Perinatal Trauma with and without loss experiences

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Journal of Reproductive and Infant Psychology, 34:4, 413-425, DOI: 10.1080/02646838.2016.1186266

Accepted 15.3.16

Word count : 3493

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Objective: The present study explored differences in mental health between women who experienced a trauma which involved a loss of foetal or infant life compared to women whose trauma did not involve a loss (difficult childbirth). **Method:** The sample consisted of 144 women (Mean age = 31.13) from the UK, US/Canada, Europe, Australia/ New Zealand, who had experienced either stillbirth, neonatal loss, ectopic pregnancy, or traumatic birth with a living infant in the last 4 years. **Results:** The trauma without loss group reported significantly higher mental health problems than the trauma with loss group ($F(1,117) = 4.807$ $p=.03$). This difference was observed in the subtypes of OCD, panic, PTSD and GAD but not for major depression, agoraphobia and social phobia. However, once previous mental health diagnoses were taken into account, differences between trauma groups in terms of mental health scores disappeared, with the exception of PTSD symptoms. Trauma groups also differed in terms of perceived emotional support from significant others. **Conclusion:** The findings illustrate the need for a change in the focus of support for women's birth experiences and highlighted previous mental health problems as a risk factor for mental health problems during the perinatal period.

Key words: Perinatal trauma, perinatal loss, difficult childbirth

Introduction

Prenatal/postnatal loss and difficult childbirth experiences, (for parsimony, called 'perinatal traumas' in this study), have been identified as predictors of postnatal mental health (Soet, Brack, & Dilorio, 2003). It has been reported that 15% to 25% of women who experience perinatal loss suffer from adjustment problems and may seek professional help for their mental health problems (Hughes, Turton, Hopper, & Evans, 2002).

Most common perinatal traumas include miscarriage, stillbirth, ectopic pregnancy, neonatal death and difficult childbirth (Brockington, 1996). Unlike other perinatal traumas, miscarriage has not been recognised as a risk factor for perinatal mental health problems until recently. One earlier qualitative study showed that miscarriage signified a major life event that changed the way in which women viewed their lives in the present, and affected the way in which they

planned for the future (Bansen & Stevens, 1992). Later studies also associated miscarriage with anxiety symptoms (Cumming et al., 2007). A recent longitudinal study also emphasised the risks for persistent psychopathology, particularly for vulnerable women, one year post miscarriage (Lok, Yip, Lee, Sahota, & Chung, 2010).

Women's experience of stillbirth has been a neglected area, but has started receiving more interest since the study carried out by Hughes and colleagues, which showed that PTSD symptoms were common during the next pregnancy following stillbirth at 1 year post – partum (Hughes, Turton, & Evans, 1999). Furthermore, in a consecutive study, Hughes and colleagues found that contact with the stillborn infant (seeing / holding) was associated with increased post-traumatic stress disorder (PTSD) and that next born infants were more likely to show disorganised attachment behaviour. The authors' findings, in a 7 year follow up study, also indicated significantly higher and enduring symptoms of PTSD following a stillbirth experience (Hughes et al., 2002).

Most studies class ectopic pregnancy as a prenatal loss, and examine the effect of such experiences within the prenatal loss construct (Beck & Driscoll, 2006; Ney, Fung, Wickett, & Beaman-Dodd, 1994). Similarly neonatal death has also been studied with other perinatal traumas e.g. stillbirth. Boyle et al., (1996) showed that mothers who experienced stillbirth, neonatal or sudden infant death syndrome (SIDS) remained more likely than controls to display high levels of both anxiety (14%) and depression (7%) more than 2 years after their loss (Boyle, Vance, Najman, & Thearle, 1996).

