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When Birth Becomes Trauma

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Editorial

When birth becomes trauma

by AIMS Journal Editors Mari Greenfield and Emma Ashworth

Welcome to this edition of the AIMS Journal, which looks at the life changing issue of traumatic birth.

In academic and medical literature, the term 'traumatic birth' is usually used to refer to a birth that was emotionally or psychologically traumatic for the person giving birth, whilst 'birth trauma' is used to include this kind of birth as well as births where the baby was physically injured. In the first article in this journal, Rebecca Moore gives us an explanation of what makes a birth traumatic, as a clear understanding of this is important in our attempts to stop it from happening in the first place.

Worldwide, up to 30% of births are a traumatic experience.[1] It is important that we recognise how profoundly a traumatic birth can affect the person who experiences it. Zoe Clark shares with us the feelings she was left with after her birth, and the parallels she felt it had with domestic violence. Births can be straightforward or complicated, but no-one should be left feeling that they have been abused after giving birth. The long-term consequences of a birth experience like this are a woman and sometimes a baby who went through a terrible experience, mental health injuries, sometimes compromised bonding with the baby, and for some, relationship breakdown.

A traumatic birth can result in post-traumatic stress disorder (PTSD). In the UK, childbirth-related PTSD is underdiagnosed, and effective treatment is hard to access. Gill Thomson reflects on the issues affecting access to one form of intervention – Birth Reflections services. We also know that one traumatic birth does not mean a subsequent birth has to be a traumatic experience. With good care, future births can be a positive experience. Hannah Palamara shares her birth story with us, in which her first births were traumatic experiences, but good care and her own fortitude in her last birth had a healing effect.

Birth supporters can also be affected by a traumatic birth too. Research shows that both fathers and midwives can be traumatised, and support services are mostly non-existent. No research has yet been published about the effect on lesbian partners, obstetricians, doulas, or others who may be present at a birth. Jenny Patterson's article reflects on how the cumulative experience of witnessing traumatic births may affect midwives, including the impact on the care they provide to women and Amy Delicate explains the impact on couple relationships when birth is traumatic.

Traumatic birth is an emerging area within academic and medical literature, and interest in studying it is growing. Gemma McKenzie reviews some of the latest research in the area, and we have an updated AIMS checklist to help those campaigning to avoid and treat perinatal mental health injuries. This important list sets out what we believe would improve the services available to those who are affected by traumatic births, and gives us a direction for our campaigning efforts.

Our sincere thanks to all those involved in sharing their stories and writing articles, and to the entire Journal team for their amazing work in making this Journal a reality.

Mari Greenfield – *Doula and academic researcher*
Emma Ashworth – *AIMS Trustee*

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Article

What is birth trauma anyway?

By Dr Rebecca Moore

"I had a difficult pregnancy physically, but emotionally I was excited and felt thrilled to be pregnant. I planned to have my baby on labour ward as I wanted an epidural. When I went into labour the midwife I spoke to on the phone said labour ward was full and I needed to go the Midwifery led unit. This made me feel really panicked because I wasn't expecting it. The midwife I was allocated was OK but I didn't know her and she was competent but not kind. She wanted me to use the birth pool and I just didn't want to do this. It seemed they wanted me to have a birth without pain relief which I didn't want and I felt I couldn't ask for an epidural. The pain was unbearable and I was so afraid. My husband didn't know how to help me and I felt so alone. I ended up pushing for a long time and I tore really badly. No one explained to me about my tear and the stitches. When they put the baby on me I felt nothing. I couldn't breastfeed. I went home feeling I had failed and played my birth over and over again in my mind."

"I went into hospital with no real thoughts of how my birth would be. The ward was really busy and my midwife kept leaving the room which made me feel really scared. My husband was panicking. My pain got really bad really quickly and by the time the midwife came back she said I was ready to start pushing which really shocked me, I didn't feel ready. Suddenly the alarms went off on the monitors and loads of people rushed in the room. I didn't know who they were or why they were there and one said "We have to get this baby out now!". I can still see their face. I thought the baby was dying. They told me they needed to cut me and use forceps and I didn't feel like there was any discussion, it just happened so fast. When my son was born he didn't cry and I kept shouting "Is he ok?" No one was looking at me and I thought he must have died. I was in such shock, nothing seemed real."

I start this article with just two stories. I have heard thousands over the past twenty years. They are powerful and shocking and upsetting, but these are the most important words in this piece. Women's stories of their birth.

When we talk about childbirth being traumatic we mean that a woman, or anyone in the birth room, has found some part of the birth deeply distressing and fearful. It's unique to each person. It's their experience and their story. Everyone's birth story is valid and real to them and most women never forget their births. The symptoms of birth trauma can persist for many years. Birth trauma does not always equal post traumatic stress disorder; some women are traumatised by birth and do not develop PTSD but they are still hugely affected on a day to day basis and have many symptoms to cope with.

We must get so much better about hearing women's stories of birth, and allow women to talk freely about their birth whatever their experience.

Birth trauma might be due to one single event that happened, or a mixture of things in pregnancy, during birth or after birth.

Increasingly, we know it is not necessarily what happens medically at birth, but how a woman is made to feel during birth that is so important in whether they then feel traumatised. A study from 2018 showed that "what mattered to most women was a positive experience giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and competent, reassuring, kind clinical staff".[1]

So, it's how we are communicated with, a lack of kindness or compassion or feeling unheard that often causes women to feel

traumatised. Feeling helpless and afraid. Fearing that you or your baby might die. Feeling alone and that no one was emotionally caring for you. For example, a woman might have a vaginal birth that on paper looks straightforward and quick, but to her felt out of control and frightening. Her requests for pain control were dismissed by her midwives (who she had never met before that day) and her midwife changed twice during her labour. She felt that no one was explaining to her what was happening, conversations were going on around her, about her but not including her.

Or a woman's partner might find her being in pain terrifying, and feel helpless to support her as they want to take her pain away but they don't know how to help. When the emergency alarm sounds they don't understand what is happening and fear their partner and unborn baby might die. Everyone then rushes out of the room and they are left alone. No one has explained to them what is happening and they cannot find anyone in the corridor outside who knows what is happening.

