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## Investigation of the current status of maternal post-traumatic stress disorder

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### ABSTRACT

**Objective** To investigate the situation of post-traumatic stress disorder in contemporary mothers, to gain an in-depth understanding of maternal mental health, to help mothers obtain more relevant supportive resources, and to provide a basis for schools, hospitals and society to understand the situation of maternal traumatic stress disorder.

**Methods** A total of 200 women in the obstetrics department of a tertiary hospital in Guangzhou from September 2024 to November 2024 were selected by convenience sampling method, and the general information questionnaire and traumatic stress disorder scale were used. The PCL-C administers questionnaires to study subjects.

**Results** The positive rate of post-traumatic stress disorder was 13.77%. There were statistically significant differences in the positive rate of maternal post-traumatic stress disorder in terms of age, educational background, number of previous cesarean sections, number of deliveries, mode of delivery, and planned pregnancy ( $P < 0.05$ ).

**Conclusion** The positive rate of postpartum postpartum traumatic stress disorder is high.

**KEY WORDS:** maternity, post-traumatic stress disorder, Positivity rate

### Introduction

Postpartum postraumatic stress disorder (PP-PTSD) and a range of psychiatric and psychological disorders (Seng, J. S., Li, Y., Yang, J. J., King, A. P., Kane Low, L. M., Sperlich, M., Rowe, H., Lee, H., Muzik, M., Ford, J. D., & Liberzon, I., 2018) PP-PTSD is a delayed mental stress disorder that occurs after childbirth, and its clinical symptoms are basically manifested as repeated painful experiences in the labor process, disgust or even fear of everything related to childbirth in daily social activities, vigilance and anxiety in the surrounding environment, stress defense at all times, and even symptoms of mental illness (such as hallucinations) (Chen, Y., Qian, H. Y., Zhu, Y. T., et al.

, 2021). Most women feel happy during childbirth because it is a positive psychological experience. However, postpartum women often face a range of challenges, such as changes in hormone levels in the body, physical trauma and repair due to childbirth, and the conflict of adjusting to their new role as mothers. These factors may contribute to postpartum depression and postpartum post-traumatic stress disorder, mainly in the areas of breastfeeding, mother-infant relationship, postpartum sexual intercourse, and infant emotional development (Liu, Y., Guo, N. F., Zhang, L., et al., 2020).

Relevant studies have shown that the prevalence of PP-PTSD in Chinese women is about 3.1%~15.7%, and the sequelae and adverse

effects of family relationships may last for ten months or even longer (Asadzadeh,L.,Jafari,E.,Kharaghani,R.et al.,2020). Early research on the disease has focused on maternal trauma. (Kamisan Atan, I., Lai, S. K., Langer, S., Caudwell-Hall, J., & Dietz, H. P.,2019) In recent years, psychological trauma has attracted more and more attention from researchers. This paper analyzes the current situation of maternal post-traumatic stress disorder in the form of questionnaires, deeply understands the current situation of maternal post-traumatic stress disorder and maternal physical health level and its influencing factors, explores the curative and recovery measures of maternal post-traumatic stress disorder, and provides early targeted intervention guidance and theoretical support for pregnant women at this stage.

In this study, we investigated the positive rate of postpartum traumatic stress disorder in women with different characteristics through questionnaire survey, which attracted everyone's attention to the postpartum postpartum traumatic stress disorder population, and the postpartum PP-PTSD will have a certain impact on the quality of life, mental health, work development, and social relationship stability of maternal patients with thi-s disease, their families and friends. This study effectively understood the mental health status of women after childbirth, aroused the attention of people from all walks of life to postpartum mental health problems, and minimized or avoided the harm to individuals, families, and society caused by adverse emotions caused by various factors (Vignato, J., Georges, J. M., Bush, R. A., & Connelly, C. D.,2017)

## 1. Subjects and Methods

### 1.1. Subjects

The survey subjects were 200 women who gave birth in a tertiary hospital in Guangzhou, Guangdong Province from September 2024 to November 2024.