Difficult/traumatic childbirth has also been associated with postpartum mental health problems, particularly anxiety disorders, and has been identified as an extremely traumatic stressor (Beck, 2004). It has been reported that 1% - 2% of women develop post-traumatic stress disorder as a result of difficult childbirth (Ayers, Eagle, & Waring, 2006; Bailham & Joseph, 2003). Alcorn et al. in a prospective longitudinal study of the prevalence of PTSD

following childbirth, found that PTSD can result from a traumatic birth experience after controlling for pre-childbirth PTSD, depression and anxiety symptoms (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010). In addition, predisposing factors such as anxiety in late pregnancy along with other psychiatric symptoms in late pregnancy, critical life events and the experience of delivery was found to be an important predictor of PTSD symptoms (Zaers, Waschke, & Ehlert, 2008). Since the recognition of individual vulnerability in response to adversity in DSM-IV (American Psychiatric Association, 2000), PTSD symptoms following a difficult childbirth have attracted lot of research interest and the current literature suggests a link between PTSD symptoms and traumatic / difficult childbirth (Ayers & Pickering, 2001; Wijma, Söderquist, & Wijma, 1997). However, no other study has examined difficult childbirth in relation to other anxiety symptoms in the postnatal period.

Although some women who experience loss or traumatic childbirth trauma adjust well to the loss or trauma, other women will continue to suffer (Badenhorst & Hughes, 2007). Boyle et al., (Boyle et al., 1996) also suggested that although bereaved mothers reported higher rates of psychological distress, not all bereaved mothers suffered from mental health problems following a perinatal trauma. Their findings suggested that women who were psychologically distressed soon after the loss were likely to still be distressed 8 months later and likely to remain so subsequently.

It has been argued that perinatal trauma may act as a trigger, turning vulnerability for mental health problems into actual disorders. Côté-Arsenault et al. suggested that it is not the gestational timing of the perinatal loss (miscarriage, stillbirth or neonatal) but the personal meaning of each loss that is important for adjustment to loss (Côté-Arsenault, Bidlack, & Humm, 2001). For example, it has been shown that women who experienced a perinatal loss may begin to question their ability to conceive and to be able to give birth to a living child like any other woman (Nansel, Doyle, Frederick, & Zhang, 2005), or they may suffer from

anxiety symptoms following a difficult childbirth and blame themselves for failing to have a successful birth and not being able to bond with their living infant (Czarnocka & Slade, 2000).

However, whilst PTSD and OCD in perinatal loss (Bailham & Joseph, 2003; McGuinness, Blissett, & Jones, 2011) have received considerable research interest, there is less research into perinatal panic disorder (Rambelli et al., 2010), agoraphobia, social phobia (Murray, Cooper, Creswell, Schofield, & Sack, 2007), and generalised anxiety disorder (GAD) (Lim et al., 2005).

Perinatal mental health complications coincide with the very crucial period where bonding to the infant takes place for the mother, and for the infant, attachment to his/her mother. The parenting behaviour of women with anxiety disorders features reduced emotional involvement, impaired communication, and the women are less responsive to their children (Field, Healy, Goldstein, & Guthertz, 1990). It is possible that anxiety disorders and their symptoms could also have a detrimental effect on the early relationship between a woman and her baby. For example, mothers with OCD and panic disorder were observed to be less warm and promoting of psychological autonomy than control group mothers (Challacombe & Salkovskis, 2009). Mothers with PTSD symptoms may have difficulties in breastfeeding and bonding with their baby (Reynolds, 1997). Also, parental behaviour low in warmth has been documented in families with anxiety disordered parents (DiBartolo & Helt, 2007). Mothers may experience difficulty in bonding with their infant following a difficult childbirth due to their increased PTSD symptoms (Beck & Watson, 2008) or if the traumatic birth is associated with the baby, mothers may have difficulties in their relationships with their infants (Ayers et al., 2006).

The degree or perception of social support a woman experiences during and after the trauma is an important predictor of outcome. Recently the ‘importance of maternity staff and

118 care pathways' and high risk populations including women who have preterm or stillborn
119 infants has been identified as a research focus on PTSD following childbirth (McKenzie-
120 McHarg et al., 2015).