When a person experiences birth trauma they often initially feel numb and shocked, they cannot comprehend what has just happened and may feel like they are in a dream. Then, often, there will be sense of feeling unable to stop thinking about the events of the birth, in their mind or in their sleep as nightmares. Those affected cannot stop these thoughts and feel unable to focus or think about anything else. People will replay the events over and over again and sometimes feel they are physically back in the birth room. Those affected may feel on edge all the time and expecting other bad things to happen, watching and scanning for new risks. Often people feel irritable and angry, or anxious and fearful: they cannot eat, sleep and have lost their sex drive. They are terrified that something bad will happen to their family or baby.

These feelings can happen for a few weeks, months, or even years after birth trauma. Trauma can persist for a very long time. Sometimes I meet women who have never spoken about their birth trauma from over twenty years ago. Symptoms may fade over time but often they do not and a second pregnancy can cause things to feel much worse again, understandably, as women face a second birth experience. Fathers, non-birthing parents and birth partners can be traumatised by birth, as can anyone in the room at the time. We know that rates of trauma are high in midwifes and other maternity professionals and that many are suffering and not being supported. We must be so much better at properly caring for, and valuing, our frontline maternity staff in order to stop them burning out and being unable to care for women in labour.

Birth trauma and/ or PTSD related to childbirth is sadly so often not well recognised or diagnosed. Many women are told that they have depression, by their GP for example, when they do not; or their experiences are dismissed, or they

are silenced by being told that their baby is healthy, so they shouldn't complain. Even if diagnosed, often women cannot access local, rapid, specialist treatment, leading to hundreds of thousands of women suffering silently each year after birth trauma.

It is so important then that we do all we can to minimise birth trauma from occurring, both for individuals and their families. We also need to change the maternity services, so that staff are better cared for and supported. As a society, we need to do more to recognise the importance of new motherhood and to ensure that all families can access the right support when needed. This is the focus of our work at Make Birth Better, a national collaborative of professionals and parents all across the U.K. Please join us via emailing us at *hello@makebirthbetter.org*. We meet in the north and south four times a year, have a vocal email group for sharing resources and conferences and we are holding our first training event in London on April 3rd 2019.

Dr Rebecca Moore is a consultant perinatal psychiatrist working in the NHS and privately with an expertise in birth trauma. She is the cofounder of **Make Birth Better,** *and a mum of two gorgeous kids.*

www.doctorrebeccamoore.com

www.makebirthbetter.org

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Trauma in Childbearing Conference

When: 15th May 2019

Venue: Edinburgh Napier Midwifery Society

Cost: from £10

Speakers include:

Sheena Byrom

Jenny Patterson

Laura Wood

Shona McCann

Geraldine Butcher

Mary Ross Davie

Michelle Wright

Sue Hampson

Birth Trauma Scotland

Emma Currer

Nurture Borders

https://www.facebook.com/events/488091368386077/permalink/492830977912116/

Article

Traumatised Midwives; Traumatised Women

by Jenni Patterson

My recent PhD research explored the development of Post Traumatic Stress Disorder in women following childbirth. Almost half of all childbearing women find childbirth traumatic (1), and 1 in 25 subsequently develop full Post Traumatic Stress Disorder (PTSD) (2) (Box A).

Box A: Features of Post Traumatic Stress disorder

The traumatic event involved:

experiencing or witnessing,
actual or threatened,
death or harm.

Experiencing symptoms in the following groups for more than 1 month

1. Flashbacks/nightmares related to the trauma
2. Avoidance of reminders of the trauma
3. Negative beliefs/thoughts, shame, blame
4. Hypervigilance, irritability, anger.

Women may experience trauma due to physical birth complications, medical interventions, or poor outcomes for themselves or their babies. However, the strongest predictors for the development of PTSD following childbirth are interpersonal factors, with a woman's negative perception of interacting with her care providers being significant (3). Thus, the woman/midwife interaction was the key focus of my research.

While many factors can influence midwives' interactions with women, here I discuss how witnessing women experiencing potentially traumatic birth events may compromise midwives' abilities to maintain positive interactions with women.

Secondary traumatic stress

Up to 60 times each year midwives may care for women who have been or are enduring a birth event where either the woman or her baby are at risk of, or suffer harm, which midwives may perceive as traumatic (4). Around 70% of midwives witness poor, disrespectful, or indifferent interpersonal care of women or high levels of obstetric interventions (Box B:1). Witnessing

women's trauma leaves midwives feeling horror (intense feeling of fear, shock and disgust) and guilt, both emotions more likely when witnessing interpersonal care-related trauma. A normal response to witnessing trauma, particularly to multiple exposure and through helping or wanting to help women, is for midwives to experience Secondary Traumatic Stress (STS). This increases their risk of full PTSD, as experienced by 17% to 33% of midwives (5, 6), which wreaks havoc on their lives (7).

Midwives are particularly vulnerable to STS

Midwives provide uniquely intimate support to women, often carrying heightened senses of empathy and responsibility. Midwives can develop close mutual relationships with women that are transformative and comforting for both, but may challenge normal professional/client boundaries. Yet, maintaining such boundaries might damage the sensitivity, effectiveness, and satisfaction of their role (8). This strong emotional involvement often means midwives open themselves and put aside their own needs. So, when a traumatic event occurs they can feel unprepared, unsupported, and overwhelmed, with a sense of failure and personal bereavement (Box B: 2, 3).

Box B: Quotes from the midwife informants in my PhD study

1. "Things were very badly managed, she was very badly treated (...) it's so frustrating. I was so angry! Brenda
2. "You do feel your care's then substandard (...) feelings of "oh', almost feelings of guilt actually." Susan
3. "cos I have not been able to do my job (...) really upset (...) really emotional" Brenda
4. "Sometimes I just switch off a little bit (...) that's a really bad thing to say but I think it's just self-protecting (...) you are battling all the time against the system (laughs) Alice
5. "conflicts between everybody" (Rosie)
6. "go between the two kind of parallel universes (laughs) and sort of try and make a bridge Brenda
7. "A lot of the time outcomes are devastating for people and we don't have any support" Rosie
8. "Not engaging with them very well but its, its like are personal...protection...of me because I can't, I know I can't." Brenda

Torn between two models of care

As highlighted in my research, midwives experience distress through trying to offer intimate, connected support through a midwifery model of 'Care as Gift' that encompasses trust, commitment, generosity, openness, respect and love. This is difficult within a medicalised model of 'Vigil of Care' that is surveillance-orientated and where the professional holds power (8, 9) (Box B: 4, 5, 6). This conflict is worsened by a dysfunctional and toxic culture in many NHS maternity services. Lack of support, disrespect, undermining, and bullying are rife, with midwives feeling vulnerable, betrayed and abandoned by their peers, and even more so by management (Box B: 5, 7). This is particularly so for student and junior midwives (7).