Inclusion Criteria: (1) 4-6 weeks postpartum; (2) agree to participate in this study; (3) married women; (4) normal reading and writing skills; (5) Chinese nationality. Exclusion Criteria: Patients with major mental illness and cognitive impairment.

### 1.2. Methods

#### 1.2.1. Survey Methodology

A convenience sampling method was used to select 200 women at 4-6 weeks postpartum. A total of 200 questionnaires were distributed, and 196 valid questionnaires were recovered, with an effective rate of 98%.

The questionnaire consists of two parts: one is the general information questionnaire, and the other is the Trauma Stress Disorder Scale-Civilian version of the PCL-C developed by Weathers(Kaloupek, D. G., Chard, K. M., Freed, M. C., Peterson, A. L., Riggs, D. S., Stein, M. B., & Tuma, F.,2010) et al., the PCL-C scale contains 17 items and 3 dimensions, items 1-5 belong to recurrent experience symptoms, items 6-12 belong to avoidance symptoms, and items 13-17 belong to alert symptomsThe Likert 5-point scale was scored, with a score of 1 being strongly disagree, 2 being disagreeing, 3 being fair, 4 being agreeing, and 5 being strongly agreeing. The score ranged from 17 to 85, with 38 points as the cut-off (Yang, X. Y., Yang, H. A., Liu, Q. G., & Yang, L. Z.,2007), and women with a score of less than 38 were without maternal post-traumatic stress disorder, and those with a score higher than 38 were those with maternal post-traumatic stress disorder and were PP-PTSD-positive patients.

## 2. Result

### 2.1. General information on maternity

A total of 196 women participated in the questionnaire survey, as shown in Table 1.

Table 1 Statistical results of general maternal information (n=196)

project	classify	Number of people (n)	Composition ratio (%)
Age (years)	> 35	48	24.49
	31-35	85	43.37
	18-30	63	32.14
Degree	Junior high school and below	42	21.43
	High School/Technical Secondary School	49	25
	College Specialty	61	31.12
	Bachelor's degree	25	12.76
	Graduate student or above	19	9.69
Place of residence	countryside	92	46.94
	city	104	53.06
Fixed work	be	124	63.27
	not	72	36.73
Gestational age	Full-term	134	68.37
	Premature or postterm births	62	32.63
The way of conception	Conceive naturally	134	68.37
	Assisted reproduction conception	62	32.63

Mode of delivery	Birth	102	52.04
	Instruments are used for normal delivery	40	20.41
	Cesarean	54	27.55
Number of deliveries	multipara	120	61.22
	First-time mothers	76	38.78
Number of previous cesarean sections	0 times	100	51.02
	1 time	77	39.29
	≥ 2 times	19	9.69
Whether you are planning to become pregnant	be	122	62.24
	not	74	37.76
Feeding method	breastfeeding	97	49.49
	Artificial feeding	73	37.24
	Mixed feeding	26	13.27
Postoperative epidural anesthesia	be	88	44.9
	not	108	55.1
Newborn gender	man	119	60.71
	woman	77	39.29
Newborn weight	< 2500g	28	14.29
	2500-4000g	138	70.41
	> 4000g	30	15.31
Whether the newborn is transferred to the neonatal unit	be	97	49.49
	not	99	50.51

### 2.2. Positivity rate of maternal post-traumatic stress disorder scale

In this study, there were 27 mothers with a PCL-C score  $\geq$  38, and the positive rate of postpartum traumatic stress disorder was 13.77%.

Table 2: Positive and negative rates of PP-PTSD in the postpartum period

	Number	Percentage (%)
Positivity rate	27	13.77
Negative rate	169	86.23

### 2.3. Positive rates of maternal post-traumatic stress disorder with different characteristics

The results showed that PP-PTSD had statistically significant differences in age, education, mode of delivery, number of deliveries, number of previous cesarean sections, and planned pregnancy ( $P < 0.05$ ).