121 Social support is conceptualised as a multidimensional construct (House & Kahn, 1985).
122 There are four identified attributes which are, emotional, informational, tangible, and
123 appraisal support (Cohen & Wills, 1985). Research confirms the importance of social
124 support, particularly emotional support, for better adjustment following perinatal trauma
125 (Cacciatore, Schnebly, & Froen, 2009; Leon, 1986). For the perinatal period, for example, in
126 a phenomenolological study following a perinatal loss, parents defined their emotional
127 support needs as physical presence; being listened to and being allowed to express their
128 feelings; acceptance of their feelings and being given sympathy by health professionals
129 (Kavanaugh, Trier, & Korzec, 2004). Another study focused on emotional needs and
130 perinatal loss highlighted the need for acknowledging and validating the feelings of parents
131 (Davis, Stewart, & Harmon, 1988).

132 Even though studies have examined a range of perinatal trauma experiences in relation to
133 mental health problems, currently no study has yet examined the mental health outcomes of
134 perinatal trauma for those women who experience loss and those women who have a
135 surviving infant. Furthermore, the perceived emotional support from significant others,
136 during and after perinatal trauma has not been compared between groups with and without
137 loss. It is reasonable to expect that survival of the infant may reduce the experience of mental
138 health symptoms in comparison to women who lost their infants before or after childbirth. It
139 may also be that the mother's perception of support from significant others moderates the
140 extent to which mental health symptoms are experienced.

141 In light of the above literature, the present study investigated whether trauma with or
142 without loss of the infant resulted in greater psychological distress, with particular focus on

symptoms of anxiety disorders including panic, obsessive compulsive symptoms, post-traumatic stress and generalised anxiety symptoms. It also examined the perceived emotional support from a partner, close family members and health practitioners between trauma groups.

Method

Sample

A total of 144 women (Mean age = 31.13) from UK, US/Canada, Europe, Australia/ New Zealand took part in this study. Women who experienced a single perinatal trauma within the last 4 years were included in this study (miscarriage (52), neonatal death (4), stillbirth (17), ectopic pregnancy (4) or difficult childbirth (77)). A total of 67 women who experienced a single perinatal trauma with loss (miscarriage, neonatal death, stillbirth and ectopic pregnancy) constituted the 'trauma with loss' group, while 77 women who experienced difficult childbirth with a surviving healthy baby constituted the 'trauma without loss' group.

Procedure

Participants were provided with an information sheet about the study which fully explained the content of the questionnaires and informed consent to participate in the study was provided by all participants. Each participant completed a set of web-based questionnaires and submitted their answers anonymously online. The study was advertised on social websites and the websites of some national and international organisations (Birth Trauma Association UK; Share US, Australia/New Zealand (Sands AU); Magic Mums). At the end of the study, participants were presented with a debriefing form signposting them to sources of support and information in case taking part in the study had distressed them in any way.

Measures

The Psychiatric Diagnostic Screening Questionnaire (PDSQ) : The PDSQ (Zimmerman & Mattia, 2001) is a self-report scale designed to screen for the most common disorders in the Diagnostic Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). The measure has good to excellent levels of internal consistency, test-retest reliability, and discriminant, convergent, and concurrent validity (Zimmerman & Mattia, 2001). In this study, the bulimia, abuse/dependence, somatisation, hypochondriasis and psychosis subscales were not used.

Edinburgh Postnatal Depression Scale (EPDS): The EPDS (Cox, Holden, & Sagovsky, 1987) was used to measure depressed mood in the postnatal period. This scale consists of a 10 item self-report scale to assess depression. It was developed and validated specifically for postnatal use and is used worldwide.

Background/demographic questionnaire: Participants also provided details of their reproductive history, perinatal trauma, demographics and past history of mental health problems prior to their perinatal trauma.

Perinatal Experience and Support Questionnaire: This questionnaire was designed to collect information on women's experience of perinatal trauma(s) and their perceived emotional support from significant others (partner/ husband, family, and health practitioners). It consisted of five separate sections for each trauma experience. It is comprised of questions regarding the details of the trauma experiences (e.g. *'type of trauma', 'when was the perinatal trauma experience'*) and questions regarding the participant's satisfaction with the emotional support received from significant others ('*Please rate the emotional support that*

you have received from Health Practitioners regarding your stillbirth experience') on a 1-5 likert type scale (1= not at all satisfied, 5 = extremely satisfied).

This study was reviewed and approved by University of Birmingham Research Ethics Committee (ERN_10-0698).

