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Psychiatric symptoms following attempted natural childbirth

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As natural childbirth has become more popular, new prenatal training groups have developed, some of which are committed to only one method of dealing with labour and delivery. This paper describes five women and four men who sought psychiatric treatment within 6 months of attempted natural childbirth that did not proceed as planned. Their symptoms included depression, anxiety, obsessive–compulsive behaviour, phobic symptoms, and marital and sexual problems. Thus, natural childbirth, although undoubtedly beneficial in most instances, is not suitable for all deliveries and may occasionally have adverse effects. Prenatal programs should emphasize an individual, flexible approach to labour and delivery and should present the possibility of the need for analgesia, anesthesia or obstetric intervention in a positive light.

Avec la montée de la popularité de l'accouchement naturel, de nouveaux groupes spécialisés dans les exercices prénatals ont vu le jour; certains ne prônent qu'une méthode de travail et d'accouchement. Cet article décrit le cas de cinq femmes et quatre hommes qui durent recourir à un traitement psychiatrique dans les 6 mois qui suivirent une tentative d'accouchement naturel qui ne se déroula pas comme prévu. Les symptômes incluaient dépression, anxiété, comportement obsessionnel, manifestations phobiques et des problèmes matrimoniaux et sexuels. Bien que l'accouchement naturel soit de toute évidence bénéfique dans la plupart des cas, il apparaît donc qu'il ne peut être appliqué à toutes les naissances et qu'il peut, à l'occasion, causer des effets indésirables. Les programmes de préparation prénatale devraient faire valoir une approche individuelle et flexible au travail et à l'accouchement et présenter sous un jour favorable la possibilité que l'on doive recourir à l'analgésie, à l'anesthésie ou à une intervention d'obstétrique.

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Following the publication of Grantly Dick-Read's "Childbirth Without Fear"[1] in 1944, Lamaze's "Painless Childbirth"[2] in 1958 and Leboyer's "Birth Without Violence"[3] in 1975, pregnant women and their partners have become increasingly interested in "natural childbirth". The term natural childbirth is a popular and highly emotional concept that means different things to different people, but it is increasingly coming to mean that the pregnant woman and her partner assume maximal responsibility during labour and delivery, with medical intervention being kept to an absolute minimum. To some proponents this means unmedicated, unassisted home delivery, and to others it means the absence of analgesics and medical intervention during labour and delivery in a hospital, provided the delivery is "normal". It often includes the presence of the partner and parent–infant contact immediately after delivery. Many women and their partners interested in natural childbirth enrol in prenatal classes, whose orientation often reflects the philosophy of the sponsoring group and may or may not fully meet each couple's needs during labour, delivery and the postpartum period.

As consultant psychiatrist to a university teaching hospital obstetric unit I have recently seen five women and four men who sought psychiatric consultation and treatment within 6 months of attempted natural childbirth that did not proceed as planned. The unplanned and upsetting events included requests for analgesia or anesthesia, forceps delivery and cesarean section for the women, and inability to participate in the labour or delivery for the men. In this paper I will describe these patients, identify factors that may have contributed to the development of their symptoms and recommend changes in some prenatal training programs.

Case summaries

Women

Case 1: A 24-year-old woman was referred by her obstetrician because of depression 7 weeks after the delivery of her first child. She had for several years been a "back-to-the-land" enthusiast and taught yoga. She

had attended yoga prenatal classes that emphasized natural childbirth and had decided on a home delivery. After a 10-hour labour at home she became tired and upset and sought admission to hospital, where she eventually requested an intramuscular injection for pain. She subsequently delivered, with an episiotomy, a healthy baby but felt she had "let the side down" and became tearful, depressed and unable to sleep well after returning home. She was fearful of facing her friends from the prenatal classes because "I'd have to admit I couldn't go through with it and failed, losing my sense of mastery over Nature". She was angry with her husband for not "taking control" and blamed him for the hospital admission and subsequent events. She became sexually disinterested and frequently quarrelled with her husband. Conjoint marital therapy for 6 months led to improvement in her mood and in the general marital functioning.

Case 2: A 37-year-old woman was referred by her obstetrician 2 weeks after the delivery of her second child. She was tearful, suicidal and preoccupied by a sense of failure following a planned natural delivery that "went wrong". She had attended prenatal classes that were enthusiastic about psychoprophylaxis. Her early labour went smoothly, with her discomfort well controlled by relaxation and breathing techniques. As her contractions became stronger she became anxious and "couldn't breathe right", despite her husband's coaching. She eventually requested epidural anesthesia and delivered a healthy infant. Since then she had been preoccupied with "not doing it right", "being a failure as a woman" and feeling she couldn't hold her head up with the other women in the follow-up class. She also felt unable to breast-feed the baby, although she had done so with her first, "because it would be hypocritical". She showed signs of classic postpartum depression, which responded well to antidepressants and psychotherapy. The only residual problem 1 year later was a feeling of failure about the delivery.