Table 3: Comparison of the positive rate of postpartum traumatic stress disorder in women with different characteristics (n=196)

variable		Postpartum traumatic stress disorder				X <sup>2</sup>	P
		Positive (n)	Percentage (%)	Negative (n)	Percentage (%)		
Age (years)	> 35	15	7.65	181	92.34	7.900	0.019
	31-35	8	4.08	188	95.91		
	18-30	4	2.04	192	97.95		
Degree	Junior high school	11	5.61	185	94.38	9.763	0.045

	and below						
	High School/Technical Secondary School	7	3.57	189	96.42		
	College Specialty	3	1.53	193	98.46		
	Bachelor's degree	4	2.04	192	97.95		
	Graduate student or above	2	1.02	194	98.97		
Place of residence	countryside	13	6.63	183	93.96	0.018	0.892
	city	14	7.14	182	92.85		
Fixed work	be	14	7.14	182	92.85	1.755	0.185
	not	13	6.63	183	93.96		
Gestational age	Full-term	22	11.22	174	88.77	2.490	0.115
	Premature or postterm births	5	2.55	191	97.44		
The way of conception	Conceive naturally	21	10.71	175	89.28	1.282	0.257
	Assisted reproduction conception	6	3.06	190	96.93		
Mode of delivery	Birth	12	6.12	184	93.87	7.525	0.023
	Instruments are used for normal delivery	1	0.51	195	99.46		
	Cesarean	14	7.14	182	92.85		
Number of deliveries	multipara	9	4.59	187	95.40	10.261	0.001
	First-time mothers	18	9.18	178	90.81		
Number of previous cesarean sections	0 times	22	11.22	174	88.77	12.168	0.002
	1 time	5	2.55	191	97.44		
	≥ 2 times	0	0	196	100		
Whether you are planning to become pregnant	be	11	5.61	185	94.38	6.162	0.013
	not	16	8.16	180	91.83		
Feeding method	breastfeeding	13	6.63	183	93.36	0.791	0.673
	Artificial feeding	9	4.59	187	95.40		
	Mixed feeding	5	2.55	191	97.44		
Postoperative epidural anesthesia	be	10	5.10	186	94.89	0.782	0.376
	not	17	8.67	179	91.32		
newborn gender	man	15	7.65	181	92.34	0.349	0.554
	woman	12	6.12	184	93.87		

newborn weight	<2500g	4	2.04	192	97.95	0.362	0.541
	2500-4000g	16	8.16	180	91.83		
	>4000g	7	3.57	179	91.32		
Whether the newborn is transferred to the neonatal unit	be	7	3.57	179	91.32	2.924	0.253
	not	20	10.20	176	89.79		

### 3. Discussion

#### 3.1. Analysis of Positive Rate of Maternal Postpartum Post-Traumatic Stress Disorder (PP-PTSD)

The findings of this study revealed a PP-PTSD positive rate of 13.77% within 4–6 weeks postpartum, significantly higher than the global prevalence of 4.0% reported in previous international studies (Cook, N., Ayers, S., & Horsch, A., 2018). Statistically significant differences ( $P < 0.05$ ) were observed in PP-PTSD incidence across subgroups stratified by maternal age, educational level, history of cesarean sections, parity, mode of delivery, and pregnancy planning status.

The highest PP-PTSD rates were identified in the following subgroups:

- Age : 7.65% in women >35 years
- Education : 5.61% in those with junior high school education or below
- Cesarean history : 11.22% in nulliparous women with no prior cesarean sections
- Parity : 9.18% in primiparous women
- Delivery mode : 7.14% in cesarean deliveries
- Pregnancy planning : 8.16% in unplanned pregnancies

This elevated prevalence may be attributed to multifactorial stressors, including:

1. Advanced maternal age-associated physiological vulnerabilities and psychological burdens during perinatal period
2. Lack of relevant obstetric experience for first-time mothers
3. Limited childbirth-related knowledge among low-educated populations
4. Trauma from surgical deliveries and prior obstetric experiences
5. Psychological maladaptation to unexpected maternal role transition in unplanned pregnancies