The impact on midwives

During traumatic birth events, midwives describe feeling the agony of being powerless to protect women while feeling responsible. They experience guilt and horror, with a sense of failing and wondering what they could have done differently (8, 10). When organisational demands leave midwives unable to provide compassionate care and feeling complicit in poor care, this creates shame, blame and further guilt that hurts midwives (11). These issues are often deepened by midwives' personal stresses and prior traumas. Yet, the pressured environment means midwives are unable to disengage and process these emotions, leaving them very vulnerable to STS and PTSD (12-14).

> *"It adds another scar to my soul" (13) p 4194*

For some midwives, STS can diminish over time. For others it can weaken their ability to adapt in future and lead to burnout, and a cycle of increased errors, more stress, more burnout. Midwives suffer extreme tiredness (6), become fearful, and their belief in the birth process is diminished (10). Midwives' confidence is damaged through this diminished belief alongside associated fears of causing harm or death, receiving criticism or facing litigation. Midwives cease to view childbirth as normal and natural

Article contd.

and so increase vigilance, risk management, and the use of interventions (6, 8, 10). In order to cope and feel less guilt midwives may gradually change their aim to offer 'Care as Gift' and align themselves to the reality of the system (15). This can reduce job satisfaction and leave midwives struggling to maintain a professional role with women, sometimes to the point of leaving the profession.

The impact on midwives' interactions with women

Midwives' experiences of STS and conflicting care models within systemic pressures that leave no time to comfort women affected by traumatic events or allow midwives to take care of their own wellbeing, can result in midwives withdrawing or switching off from women. Midwives may suppress their emotions and present a hardened demeanour, thus becoming less empathic or compassionate towards women, no longer be willing or able to enter intimate mutual relationships with women (4) (Box B: 4, 8).

While this may protect midwives from further STS, the loss of empathy and compassion, alongside being fearful, may lead to compromised care that ignores women and instils fear in women (6, 13). This is crucial, as for women who develop PTSD post childbirth, being ignored is the most frequent negative experience in women's interaction with midwives (3). My PhD research showed that positive interactions are most likely when the human needs of both women and midwives are acknowledged and met within the maternity care system, alongside the promotion and protection of compassionate woman/midwife relationships.

Positive growth for midwives

Following traumatic events and the development of STS, some midwives experience positive growth in areas of personal strength, appreciation of life, relating to others, spiritual change, and new possibilities. While personal characteristics influence this, being able to access safe, non-judgemental peer or managerial support to process their stories is beneficial (16). Often STS strengthens a midwife's resolve to better support women. They want their experience to inform and improve their practice and future collaboration with their colleagues. Positive growth following trauma can reduce fear and improve confidence. Midwives feel they can become better midwives, are able to maintain positive interactions and relationships with women and reduce their future risk of STS (6, 13).

The resilience of midwives versus organisational responsibility

Witnessing and being involved in traumatic childbirth events are inherent aspects of the midwife role. The ability to grow from these events or be brought down by them can depend on resilience. The responsibility for midwives to practice self-care and develop resilience is widely called for and an important skill in midwifery (17). However, when midwives experience trauma through witnessing poor interpersonal care; being prevented from providing best care due to systemic pressures; or being disrespected, undermined or bullied; the responsibility for improvement lies with the organisation. This requires NHS services to acknowledge and address damaging cultures. Throughout the hierarchy of staff, there must be an attitude of zero tolerance towards all actions and inactions that serve to undermine and harm midwives; damage care quality and interactions with women; and compromise midwives' abilities to cope during traumatic events.

When midwives experience trauma from witnessing adverse obstetric events or poor interpersonal care towards women, they require a non-judgemental culture in which their normal human responses and subsequent needs are acknowledged and appropriately responded to. This requires management to prioritise listening, providing time, offering nurturing care and psychological treatment as appropriate. Often, simply spending time with a sympathetic listener can help restore midwives to a place of equilibrium rather than trauma (12). Talking through traumatic experiences in a safe, supportive, non-judgemental environment can heal without scarring. Also, the traumatic event can be safely absorbed into the midwife's body of knowledge, while feelings of self-blame, responsibility, and incompetence can be alleviated. Midwives can explore how to do better rather than becoming defensive, which can help them offer and maintain positive compassionate interactions with women (13).

Take home points

1. Midwives can experience STS and PTSD from witnessing traumatic birth events or poor interpersonal care of women, or from conflict between models of midwifery care and working within a toxic culture.

2 STS and PTSD negatively impact on midwives' lives and wellbeing and their abilities to provide positive compassionate interactions with women.

3 Women's negative perceptions of their interactions with midwives is a significant factor in the development of PTSD in women following childbirth.

Steps for improvement

1 A non-judgmental culture is required to acknowledge and respond to midwives needs.

2 Damaging workplace cultures must be recognised and addressed.

3 An attitude of zero tolerance needs to be developed towards actions/inactions that undermine midwives' interactions with women.

While individual midwives can strive to support peers and challenge damaging behaviour, the ultimate responsibility lies at the highest levels. Such steps need to be sanctioned and upheld across UK maternity services by CCG's, Trusts, Health Boards, and management.

Improving the workplace culture and addressing midwives' needs will improve not only the working lives of midwives, but their interactions with women, and thus, women's mental health outcomes.