Case 3: A 24-year-old woman was referred by her family doctor because of depression 8 weeks after the birth of her first child by cesarean section following abruptio placentae. She had always been distrustful of medical personnel and hospitals and had chosen a prenatal group that had some similar attitudes. She saw cesarean section as "a last resort that was dangerous to the mother and the baby". She reported that an information booklet she had received at a prenatal class warned "not to let doctors and nurses force you into an unnecessary cesarean — you can do it naturally". She was preoccupied with the operation, felt angry and guilty about it and could not accept that it had probably been life-saving for both herself and the baby. She was sleepless, tearful, losing weight and contemplating a lawsuit when first seen in psychiatric consultation. Her postpartum depression responded over a 5-month period to antidepressants and psychotherapy.

Case 4: A 32-year-old primigravida was referred by her obstetrician at 42 weeks' gestation because of anxiety and refusal to undergo nonstress testing, fetal monitoring or evaluation in hospital of the fetal condition "in case it leads to interference (such as induction) in the natural events". She was enthusiastic about natural childbirth and had attended prenatal classes with her husband. At 44 weeks she spontaneously delivered a postmature infant with severely depressed respiration who spent 3 weeks in a neonatal intensive care unit and had neurologic sequelae. She felt guilty, became tearful and angry at "the unfairness of it all" and had trouble sleeping. Psychotherapy had good results after 12 weeks.

Case 5: A 26-year-old woman was referred by her family doctor 3 months after the delivery of her first child. She had generalized anxiety, guilt about requesting epidural anesthesia and obsessional ruminations that her baby might be brain-damaged. She had attended prenatal classes and wanted the delivery "to be a family affair". She was initially upset at the prenatal hospital tour, where she reported being given a choice about many things, including delivery in stirrups or in bed, in the case room or a birthing room, and drops in the baby's eyes at the time of delivery or 2 hours later, but no choice about something she felt very strongly about — the use of her own surname rather than her husband's. She had always had a low pain threshold yet hoped to have a natural delivery and was surprised and upset when she found labour painful. She eventually asked for epidural anesthesia and was upset when outlet forceps were employed for the delivery. Despite reassurance from her husband, obstetrician, pediatrician and nurses she became preoccupied that the baby might be brain-damaged from use of the forceps. She felt guilty about the epidural anesthesia and inferior that she couldn't stand the pain. After 4 months of psychotherapy she felt better about the delivery and confident that her baby was normal.

Men

Case 1: A 36-year-old man was referred by his family doctor 6 months after the delivery of his first child. He complained of persistent anxiety, phobic symptoms in closed spaces and impotence. Although he had suffered from mild anxiety in stressful situations in the past, he had never required treatment for this. The current symptoms began in the delivery room, which he had felt compelled to enter because of the attitude of his wife and their prenatal group; all the films they had seen had shown the husband in the delivery room, and it was assumed in discussions that the husband would be there. Although he was aware of his fear and ambivalence about being in the delivery room he did not discuss his feelings with anyone, and when the nurse in the labour room handed him delivery room clothes and said "Get changed" he passively complied. In the delivery room he felt nauseated and faint at the sight of blood and his wife in pain, and he began to experience acute panic, which prevented him from coaching his wife as they had planned. At the time of psychiatric consultation he had begun to avoid going to work and was fairly incapacitated by anxiety. A year of psychotherapy and behavioural therapy had good results.

Case 2: A 28-year-old television cameraman was referred by his family doctor 2 weeks after delivery of his first child. He had attended natural childbirth classes with his wife and was excited about the delivery to the point where he planned to make a home movie of

the event. In the delivery room he became acutely anxious and unable to think and concentrate on the film-making despite its being routine to him. He wanted to run out but felt constrained to stay by the expectations of his wife, the staff and his prenatal training. He was especially upset by his wife's panting and by the blood, and he feared that his wife and the baby would die. Following the delivery of a healthy son he felt better, but on returning to work he began compulsively checking equipment "so I wouldn't screw up again like I did in the delivery room". He was treated with psychotherapy. The symptoms persisted for 4 weeks, causing some work problems, but diminished in intensity and were gone by 12 weeks.

Case 3: A 38-year-old man was referred by his family doctor because of depression and marital problems, which he dated to the delivery of his second child, 6 weeks earlier. He had attended prenatal classes with his wife and was enthusiastic about attending the delivery. However, once in the delivery room he began to feel faint and upset. He was afraid to admit this, as he worked in the same hospital and was worried that he might "disgrace" himself by fainting or getting emotional. He denied feeling upset when asked by the anesthetist if he was all right. He was unable to talk to his wife or to coach her breathing as they had intended, and she eventually requested epidural anesthesia. Several days later he began to feel he was a failure as a husband and father and experienced the onset of depressive symptoms. He and his wife quarrelled frequently about "whose fault it was that the delivery didn't work out right". They both felt unable to cope with the demands of their newborn and were seen in conjoint marital therapy for 3 months, after which both felt improved.