Results

A preliminary analysis revealed that there were no significant differences between the two trauma groups in terms of relationship, education, ethnicity, job status and age. However, the two groups differed in past mental health history. A higher rate of previous mental health problems was observed in the trauma without loss group. The results are presented in Table 1. (A pairwise execution was used for the analysis thus the number of participants varied in analyses, as indicated in the tables).

Following to the preliminary analysis a series of one-way ANOVAs were conducted to examine mean differences between trauma groups in the PDSQ total and PDSQ subscales. The findings are presented in Table 2 and Figure 1. There was a statistically significant difference in women's PDSQ total scores between the trauma groups. The trauma without loss group reported more psychological distress than the women who experienced trauma with loss. Despite reaching statistical significance, the actual difference in mean scores between the groups was small.

PDSQ sub-scores and EPDS by trauma groups

Similarly, this difference in psychopathology remained in symptoms of OCD, Panic, PTSD and GAD. Homogeneity of variance assumptions was only violated for the trauma group's OCD scores. However the trauma group's OCD scores were significantly different at a stringent significance level (p=.01). The differences between groups in Major Depression,

Agoraphobia and Social Phobia were not statistically significant. Furthermore there was no statistically significant difference for the EPDS scores between groups (see Table 2 and Figure 1).

Current mental health symptoms of trauma groups by previous mental health problems

It was noted that the groups differed in terms of previous mental health problems. In order to understand whether the differences in the mental health scores for the trauma with and without loss groups comes from higher pre-existing problems in these women, the above ANOVA analysis was re-run examining only the mental health scores of the women (n=107) in each group who did not report any previous mental health problems prior to their trauma experience (Table 3).

As presented in Table 3 none of the general and specific mental health scores other than PTSD scores differed between trauma with loss and without loss groups. Women with no prior history of mental health problems, but who experience a perinatal trauma, are more likely to report higher PTSD symptoms if their trauma involves a surviving infant than a loss.

Perceived emotional support by trauma groups

A series of one-way ANOVAs were conducted to examine mean differences between trauma groups in perceived emotional support from significant others. The findings revealed a significant difference in perceived emotional support from Health Practitioners and Partner between the two trauma groups. For the trauma with loss group, perceived emotional support from Health Practitioners and Partner was significantly higher than perceptions of support reported by those without loss (Table 4).

Discussion

This study aimed firstly to explore differences in mental health scores between women who experienced perinatal trauma with and without loss. Contrary to the expectations, analysis

revealed that the trauma without loss group reported significantly higher mental health problems than the trauma with loss group. This difference remained in the anxiety specific mental health problems OCD, Panic disorder, PTSD and GAD but not in major depression, agoraphobia or social phobia. It appears that women who experienced a perinatal trauma without an infant loss, suffered from more anxiety symptoms than women who experienced an infant loss. However, once the previous mental health history was taken into account, this difference disappeared for the general and specific mental health scores. However, there remained a significant difference in PTSD scores, with women who experienced trauma without loss reporting greater PTSD symptomology. This finding supports other literature suggesting a link between increased PTSD and difficult childbirth (trauma without loss) (Ayers & Pickering, 2001; Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008).

The women who experienced perinatal loss appeared to have fewer mental health problems in comparison to the trauma group with a living infant; however, they still suffered from general and specific mental health problems (Figure 1). It would therefore be inaccurate to conclude that women who experienced perinatal trauma without an infant loss are 'worse off' than the women who experienced perinatal trauma with loss. This study actually underlines the importance of understanding the trauma and individual vulnerabilities in relation to perinatal mental health. It appears that although women survive the perinatal trauma with a living infant, their view of their trauma experience appears to count more than the outcome of the trauma – a living infant vs. a deceased infant.