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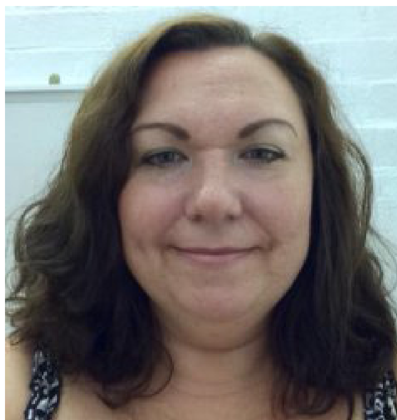
Article

The Trauma Between Us

by Amy Delicate



Birth trauma can have far reaching consequences on the wellbeing of women, partners, their infant, and the bonds between them[1]. Women and their partners can have a trauma response to childbirth[2] but the way they relate to, and process the birth trauma can be different[3]. Symptoms of birth trauma, particularly when experienced along with depression, are related to low couple relationship satisfaction[4]. This article aims to explore this topic further and outline the perceived impact birth trauma can have on the relationship between parents.

The quality of a couple relationship is important on many levels. Having a good quality, satisfying relationship with one's life partner supports positive personal well-being and good physical health. When a relationship is poor between parents it can impact on effective parenting, child-parent attachment and is associated with poorer child welfare, and more child development problems.

Whilst research on the impact of birth trauma on the couple relationship is limited, a recent review investigated and summarised what is known[5]. By analysing the qualitative evidence from seven international studies, four negative themes were found: negative emotions, lack of understanding and support, loss of intimacy, and strain on the relationship, along with one positive theme of strengthened relationship. The findings of this review are summarised in this article.

Experiencing negative emotions was reported in all the studies reviewed, with the most common emotion being anger between partners. Other negative emotions between partners included increased arguments, guilt around 'letting' the trauma happen, and conversely women 'blaming' partners for the trauma. In contrast to these hostile emotions, depressive mood was also apparent with relationship symptoms such as emotional numbness and detachment. This theme also highlights the considerable overlap seen between trauma and depression symptoms in the postnatal phase.

A lack of understanding and support between partners was highlighted in the review experienced as indifference, partners not understanding what women are going through, or partners showing irritation that the women's distress is prolonged. Some women also reported feeling neglected by their partner and a mismatch of support between partners was evident. This disparity in support was highlighted in terms of partners trying to help women through their difficulties but offering support that was ineffective, or not accepted by the women. Women identified that their partners also required support, but they were personally unable to provide this due to the difficulties that they were experiencing. Couples reported a reduction in how much they communicated due to a lack of understanding about the personal impact birth trauma had on a partner, or due to the process of talking about the trauma being too painful.

Following birth trauma, sexual relationships were often affected, with a loss of intimacy and reduction in sexual activity. Some women and partners reported having flashbacks when initiating sex, or avoiding sexual intercourse due to fears about becoming pregnant and having to go through the birthing process again. It was not just intimacy that was reported to be lost between couples, but this theme also noted that closeness, love and romance could also reduce between couples with some women highlighting that the dynamic of their relationship had changed to friendship.

There were also examples of some relationships being strained to the point of breakdown. Before breakdown, these strains were expressed as relationships being demanding, experiencing barriers in connection, frustration between partners, and treating a partner badly. However, in contrast, there was also evidence of birth trauma leading to couples working together to recover and heal - which had the effect of strengthening their relationship. Unfortunately, from the available evidence it was not possible to ascertain why some relationships strengthen when others decline after birth trauma. Future research in this area could provide vital information for protecting the couple relationship and therefore family wellbeing following birth trauma.

The findings from the review discussed above, were developed into a diagram (Figure 1) to illustrate how the relationship symptoms caused by birth trauma may interact. The diagram shows that the themes of negative emotions, lack of understanding and support, and loss of intimacy feed into the overall effect of perceived strain on the relationship. For some couples, traumatic growth can occur as they move through strain to experience strengthening of the relationship or, conversely, strain becomes too much, and the relationship ends.