Case 4: A 32-year-old man was referred by his family doctor 8 weeks after the delivery of his first child. He and his wife had enthusiastically attended natural childbirth classes, and he had planned to attend the delivery. All went well until his wife's labour did not proceed as expected and there was meconium staining of the amniotic fluid and other signs of fetal distress. When the obstetrician advised a cesarean section the husband felt nauseated, and he fainted on his way to the case room. He was helped to the father's waiting room while his wife proceeded to surgery. He felt humiliated and angry and described himself as "a cop-out". He also felt angry with his wife "for subjecting [him] to a section". He was disinterested in the healthy baby, who had been joyfully anticipated by both of them, and he slept badly and had a poor appetite. He was sexually disinterested in his wife and stated that he was thinking of starting an affair to regain his self-image. After a year of psychotherapy he felt less depressed but was still angry with his wife.

Patient characteristics

In general the patients referred to me for psychiatric consultation were older and better educated than the average woman delivering at the same hospital and her partner. They were all of the upper and middle class, had not previously undergone psychiatric treatment and shared the social characteristics described by Cave[4] in her study of couples who attended natural childbirth classes. All the patients except one woman had healthy babies, all were themselves physically well, all were married at the time of delivery, and for most this was their first child. They were highly organized people who functioned well in their personal and work lives and put a high premium on "being in control". All had actively sought out and completed prenatal education classes. They all attributed their symptoms to events during labour or delivery. The symptoms — depression, anxiety, obsessive–compulsive behaviour, phobic symptoms, and marital and sexual problems — responded to psychiatric intervention, as one might expect for symptoms precipitated by acute stress in people previously functioning well.

Prenatal classes

In the Toronto area 70% of prenatal classes either are conducted by public health nurses with obstetric and teaching experience or are hospital-based. None of the patients described had attended these classes; instead they chose classes whose leaders' backgrounds varied but were nonmedical in orientation, with an emphasis on natural childbirth and expected participation of the partner. A survey of the many groups offering prenatal education in our area revealed interesting differences in philosophy and in the stated background of their instructors, who ranged from public health nurses to "childbirth educators", "anyone who has been a mother and has studied our method" and "Yoga teachers who subscribe to our method and spiritual guidance".

Discussion

There is now a vast and rapidly growing literature describing the positive effects when pregnant women maintain control over their pregnancy, labour and delivery, with minimal medical intervention if the delivery and the infant are normal.[5,6] Reports document lower levels of analgesia requested and administered,[6] shorter labour,[7] a lower frequency of obstetric intervention, including forceps delivery, episiotomy and cesarean section,[6] greater responsiveness of the infant at birth,[6] higher Apgar scores,[6] a lower frequency of respiratory depression in the infant,[5] lower infant mortality,[6] improved infant–parent bonding[6,8] and a more positive attitude toward future pregnancy, with women and their partners feeling better about the experience.[6]

Prenatal training for childbirth, including the psychoprophylactic methods of education, distraction and relaxation training proposed by Chertok,[9] Lamaze[2] and others, has been important in these improvements. The women's movement, public awareness of medical practice, and medical consumerism have also had an impact on obstetric care. The role of prenatal groups as motivators for change in current obstetric practice is also important but beyond the scope of this paper.

As with most trends in health care some patients benefit from the changing emphasis and others, such as the patients described, suffer from it. I have no doubt that the majority of couples attending prenatal classes

that emphasize natural childbirth have benefited from them, but health care professionals and others involved in this area should be aware that natural childbirth is not suitable for all couples and may occasionally have adverse effects.

It seems important, especially in prenatal training but also during labour and delivery, to encourage the partner to attend the delivery only if he really wishes to and to present the possibility of the need for analgesia (including epidural) or obstetric intervention, including episiotomy, forceps application and cesarean section, in a positive light. The need for a balanced approach to prenatal training is clearly shown by Melzack and associates' recent study, which found that 83% of women who received childbirth training by the orthodox Lamaze technique requested epidural anesthesia despite their instructor's advice against it.[10] Since depressive feelings are extremely common post partum, perhaps efforts should be directed in the antepartum period toward reducing guilt and enhancing self-esteem by encouraging the woman and her partner to deal with labour and delivery in a way that feels emotionally comfortable to them and is safe for them and the infant. This is probably best accomplished by encouraging an attitude of flexibility during prenatal training rather than commitment to a prescribed method of coping with labour and delivery.

Flexibility may well be the approach of most prenatal instructors and may be the reason none of the patients described had received prenatal training from public health nurses or hospital-based instructors, who provide most of the prenatal training in the Toronto area. Clearly a controlled trial comparing "medical" and "nonmedical" prenatal training would be useful in determining whether psychiatric symptoms are more common with the latter form of training or whether the small group of patients described is in some way atypical of the general population (perhaps more obsessional and needing to be in control). However, it appears that in some prenatal classes and among some groups in society there is a need for more emphasis on the final outcome of labour and delivery — a healthy mother and baby — and less emphasis on the means by which this is accomplished.

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