#### 3.2. Heterogeneity in PP-PTSD Prevalence Across Maternal Characteristics

##### 3.2.1. Age-Specific Analysis of Postpartum PP-PTSD Prevalence

Our study revealed statistically significant age-related differences in the prevalence of postpartum post-traumatic stress disorder (PP-PTSD) among parturients ( $P < 0.05$ ). Women aged >35 years exhibited the highest PP-PTSD positive rate (7.65%), surpassing rates observed in the 31–35 and 18–30 age cohorts. This elevated risk aligns with Xiao-Yan Chen's research (Chen, X. Y., 2022), highlighting advanced maternal age as a critical determinant.

Advanced maternal age represents a distinct obstetric population characterized by multifactorial challenges during the perinatal

period, including heightened psychosocial stressors (e.g., interpersonal conflicts, health concerns) and physiological vulnerabilities. These cumulative stressors create significant psychological and physiological barriers to labor progression and postpartum recovery, predisposing this cohort to neuroendocrine dysregulation, emotional dysphoria, and consequently, elevated PP-PTSD risk.

Clinical Recommendations:

1. Enhanced Mental Health Support :
  - Implement targeted mental health screening for women of advanced maternal age during prenatal visits
  - Strengthen postpartum nursing follow-ups with priority psychological evaluations for high-risk cases
2. Community-Based Interventions :
  - Facilitate structured peer-support networks to improve maternal social connectivity
  - Organize perinatal education workshops addressing stress management and role transition
3. Multidisciplinary Care Models :
  - Establish obstetric teams integrating psychiatrists, nutritionists, and social workers
  - Develop digital health platforms delivering evidence-based coping strategies for postpartum adaptation

These interventions aim to stabilize perinatal mental health trajectories, mitigate PP-PTSD incidence, and improve quality of life for older gravidae (Chen, Y., 2022, Du, J., Zhao, L. M., Zheng, W. K., et al., 2023). Furthermore, healthcare systems should prioritize the standardization of age-specific perinatal mental health protocols, ensuring timely resource allocation for this vulnerable population.

##### 3.2.2. Educational Attainment-Related Differences

Significant education-level disparities were observed ( $P < 0.05$ ), with the highest PP-PTSD prevalence (5.61%) in women with  $\leq 9$  years of formal education. This aligns with Yi-Jia Bao's research highlighting knowledge gaps in childbirth preparedness among low-literacy populations. Notably, international studies present conflicting evidence, with some Western cohorts showing elevated PP-PTSD risks in highly educated women experiencing occupational stress-mediated pregnancy complications Bao, Y.J., & Chen, H.F., 2017).

Intervention strategies:

- Develop health literacy-adapted patient education programs
- Train caregivers in low-health-literacy communication techniques
- Promote stress-reduction modalities (e.g., music therapy, postpartum exercise, peer-group counseling)

- Implement hospital-community linkage systems for longitudinal mental health monitoring (Lu, Q. R., Ding, L., Wang, Y. L., et al., 2019)

Healthcare systems should prioritize:

- Culturally competent perinatal mental health services
- Digital health platforms for remote psychoeducation
- Community health worker-led support groups
- Regular mental status assessments during postnatal follow-ups

### 3.2.3. Parity-Specific Variations in PP-PTSD Prevalence

Our analysis demonstrated significant parity-dependent differences in PP-PTSD incidence ( $P < 0.05$ ), with primiparous women exhibiting a higher positive rate (9.18%) compared to multiparous women. These findings align with the research conducted by Dr. Jun Zhang's team at Wuhan University Health Science Center, which identified primiparity as a critical risk factor for PP-PTSD (Zhang, D., Zhang, Y., Gan, Q., et al., 2018). The elevated vulnerability in nulliparous women may stem from:

- Insufficient experiential knowledge of labor physiology
- Heightened fear of childbirth amplified by exposure to sensationalized negative birth narratives (e.g., through social media or entertainment platforms)
- Prolonged active labor duration 2–3 hours longer than multiparous counterparts (World Health Organization, 2018)
- Physical trauma from perineal lacerations and psychological distress from genital exposure during vaginal deliveries

Clinical interventions:

1. Peer-supported nursing framework :
  - Establish multidisciplinary teams comprising:
    - Lead obstetricians
    - Senior midwives
    - Licensed psychotherapists
    - Peer mentors (primiparous women with successful postpartum adaptation)
  - Implement standardized training modules covering:
    - Peripartum trauma management
    - Postnatal mental health literacy
    - Emotion regulation techniques
2. Digital health integration :
  - Develop hospital-branded maternity apps featuring:
    - "Birth Story" forums for verified positive delivery experiences (ethics committee-approved content)
    - Real-time Q&A with certified perinatal specialists
    - Create moderated social media groups to facilitate anonymous peer support

### 3.2.4. Delivery Mode Stratification

Significant disparities emerged across delivery modes ( $P < 0.05$ ), with cesarean deliveries demonstrating a 7.14% PP-PTSD rate versus vaginal births. This corroborates Meng Yixin's findings from Jiangsu Provincial Hospital (Meng, Y. X., Sun, D. D., & Li, Y. L., 2023), highlighting:

- Dual trauma from concurrent labor pain and surgical intervention
- Psychological impacts of instrument-assisted deliveries (forceps/vacuum extraction)

- Postoperative complications exacerbating recovery challenges (Wu, X. L., Shi, Y. X., & Zhang, Y. Z., 2021)

Enhanced care protocols for cesarean deliveries:

- Preoperative :
  - Detailed counseling on neuraxial anesthesia efficacy
  - Surgeon credential transparency to build trust
- Postoperative :
  - Multimodal pain management (scheduled analgesics, patient-controlled epidural analgesia)
  - Environment optimization (noise reduction, circadian lighting)
  - Family-mediated distraction therapy during acute recovery phases (Liu, T. T., Fei, Y. J., & Li, Y., 2020)

### 3.2.5. Prior Cesarean History and PP-PTSD Risk

Nulliparous women with no prior cesarean history exhibited the highest PP-PTSD incidence (11.22% vs. 2.55% in multiparous women with  $\geq 1$  cesarean,  $P < 0.05$ ). This paradox may reflect:

- Catastrophizing of unknown surgical experiences
- Mismatched expectations between anticipated vaginal and actual operative deliveries (Chen, Y. F., Xie, R. H., Li, M., et al. 2021)

Preventive strategies:

- Pre-labor psychometric profiling for risk stratification
- Blockchain-secured digital health records tracking psychological vulnerabilities
- AI-driven predictive analytics for high-risk cohort identification (Tang, C., Goldsamt, L., Meng, J., et al., 2020)

### 3.2.6. Pregnancy Intention Status

Unplanned pregnancies demonstrated significantly elevated PP-PTSD rates (8.16% vs planned pregnancies,  $P < 0.05$ ), revealing complex psychosocial dynamics:

- Career discontinuity anxiety in working professionals
- Role conflict-induced perceived isolation
- Inadequate perinatal identity transition support

Multilevel interventions:

- Corporate : Pregnancy transition programs with phased return-to-work options
- Familial : Culturally tailored kinship education modules
- Clinical : Trauma-informed care protocols integrating:
  - Narrative exposure therapy
  - Perinatal legacy-building exercises
- Dyadic (mother-partner) psychoeducational counseling

## 4. Conclusion

The level of positive rates of maternal postpartum PTSD is high; it is recommended that individualized psychological care should be provided according to the specific situation of the mother, and a targeted perinatal mental health maintenance support system should be implemented; a comprehensive perinatal education program should be developed to improve the knowledge of maternal health; and standardized training protocols should be provided to birth attendants on PP-PTSD identification and mitigation strategies. These evidence-based measures are used to reduce the rate of maternal PP-PTSD positivity.

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