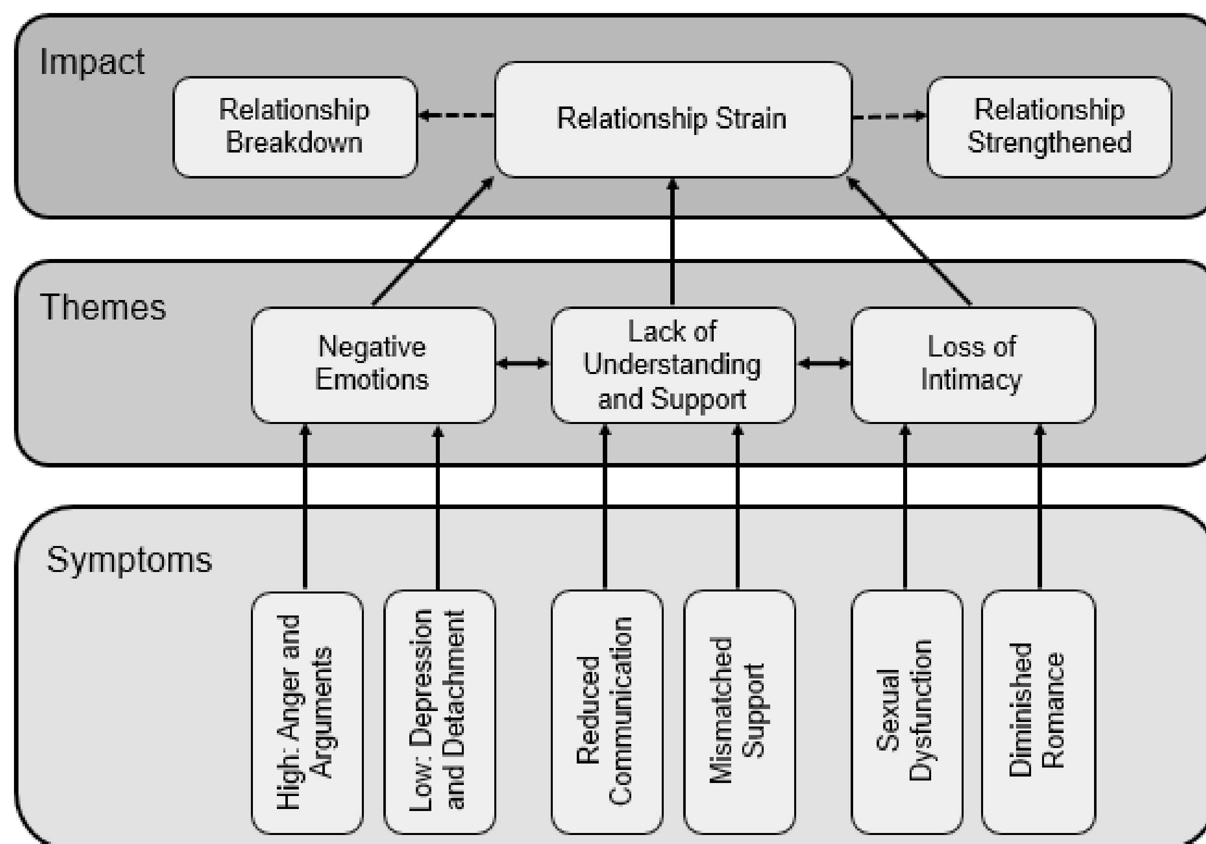


Figure 1. Perceived Impact of Birth Trauma on a Couple Relationship

A recent review[6] showed that there is similarity between the impact of birth trauma on a couple relationship and the relationship changes that many new parents experience. However, birth trauma appears to have a more severe, negative effect on the couple relationship. The transition to parenthood is a known stressor on a couple relationship and it is proposed that experiencing birth trauma may magnify those problems further.

Birth trauma, with its wide range of symptoms can affect all areas of life, including making it harder to cope with caring for a baby and create strong parent-child bonds. Parents often report feeling isolated, unable to talk about their birth trauma with other parents, friends, family or professionals. Therefore, at a time when a supportive couple relationship is a vital foundation to help overcome trauma, it is worrying that the opposite may be true. Birth trauma can place a great strain on a couple relationship which may reduce the quality of the couple's connection and even lead to relationship breakdown.

It is encouraging that research interest in perinatal mental health and birth trauma continues to grow and that referral pathways with suitable services are being developed to support prevention and recovery[7],[8]. The impact of birth trauma on a couple's relationship is a complex issue; one that needs to be further acknowledged and understood as motivation for the prevention of birth trauma. Similarly, it is vital that resources to prevent birth from being traumatic, and services to treat those with birth trauma are designed to meet the needs of women, partners, and their relationship.

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Article

After-birth service provision – an opportunity for resolution and renewal

by Dr Gill Thomson (BSc, MSc, PhD, FHEA)

Birth trauma, as with other forms of trauma, comes from being in a frightening, unbearable, powerless and helpless situation, and can lead to post-traumatic stress disorder (PTSD) onset. PTSD is a clinical anxiety disorder with available evidence identifying that around 3% of women in general population samples and around 17% of women who have more complex backgrounds or experiences (such as those with a mental health condition, women who had a stillbirth or premature infant) develop PTSD following childbirth (1). However, it is important to note that many more women (about 20-40%) experience PTSD trauma related symptoms (i.e. intrusive thoughts and images, avoidance, being on constant alert for danger (hypervigilance) and negative thoughts and emotions) without being diagnosed as having PTSD. While there are antenatal and intrapartum risk factors for PTSD, such as: a history of depression, previous PTSD, intrapartum complications and obstetric factors (1), it is women's subjective perceptions that are most important (2). Birth trauma is in the 'eyes of beholder' (3) and can occur irrespective of how the baby is born.

Trauma disrupts our memory processes. When we experience an overwhelming, frightening, inescapable event, our normal memory processes break down. The sights, sounds, smells and emotions associated with trauma become stored

as fragmented memories, rather than the experience being stored as an integrated memory that combines factual and emotional information. As the fragmented memories have not been adequately processed, they get replayed through nightmares and flashbacks outside our conscious control. Without some means to integrate these memories, the emotionally-imbued fragments continue to haunt us, leading to physical and psychological difficulties. Resolution of trauma involves the reprocessing of memories. Two recommended psychological-based interventions for PTSD are Eye-Movement Desensitisation Response and Cognitive Behaviour Therapy. These interventions involve techniques to encourage the individual to re-live the trauma in a safe, protected space and to resolve their negative emotions. While there have been some studies to assess and explore the impact of these therapeutic interventions for PTSD following childbirth, as yet, we have little high-quality evidence of what could really help women who are in this situation (4).

Women often want to talk about their traumatic birth experience with others – however their voices can be minimised through comments such as "the baby is fine", with childbirth relegated as a means to an end. When women's experiences are not shared by others, this can reinforce their feelings that their reactions are abnormal. Women who had a more straightforward birth (i.e. vaginal birth with minimal intervention) can also feel they have no grounds for complaint when compared to horror stories of prolonged labours, clinical procedures and postpartum complications. In the UK, after-birth debriefing type services were introduced in the 1990s for women to discuss and review their birth with a maternity professional, with service provision originally based on structured psychological-based therapies, e.g. Critical Incident Stress Debriefing (5). On one hand after-birth service provision was perceived by hospital trusts to be an important financial risk management tool, with opportunities to discuss the complaint enabling an early resolution; as litigation claims for maternity services have been reported at £3 billion+ over a 10-year period (2000-2010) (6), it offers a plausible solution. However, a further reason was the recognition that women needed to process and comprehend what happened during the birth. A recent study found that, while women did not often seek out support following a distressing or traumatic birth, the most preferred support option was to discuss their birth with a maternity professional. Women want to understand what happened to them and why, to receive validation and resolve self-blame – to know whether there was something they could have done to make a difference – and to prepare them for future pregnancies and births (7).

There is very little good evidence about the effectiveness of after-birth debriefing in terms of how it improves the emotional state of women who have had a difficult or traumatic birth. This lack of evidence led to a recommendation to not formally debrief women following childbirth in the UK's postnatal care guidelines (8), rather that women should be encouraged to discuss the birth and to receive answers as part of routine postpartum care. However, despite this recommendation, available evidence suggests that many UK NHS hospital trusts continue to provide an after-birth service in response to women's needs. These services are often solely provided by nominated midwifery staff (although they can be delivered as part of a multidisciplinary team, e.g. obstetricians, psychologists, counsellors, psychiatrists etc), and generally offer women opportunities to review their maternity notes, to discuss their emotional responses and for referrals into wider support to be offered as required.

