Do Teenage Mothers Experience Childbirth as Traumatic?

ABSTRACT
Although several hundred thousand teenagers give birth each year in the United States, little is known about their psychological experience of childbirth, especially with respect to its traumatic impact. This article highlights the findings of a pilot study of 28 teenage mothers who reported on their traumatic and depressive symptoms related to childbirth. Literature on adolescent childbearing, posttraumatic stress, and postpartum depression is also reviewed.

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Teenage mothers may be at special risk for posttraumatic stress (PTS) by virtue of the birth experience. Although posttraumatic stress disorder (PTSD) is often thought of in the context of soldiers and combat, traumatic events and PTS may also occur in childhood and adolescence (Copeland, Keeler, Angold, & Costello, 2007). In general, more than two thirds of children report at least one traumatic event by age 16, and approximately 14% of those teenagers exhibit symptoms of PTS (Copeland et al., 2007). The highest rates of PTS are related to violence or sexual trauma; a history of chronic family adversity such as abuse and neglect will predispose children subjected to trauma to PTS (Copeland et al., 2007).

Although there is no doubt PTSD can exist in children, the exact definition of the term has eluded researchers. The original criteria for PTSD were derived from the experiences of adult veterans of the Vietnam War and did not take into account developmental stages of childhood and adolescence (Kaminer, Seedat, & Stein, 2005) or the ordinary event of childbirth. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), broadened the view of PTSD with the subjective appraisal of traumatic events across age groups (American Psychiatric Association, 2000). Although the next version of the DSM will further describe PTSD in youth, it is currently clear that children at risk for PTS require a thorough psychosocial assessment.

The phenomenon of children giving birth to children is all too common: In the United States, 41.9 of 1,000 live births in 2006 involved girls ages 15 to 19, an increase of 3% from 2005 (Dunham, 2007). Pregnancy, labor, and delivery can be emotionally stressful to any woman, but teenagers with little social support and who have backgrounds of harsh caregiving often fare worse in the birthing experience (Reid & Meadows-Oliver, 2007).

Acute stress disorder is defined as occurring within the first month postpartum and may lead to delayed and/or chronic stress symptoms developing years after the initial traumatic event. PTSD and depression may frequently be comorbid in the perinatal period (Creedy, 2000). Symptoms of postpartum depression (PPD) can follow. PPD has been identified at an alarming rate in teenage mothers, especially in those experiencing family conflict, limited social support, and low self-esteem (Reid & Meadows-Oliver, 2007).

**ADOLESCENT MOTHERS’ REACTIONS TO BIRTH**

Birth trauma is described as the adverse psychological events occurring around the labor and delivery process involving actual or threatened serious injury or death to the mother or infant (Beck, 2004). Perceived birth trauma can include complications of labor and delivery due to lack of prenatal care, limited support, preterm or cesarean delivery, and infant abnormalities or illness.

Despite the hundreds of thousands of children born to adolescent mothers each year in the United States, there are scant findings in the literature describing the psychological consequences of pregnancy and birth as experienced by adolescent mothers. Childbirth has the potential to be perceived as traumatic by adult women and thus can lead to a PTS reaction (Soet, Brack, & Dilorio, 2003) and PPD (Creedy, 2000). Unfortunately, a lack of clarity in diagnostic criteria for PTSD in children and adolescents (Tierney, 2000) continues to contribute to the underrecognition of PTSD, especially in the pregnant teenager population.

Of more frequency are the reports of symptoms of PPD among adult and teenage mothers. Landmark research by Beck (1993) among adult mothers discerned that depressive symptoms occur as early as a few days after delivery or as late as 6 to 9 months after childbirth at a rate of approximately 10%. A review of national infant health data revealed that as many as 48% of adolescent mothers experience symptoms of PPD (Deal & Holt, 1998). Other reports found prevalence rates of depressive symptoms among pregnant adolescents between 16% and 44%, twice as high as the prevalence rates among pregnant adults and nonpregnant adolescents (Szegethy & Ruiz, 1999).

**THE PILOT STUDY**

In a study approved by the Institutional Review Board of the participating university, the investigators interviewed 28 teenage mothers ages 15 to 19 by telephone. The purpose of the pilot study was to assess for symptoms of PTS and PPD. Participants in the study were enrolled previously in a nursing educational program in which labor, delivery, and newborn information was provided by senior-level maternal-child health nursing students. All teenagers previously enrolled in the program were contacts for enrollment in the pilot study. Criteria for inclusion in the pilot study were that they were ages 12 to 19, spoke English,
Youth in Mind and had a telephone. Investigators interviewed the participants by telephone in one retrospective review 9 months after their childbirth experiences. This time frame was selected on the basis of peak times of PTSD symptomatology as noted in the literature.