Findings from this study also suggested a significant difference between the trauma groups' perceived emotional support. It appears that mothers who experience a trauma without loss perceive less emotional support from their partners and health practitioners. In other studies mothers reported a lack of validation for their experiences (Ustundag - Budak, Larkin, Harris

& Blissett, 2015) particularly from health care staff (Beck, 2011) as the outcome of the birth was a live birth and the mothers perhaps felt that their experiences as whole were not acknowledged. Social support, particularly emotional support from health care providers, has been identified as an important factor for better adjustment following perinatal traumas (Cacciatore et al., 2009; Iles & Pote, 2015). In addition, Beck, in a recent metaethnography analysis of traumatic childbirth, discussed the multiple, recurring, reinforcing, intensifying causal loops, encompassing feedback behaviour and how such loops, in a domino effect, influence the mothers' experiences after trauma. Beck stressed the importance of feedback in order to tackle the reinforcing causal loops (Beck, 2011).The findings of the current study thus highlight the importance of validation of mothers' experiences and the need for compassionate care (Cornwell & Goodrich, 2009) for women who suffered perinatal trauma without loss. Health care staff and partners may show more compassion towards women who experienced a perinatal trauma with loss (e.g. stillbirth or neonatal death) in comparison with women who survived the trauma with a living infant because their focus is on the outcome of the experience. It is plausible to speculate that this invalidation of experiences and feelings could be detrimental to mental health, particularly in symptoms of PTSD. It has been argued that validation, including empathy and accurate reflection of individuals' experiences, is quintessential to both healthy development and treatment of psychological problems (Rogers, 1951). This may require further research in terms of perinatal trauma and also may have implications for therapeutic interventions and their need to focus on the validation of experiences. A current review of post-traumatic stress disorder following childbirth (McKenzie-McHarg et al., 2015) highlights current issues around the failure of diagnoses of PTSD symptoms where there has not been tangible trauma, for example a third-degree tear or internal bleeding. The review also underlines the importance of acknowledging sub-threshold symptomology. Women may suffer from a variety of symptoms of PTSD but not meet the

criteria for PTSD diagnoses. Women are also less likely to receive emotional support and validation from health care professionals where their trauma experiences are not acknowledged. It is possible that the participants of this study may have perceived the lack of emotional support due to their unrecognised trauma experiences.

Parallel with previous literature, the findings of the present study may suggest that previous vulnerability to mental health problems is an important risk factor for poorer mental health scores following a perinatal trauma experience (Milgrom et al., 2008). Pre-pregnancy mental health history has been identified as a risk factor particularly for PTSD symptoms following difficult childbirth (Ayers et al., 2009; Wijma et al., 1997; Zaers et al., 2008). However, the findings also indicated a remaining significant difference between the PTSD scores of the trauma groups with and without loss, who did not have previous mental health problems. This suggests that women who experienced difficult childbirth maybe at risk for PTSD even in the absence of vulnerability caused by previous mental health problems and that this effect may be stronger in those women who have a living infant.

The subjective experience of adverse experiences underlines the importance of individual variability in response to a trauma experience. Beck drew attention to the fact that what a mother perceives as birth trauma may be seen quite differently through the eyes of health professionals, who may focus on the live birth following traumatic birth experience (Beck, 2004). It has been recently highlighted that the experience of difficult childbirth, suggests a near death experience for both mother and child, unlike other trauma experiences (McKenzie-McHarg et al., 2015). It is plausible that when women experienced a threat to the survival of themselves and/or their infant, their infant then may be a constant reminder of their trauma experience while they struggle to adjust (Ayers et al., 2006). They may also be dealing with difficulties in bonding and negative feelings such as failing to love or look after their infant

well enough (Czarnocka & Slade, 2000; Elmir, Schmied, Wilkes, & Jackson, 2010). These may contribute to the worsening mental health symptoms in this group.

This study has shown that mental health problems may be experienced by women who have experienced both a live birth after a traumatic event as well as mothers who have experienced an infant death. Mental health problems are more likely to be observed in those mothers who had a previous history of mental health problems, but post-traumatic stress responses may well be observed where there has been no such previous history. Examining and understanding the influence of such factors is important in order to support women accordingly.

Limitations

A possible improvement for this study would have been to record the time that had passed since the traumatic event. In this way, we could have examined the time since the trauma in relation to experience of mental health symptoms. However, mothers were only eligible for the study if they had experienced their trauma within a 4 year period and so all traumatic and loss experiences were relatively recent events.