A review of research into women's experiences of after-birth support reports that women recall a range of benefits such as increased understanding of what happened during their birth, feeling reassured, believed and empowered (9). Many women often only access after-birth support when they are pregnant again; when the enormity of having to re-face a traumatic ordeal becomes overwhelming. On these occasions, the after-birth support serves a dual function of helping the woman understand what has been and to prepare them for what's to come. In my PhD study (10), pregnant women who accessed the after-birth service were offered a range of support options from reviewing their hospital notes, re-visiting the birth environment, being allocated to a caseload midwifery team for the current pregnancy, and/or appointments with midwives and/or consultant obstetricians to co-construct birth plans. Women's birth partners often attended the after-birth meeting, and for some this provided the first opportunity to openly discuss their experiences and how they had been impacted. Women referred to how this support had been essential in enabling them to release some of the negativity

associated with their traumatic birth and to develop the strength and resolve to make their future birth a more positive event. Access to the after-birth service operated as a pivotal intervention that provided women with a sense of control and confidence. All of the women in this study went on to experience what I describe as a 'redemptive birth', a birth that enabled them to resolve and release the blame associated with the former birth and to feel proud and self-accomplished, irrespective of how the baby was born. While a key tenet of a positive birth is supportive caregivers, for these women, access to the after-birth service and consequent support was a key contributory factor (10).

It is important to reflect, however, that not all women's accounts of after-birth support have been positive. For instance, there are reports of women not being aware that the after-birth service existed, not being able to access it when needed, women feeling blamed or judged, and the support not meeting their needs. A recent survey of after-birth provision in England found that most services were under-funded, not well promoted, there were variations in when and how often women could access them, and while just over half were provided by midwifery professionals who had received no specific training, amongst those who had received training, the level and content varied widely (11).

Evidence highlights that women want timely access to non-judgemental, empathic support from maternity professionals to help them make sense of their traumatic or distressing birth (7). However, we are currently caught in a vicious circle in that, while after-birth services are provided in response to maternal requests, as 'debriefing' is not recommended in national guidelines there is a lack of evidence to underpin service provision. This leads to services offering what they can, often with insufficient resources and variable service provision. Due to high numbers of women affected by birth trauma and the negative and pervasive impacts of such on maternal, infant and family functioning, early intervention and support is crucial. The need to improve parental mental health is highlighted as a national priority. After-birth service provision offers great potential to help women process their memories of the birth, to help resolve their negative emotions, and to facilitate women's access to wider support. As such, further research to inform well-funded, evidence-based after-birth service provision should be prioritised.

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Article

Why didn't she leave?

by Zoe Clark

When they first met, she was obviously nervous. But excited, with a sense that something wonderful would happen. He promised her he would take care of her. That everything would be fine. She took such comfort in that. The future was bright and exciting, and she was filled with hope.

Over time, she found that he was pushy, no mistake. But he always had her best interests at heart, and she valued his advice. Sometimes she had her doubts, but she knew he was wiser, so she relented. She knew he would take care of her. Sometimes he was too busy to talk to her properly, but he always meant well. Sometimes he made her doubt her choices, and told her what she hoped for could never work. She wasn't always comfortable with that, but he always said if it really mattered, he'd help her to get what she needed.

Then the day came when she really needed his help, so she went to him. But he was so stressed from work and so worried about other things that he brushed her off. It was clear he did not care. He touched her in ways she did not want to be touched, and when she objected he told her that she was being silly, that she didn't know what she was saying. She stayed, because she didn't know what else she could do. He told her she was a failure, and that she needed him to help her, over and over again. She couldn't leave, and he wouldn't listen to her. Eventually he lost patience with her, and cut her up. It was for her own good, he told her.

She spent three days in hospital, and was permanently scarred. She would never be the same. She only learned later how bad the damage was. She was scared. He visited her house in the days following, and she smiled and nodded, just waiting for him to leave so that she could cry.

Then one day he asked her to come back to him. He understood that things had been really horrible for her, and he was honestly sorry. Things would be different this time, he said. And she knew he meant well.

Her mother encouraged her to return. Things were bad, she reasoned, but they could have been much worse if she hadn't had his support. And besides, she needed to think what was best for the baby. She'd be silly not to go back.

Anyone could see she shouldn't go back to him. They'd call her a fool.

This is my story. But it is not about a man who damaged me. It was my antenatal team. My midwives.

Article

The Night that was neither Silent nor Holy

by Beth Whitehead

I seem to struggle a great deal with flashbacks and anger about my births around my children's birthdays and Christmas. The latter caught me by surprise. I thought the trouble I had the Christmas before was because it was close to my second birth. With all the tinsel and sparkles, I couldn't feel much joy or excitement, and I was hardly functional on Christmas day. Having graphic scenes of birth and glowing scenes with sentiments of immaculate midwives on recurring ads by a major nappy brand just got too much for me. Sentiment by association sells I suppose, but a quick visit on the brand's Twitter page saw other women in a similar situation to me who found the graphic details triggering and unnecessary for TV too.

It is difficult to escape the thought of birth when many of the festive songs are about Christ being born, the holiness and silence of the night and the juxtaposition for me. I hope Mary was not expected to birth in silence. At my own births, a number of midwives made comments about me being loud (they even recorded this in my notes), having a low pain threshold and moving around too much. It was completely unprofessional and unkind. A birthing woman should be free to make as much noise or move how she likes. Birth was never meant to be judged by anyone. The people who think that they have the right to judge those giving birth are not safe to have around. They fail to make women feel safe by denying their inner knowledge.

Very often I see discussions of poor treatment of birthing women accompanied by a disclaimer that health care providers are well-meaning, have difficult jobs to do and didn't mean to cause harm. This does not really help anyone. There are layers and layers of people who defend health providers' practice. They even get to write in our maternity notes, a legal document, about what happened to us in pregnancy and birth. Words that may not always be fully reflective of our experience but can still be used as evidence. Their version of the "truth".

These are full grown, educated adults who know full well their position of perceived authority and influence. They have a choice in how they treat another human being. In my experience, when I said NO, I didn't want to be touched or given a certain medication, I expected to be respected because it was my decision. When someone forced entry to my room, coerced and deceived me to carry out protocols, well-meaning or not, abuse, assault and human rights violations took place.

