and support networks. Birth trauma is likely even greater in individuals who identify as BIPOC (Black, Indigenous, and People of Color) due to known racial/ethnic disparities in pregnancy-related morbidity and mortality [40,41]. There is little existing research on psychological trauma experienced by BIPOC individuals in relation to birth. While the major themes were expressed by both White and BIPOC individuals enrolled in our study, it is likely that the small number of participants that were BIPOC, less educated, and insured by Medicaid did not uncover the myriad of ways in which these traumatic births differ for these other populations. It is imperative that future work on birth trauma should specifically focus on elucidating the experiences of those individuals. People of color are underrepresented in mental health research and experiencing birth trauma from systemic racism could enhance distrust of research and the healthcare system [42]. Investigators could consider using a multi-pronged recruitment...
approach that includes in-person recruitment with community champions and outside of the healthcare setting to truly hear from a more racially, ethnically, and socioeconomically diverse sample. In addition, of the individuals who met inclusion criteria, only a third enrolled in the study and completed the interview. Thus, we may have heard from a disproportionate number of participants who were educated on their trauma and were willing to speak about their experience. We may not have uncovered themes and recommendations from individuals who are not connected to mental health support resources or are reticent to discuss their experience.

In summary, obstetric professionals must recognize that any individual can perceive their delivery experience to be traumatic. All patients deserve to have traumatic delivery experiences be acknowledged, validated, and addressed. Utilizing a trauma-informed approach throughout the postpartum period can increase opportunity to recognize childbirth trauma and understand who may need additional mental health assessment and support. Postpartum mental health support should be an ongoing process and systems-wide goal of care for all patients.

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Author Statement

Ms. Xu is the lead author of this paper and led all aspects of the study, including conceptualization and design of the project, communication with participants, interview conduction, data analysis, and manuscript preparation. Dr. Byatt was involved in the conceptualization of the design of the project, recruitment, and revision of the manuscript. Ms. Boama-Nyarko and Ms. Masters were involved in the qualitative coding, overall analysis, and revision of the manuscript. Dr. Moore Simas was involved in the conceptualization of the design of the project, participant recruitment, and revision of the manuscript. Dr. Ulbricht was involved in revision of the manuscript. All authors have approved the final manuscript.

Data availability

Data will be made available on request.

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