Implications and Further Research

This study has implications for current provision of perinatal support. The findings emphasise the need for emotional support for mothers who have experienced a difficult childbirth with a living infant. In addition, there is an emerging need for a shift from outcome based focus (the survival of infant), to an individual based focus for women's birth experiences. In particular, the awareness of health professionals involved in childbirth and the perinatal period, about how such traumas may have an effect on the mothers, regardless of their healthy infant's survival, may improve the care provided to women who experienced a traumatic birth. Psychological support may also be necessary for those women with

previous mental health problems who experienced perinatal trauma. Health practitioners should be informed of the emotional support needs of mothers who experience perinatal trauma and there is a need for a greater awareness of the potential impact of trauma without loss on later adjustment. Specific training for health practitioners about how to validate women's experiences should be considered. Similarly, the need for support after traumatic perinatal trauma could also be disseminated to women's partners. These findings call for a significant shift of emphasis in the prioritisation of care to include support for women who have experienced difficult births as well as mothers who have suffered a pregnancy loss. The research implications of this study are twofold. Firstly, it is very important to understand the underlying factors that influence the women's view of their own trauma experiences in order to support women perinatally. Further research is needed to understand the factors which may influence women's view of their traumatic experiences and perceived social support. Secondly, there is a need to investigate whether health professionals may behave more sympathetically towards women who have given birth to a deceased infant and yet failed to validate experiences of women who had a difficult childbirth with a living infant. These hypotheses require further research.

Acknowledgements

The authors would like to thank all the women who participated in this study.

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Tables

Figures

512 Table1. Demographic differences in PDSQ scores of single trauma with or without loss

513 groups (n=144)

		Trauma without loss		Trauma with loss	
		N	**%**	**N**	**%**
Relationship	Single	1	1.5	3	3.9
	In a Relationship	14	20.9	12	15.6
	Married	52	77.6	62	80.5
X^2 (2, N(144)=1.34, p =.51 (NS)					
Education	School education	3	4.5	13	16.9
	Post school	18	26.9	21	27.3
	Degree level	32	47.8	18	23.4
	Postgraduate level	13	19.4	22	28.6
X^2 (4, N=140)=12.30, p =.06 (NS)					
Ethnicity	Black	-	-	-	-
	Asian	2	3	5	6.5
	White	63	94	69	89.6
	Other	2	3	3	3.9
X^2 (2, N=144)=1.07, p =.59 (NS)					
Job Status	Unemployed	3	4.5	5	6.5
	Unskilled	7	10.4	11	14.3
	Skilled	45	67.2	50	64.9
	Managerial/Professional	12	17.9	8	10.4

X^2 (5, N=141)=3.68, p =.60 (NS)					
Previous Mental Health Problem	Yes	24	35.8	13	16.9
	No	43	64.2	64	83.1
X^2 (2, N=144)=5.77, p=.02 (S)					

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Table 2. Univariate analysis of variance for the differences between trauma without loss and trauma with loss scores on the PDSQ and PDSQ sub scores (n=144)

	Trauma without Loss			Trauma with Loss					
	M	SD	N	M	SD	N	F	Df	p
PDSQ Total	29.74	17.49	61	23.14	15.20	58	4.81	1-117	.03*
Obsessive Compulsive Disorder (OCD)	1.02	1.52	66	0.47	0.94	73	6.66	1-137	.01*
Panic Disorder	2.45	2.72	65	1.35	2.05	71	7.07	1-134	.01*
PTSD	7.23	4.23	62	4.65	4.11	63	11.93	1-123	.03*
Major Depression	6.75	5.14	61	6.32	4.42	62	.25	1-121	.62
Agoraphobia	1.82	2.60	62	1.33	2.02	63	1.38	1-123	.24
Social Phobia	4.47	4.13	62	3.63	4.29	59	1.21	1-119	.27
Generalised Anxiety Disorder (GAD)	5.61	3.46	62	4.34	3.44	61	4.16	1-121	.03*
Depression measured by EPDS	14.40	6.99	56	12.90	5.57	52	1.53	1-106	.22

* $p < 0.5$

Table 3. Univariate variance analysis for the differences between trauma without loss and trauma with loss scores on the PDSQ and PDSQ sub scores of women with no mental health history *(n=107)*