We need to be honest in the narratives of birth abuses and stop excusing them. Only by acknowledging the realities of unbalanced power dynamics, the lack of professional accountability, the obscure ideas of birth/how women should birth and acknowledge that poor attitudes towards women exist, can they be addressed. Birth can be painful and exhausting, like running a marathon, but it doesn't have to be traumatic. The kind of hurt and trauma that insensitive words, forceful actions and lack of compassion, respect and dignity cause are mostly preventable. They are in the control of the health care providers.

Our healthcare system has got to get better at treating women well when we need its care and support the most. We have every right to be angry, and to demand better. Not every woman wants to be subjected to the highly medicalised model of birth. A model which benefits pharmaceutical and medical equipment companies, while bankrupting the NHS and hurting mums and babies that would have had better outcomes if their physiological births were genuinely supported. Choosing where to birth, home, midwife-led unit, hospital, stables, etc. is an expectant mother and her baby's birth right. It should be supported.

My daughter walked over cuddling her new doll and said, "Mummy, what are you doing?" I held her hand and looked into her eyes. I wanted to say, you were born out of love, to be loved, and not meant to be an object to be abused by people. This world needs to change to respect women and human rights. The war on birth freedom is not yet over. We must break the silence so obstetric violence can be addressed and peace will return to women and families. I went into the kitchen and lit a candle to remember all the women and babies that have been harmed. I pray that one day, the wounds in our hearts and on our bodies will heal, and the freedom to birth will return.

Improving Maternity Services for positive mental health outcomes: a checklist for action

In 2007, AIMS proposed a checklist of actions[1] which we believed were necessary to improve how the maternity service worked with the issue of perinatal mental health. At that time, we said that we had to think outside the box and concentrate on a broad strategy for the future. We noted that the primary prevention of trauma was crucial.

The awareness around the topic of perinatal mental health - as it affects mums, dads, babies and the wider family, not forgetting health care professionals too - has grown tremendously since that first checklist was published. And whilst the taboo around perinatal mental health problems has not yet disappeared, it has certainly been challenged in recent years, with increasing numbers of individuals prepared to tell their story.

There was an important focus on perinatal mental health in Baroness Julia Cumberledge's Better Births report (2016) and the priority of the issue in the Maternity Transformation Programme has again been confirmed in the NHS Long Term Plan (2019). But there is a huge difference between policy intention and successful policy implementation. The AIMS campaign group have therefore updated our checklist to reflect the views of campaigners seeking to achieve positive change in this area.

As the articles in this issue demonstrate, the research into this subject is growing, and we know much more now than we did in 2007. In that context, we find that too many of the issues on the original AIMS checklist remain both relevant and outstanding. In addition, calls to the AIMS helpline suggest that improvements to the maternity services in this area are still desperately needed.

Over the next few months, AIMS volunteers, as part of the Make Birth Better collaboration, will be discussing how we can all work together to keep a focus on achieving these campaign objectives. Do get in touch (*www.aims.org.uk/contact*) if you would like to be part of this work.

A CHECKLIST FOR ACTION

1. **We call for the full implementation of a Continuity of Carer model of maternity care for all women and families, in which all maternity staff are trained to offer culturally-safe care.** Mental health issues are not limited to specific groups and we suggest that the protective care of a known and trusted midwife throughout pregnancy, birth and the postnatal period, working as part of an effective multidisciplinary team, might play a large part in improving perinatal mental health outcomes, including by better identifying service-users most at risk of trauma and by working to both prevent and help resolve that trauma.
2. **We call for a greater emphasis to be given, both in research and in obstetric and midwifery training, to the psychological vulnerability of all those involved in the delivery of maternity services, including service-users, their family and supporters, and service providers.**
3. **We are keen to see epidemiological studies of incidence and likely causes of birth-related trauma and birth related post traumatic stress disorder (PTSD) rates (a) by birth setting and type of care and (b) by geographical area.**
4. **We are keen to see quality ratings for maternity services which include psychiatric morbidity rates as well as an appraisal of the quality of the local trauma specific treatment pathways available.**
5. **Where a woman's mental health has been negatively affected during her maternity care (either due to the nature of the birth or due to her experience of the maternity care provided, including interactions with staff), we call on each Trust to implement a system of case-specific investigations, assessing local processes as well as the actions of individual staff that may have contributed to this outcome.** These investigations should be focused on learning, and offer ongoing support for all staff involved. In the context of a no-blame learning culture we believe that mandatory reflective practice for all staff would contribute to the reduction of such incidents, but where staff are unable to meet the standards required then we call for a full range of remedial actions to be available, including retraining, suspension or dismissal.
6. **Recognising the ongoing mental health issues suffered by some women, we call for the abolition of the 12 month time limit for complaints about maternity care.** We suggest that PTSD sufferers are

often incapable of making a complaint within that time-period, given the likelihood of severe flashbacks being provoked by the premature reading and writing about their experience.

7 **We call for an improvement in the quality of postnatal care, in all settings including home, to prevent the exacerbation of trauma damage by poor postnatal care and also to ensure the early identification of mothers who would benefit from additional support.** This links to our call for the implementation of a Continuity of Carer model of maternity care, which should offer midwives the opportunity to agree a personalised schedule of postnatal contacts and which should extend to a smooth transition between the midwife and health visitor.

8 **We are concerned about local variability in the availability and effectiveness of care offered to women suffering from birth-related trauma, including the availability of specialist therapy and access routes to these.** In addition to the existing referral mechanisms, there should be universal self-referral mechanisms in place. Where Trusts do not provide the required services, or where women are keen to access care from an alternative provider (for example, if further contact with their usual provider is likely to cause further harm linked to previous experiences), CCGs must ensure that care pathways are commissioned so that women are able to access suitable out-of-area or independent care.

9 **We call on the researchers working on Confidential Enquiries into Maternal Deaths to report in more detail on associations between perinatal mental health and suicide.** In particular, where postnatal psychosis or depression has been ruled out in cases of maternal suicide, we believe that more detailed enquiries might sometimes identify traumatic birth and PTSD as a cause of suicide.