The average participant’s age was slightly older than 16. One teenager was married; 13 were Latina, 8 were African American, and 6 were Caucasian. (One participant did not report her racial background.)

RESULTS

The investigators asked the teenagers to recall and rate their perception of their childbirth experience on a scale from 1 (awful) to 10 (great). Overall, most participants remembered their childbirth experiences at midpoint between awful and great, but 4 participants classified their experiences as awful. On a scale of 0 (none) to 5 (very much), most of them recalled feelings of fear and anxiety to some degree: No participants reported the absence of fear, and only 1 reported the absence of anxiety. Thirteen participants believed they were going to die; 14 feared they were losing control in labor.

A major concern to these teenagers was the management of pain: Nearly one third feared they would have insufficient pain control during labor. Most participants (n = 21) were in labor for more than 9 hours before delivering by vaginal birth (n = 22). No infant complications were noted at birth, and the majority of the mothers (n = 25) reported adequate prenatal care (more than 9 visits). Six pregnancies were reported as planned pregnancies. Fortunately, for the majority of teenagers in this study, care providers were perceived as “supportive” (n = 26) and “kind” (n = 23). Additionally, 14 participants reported the presence of the baby’s father during labor.

The incidence of PTS among the participants varied. The Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979), a questionnaire measuring trauma impact, was used to assess the posttraumatic impact of childbirth. The total score of the IES ranges from 0 (no distress) to 75 (highest distress). In this sample of 28 teenagers, IES scores ranged from 1 to 34 (mean = 13.96, SD = 10.75). Six of the participants had scores between 19 and 25, indicating mild PTS; 2 had scores greater than 26, indicating moderate to severe PTS. Both younger (age 15) and older (ages 18 and 19) teenagers had significantly higher IES scores than did teenagers age 16 and 17.

PPD rates were noted to be higher among these teenagers than were trauma rates. PPD scores were measured by the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987). Scores on the questionnaire range from 0 to 30, with higher scores reflecting higher depression. In this sample, EPDS scores ranged from 0 to 18 (mean = 9, SD = 5.13). Fifty percent (n = 14) of the participants received scores that characterized mild to severe symptoms of depression; 2 of these participants’ scores were in the moderate to severe range.

LIMITATIONS

One limitation of this study was that the incidence of PTS prior to delivery was unknown. Several of the teenage mothers had reported a history of child abuse or had witnessed a traumatic event in their lives. A recommendation for future studies would be to administer the IES and EPDS prior to delivery.

IMPLICATIONS FOR NURSES

Psychiatric nurses often care for adolescent girls with histories of abuse, sexual assault, eating disorders, and drug and alcohol the event of childbirth can be traumatic to teenagers..., inviting negative health outcomes for both mothers and their babies.
abuse. Another layer of complexity is added with the life events of pregnancy and childbirth. Approximately one third of the teenagers in this pilot study reported mild to moderately severe PTS as a result of their childbirth experiences. Additionally, one half of the participants also had symptoms of PPD ranging in severity from moderate to severe.

In addition, we found that younger and older teenagers had higher rates of PTS. Although most would acknowledge that younger teenagers might be especially vulnerable during childbirth, older teenagers in the 18-to-19 age group may also require more attention and support than was previously thought. These older teenagers often seek to maintain a façade of control and will not ask questions, and nurses may credit these teenagers with more knowledge or lack of anxiety and fear than is present.

Therefore, some teenage mothers will be vulnerable to PTS and PPD following childbirth. These vulnerabilities can be minimized through a careful and nonjudgmental assessment of the patient’s history. In addition, an educational program, specifically directed at teenagers, covering the process of labor and delivery, pain management, and postpartum care can help provide a less frightening childbirth experience and potentially a reduction of PTS and PPD symptoms.

Collaboration between psychiatric nurses and maternal-child health nurses can improve care for pregnant teenagers, ensuring more positive outcomes for both mother and baby. Psychiatric nurses with knowledge of pregnant teenagers who have histories of preexisting trauma can improve continuity of care by communicating with the teenagers’ obstetrical care providers (with informed consent of the patient). Maternal-child nurses should evaluate the mental health of pregnant teenagers and refer them to mental health clinicians when necessary.

SUMMARY

The event of childbirth can be traumatic to teenagers, resulting in PTS or PPD, inviting negative health outcomes for both mothers and their babies. Assessing teenagers regarding past traumas and providing positive childbirth experiences via caregiver support, involvement of the father of the baby, a nonjudgmental attitude, education, allowance of decision making by the teenager, and overall concern may help diminish the psychological sequelae of childbirth.

REFERENCES