	Trauma without Loss			Trauma with Loss					
	M	SD	N	M	SD	N	F	df	p
PDSQ Total	23.74	15.05	38	22.09	14.40	46	0.26	1 82	0.61
OCD	0.69	1.30	42	0.48	0.97	60	0.86	1 100	0.36
Panic	1.69	2.41	42	1.26	1.90	58	1.00	1 98	0.32
PTSD	6.38	4.14	39	4.31	3.94	51	5.84	1 88	.018*
Major Depression	5.26	4.55	38	5.86	4.31	50	0.39	1 86	0.53
Agoraphobia	1.05	1.85	39	1.28	1.95	50	0.32	1 87	0.58
Social	3.62	4.13	39	3.67	4.34	46	0.00	1 83	0.95
GAD	4.46	3.36	39	4.23	3.32	48	0.10	1 85	0.75
EPDS	12.12	6.63	35	12.43	5.36	40	0.50	1 73	.821

*$p<.05$

Table 4. Univariate analysis of variance for the differences between trauma without loss and trauma with loss scores on perceived emotional support (n=142)

	Trauma without Loss			Trauma with Loss					
	M	SD	N	M	SD	N	F	df	p
Perceived Emotional Support from Health Practitioner	1.92	1,03	66	2.67	1.20	76	15.55	1 140	0.0001*
Perceived Emotional Support from Partner	3.27	1.44	66	3.91	1.25	76	7.94	1 140	0.01*
Perceived Emotional Support from Family	2.93	1.33	61	3.00	1.24	74	.088	1 133	0.77

*$p<.05$

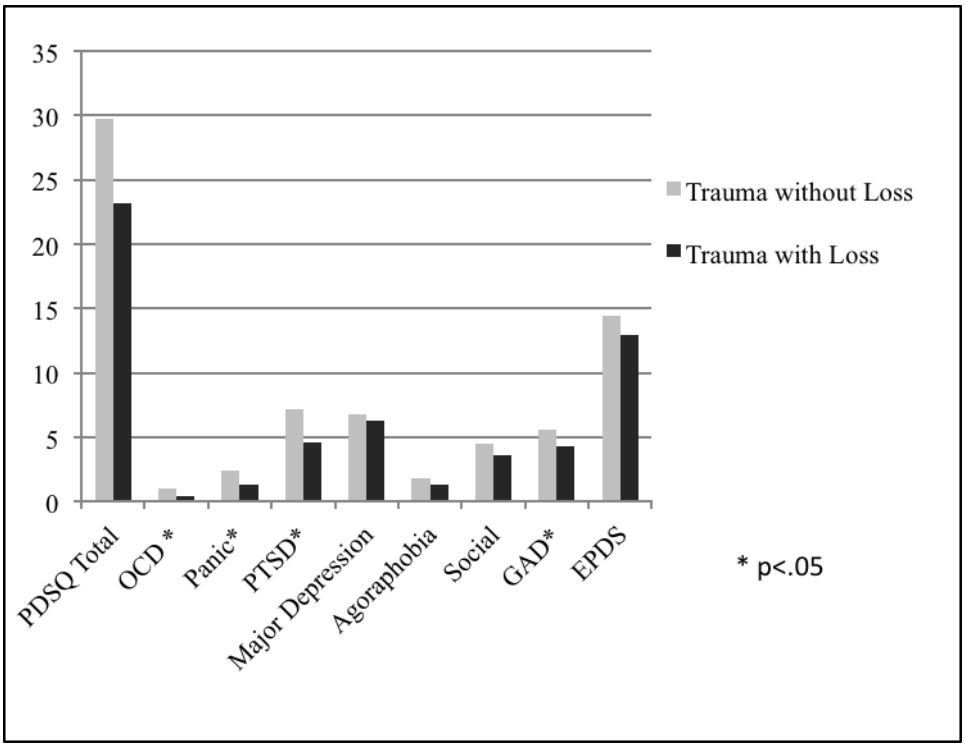

Figure 1. PDSQ total and sub scale scores by trauma group