Links:

1 www.aims.org.uk/journal/item/post-traumatic-stress-disorder

Birthing Journeys: Positive birth after trauma

By Hannah Palamara

My journey to achieving my positive birth, a vaginal birth after two caesareans (VBA2C) was just as important as the birth itself. It was not an easy road but I am so glad that I believed in myself, and my ability to give birth.

It began seven years ago when I gave birth to my first daughter. I was 22 and had no idea that birth could be complicated…complicated by medical professionals. I just thought that I would go into labour, go to the hospital and give birth. I knew that I wanted a natural, drug free birth and that I wanted to use the pool. At 39+6, a Sunday, I woke up with strong period type pains and my contractions started a few hours later. They were every 15 minutes and pretty strong. I tried to carry on as normal, taking walks, having lunch with my family as it was mother's day, and getting reflexology to help things along. I went into hospital the next day as I had been up all night contracting and was exhausted. I was found to be 2cm and fully effaced but still in early labour so they sent me home with something to help me sleep. That night I slept and my contractions died off. The next morning they came back with a vengeance and by the afternoon they were very strong and getting closer together so I went back to hospital. I was very pleased to be 4cm and fully effaced and my labour progressed quite quickly from this point.

After about 4 hours I was 8cm and the midwife suggested breaking my waters. I had been using the pool and gas and air and everything was progressing very normally. I agreed, as I didn't realize I had a choice. I thought that was what was meant to happen if they were advising it. Looking back there was no reason to break my waters. Not long after they were broken I went into transition and then the baby's heart went down but then recovered. Then it went down again and stayed down. I was literally thrown on a bed and run to theatre screaming my head off. I was given a GA and a crash section. My baby was fine and she breastfed well straight after delivery.

I was traumatised by the birth and I suffered with PTSD and depression in the months afterwards. No one offered me counseling or talked through the birth with me. I was offered anti-depressants, which I declined. The doctor at the hospital muttered something about CPD (cephalopelvic disproportion – where the baby can't fit through the woman's pelvis) and baby not fitting so I started believing that my baby had got stuck and I could not fit her through my pelvis and that she had nearly died so thank goodness I had a caesarean. She was 7lbs and had never descended into my pelvis so a brash diagnosis of CPD was just an excuse and a label. Unfortunately I believed this and carried it with me.**In the years to follow I would always look back on the birth and feel traumatized and frightened by the experience. I had flash backs and the trauma stayed with me for a very long time, affecting me in my new role as a mother.** I was disappointed and felt that my body was a failure and somehow flawed. I felt that I would never give birth naturally and I so longed for that experience. I felt a strong primal need to birth a baby as though I wouldn't feel like a whole woman if I didn't experience it.

When I became pregnant with my second daughter 3 years later, I was determined to try again. I didn't even care if it was dangerous for me, as my parents told me it would be, I wanted a vaginal birth. At the hospital I was referred to the clinic for women wanting a vaginal birth after a caesarean (VBAC) and was very happy to be told that I could try for a VBAC. I was told I would need constant monitoring, regular vaginal exams, etc and I agreed, as I knew nothing about VBAC or about interventions during labour. Again I blindly handed myself over to the medical professionals thinking that they would take care of me.

During my pregnancy I followed a holistic birthing program to prepare my body and mind for a natural birth. I ate healthily, I exercised, I did yoga and listened to a hypno birthing CD. I also read positive birth stories. I didn't research VBAC or natural birth in much detail and just assumed that whatever they told me at the hospital was what was best for me.

Most importantly I did not deal with the fear and trauma I still carried from my first birth. When they offered me sweeps from 39 weeks I agreed excitedly thinking it would bring my baby sooner but not knowing anything about the risks of sweeps, especially when having a VBAC. At 40 weeks the midwife told me my vaginal arch was very narrow and she could barely reach my cervix. She also said she didn't think I had much chance of a successful vaginal birth.

This was a midwife working on the VBAC clinic in the hospital. I wasn't fully aware of it but the fear set in at that point. What if she was right and the baby couldn't fit through? I felt like a failure again like there was some abnormality with my body. That night my husband and I had a huge screaming row. I was so terrified that instead of voicing my fears to him I lashed out instead.

As the days passed by I grew more miserable and more fearful I had never expected to go 'overdue' as my first had been on time. I had a total of about 4 sweeps from 39-41 weeks. At the final sweep at 41+1 she was able to do a proper sweep as my cervix had opened and come forward a little. The next day I had some strong period pains just like with my first baby and got very excited that things were happening but no contractions followed so I felt disappointed. I ate a huge lunch and decided to take a nap. As I went to the bathroom afterwards my waters went with a pop. I excitedly ran and told my husband. The contractions started about 5 minutes later and were extremely strong. They were coming every 5 minutes so I called the hospital and they advised me to come straight in as I was a VBAC so we rushed to get ready. By the time we left they were every 2 minutes and I was so frightened as I thought the baby was coming right then.

At the hospital I felt completely out of control and out of my body. I was terrified that the same thing would happen as my last birth and could not settle myself into the contractions. I was examined and was 2cm, which really disappointed me. I had no idea that I could go from 2-10cm in a short time and thought I would be two days again with these much stronger contractions. Before my mother and my doula arrived I asked for an epidural, which of course they gladly gave me.

Fast-forward 18 hours and I had got to 9cm again with no help or drugs to speed up the process. The baby was not in a great position for birth. As I had an epidural I couldn't move or stand to help the baby to move down and I stayed at 9cm for four hours at which point the doctors started

talking about a section. They told me it was the best thing for the baby and me as we were both tired. My baby was fine, there were no signs of distress and I am pretty sure that had I turned off my epidural or just waited a little longer I would have birthed that baby vaginally. I consented and had a better experience with the caesarean than my first. I was awake and it was calm. My baby crawled up to my breast as I was wheeled in to recovery and started feeding all by herself.

Afterwards the doctor came and spoke to me and told me I should not try again for a vaginal birth as my pelvis was just too small and she didn't advise it. Again I was happy to have a healthy baby and a safe birth but I felt like a failure and told myself I just couldn't birth a baby naturally.

Almost 3 years later we were surprised to discover that we were pregnant again. I was still recovering from having meningitis one year previously, which had left me with some health problems, and I had just started an Open University course and was pursuing a career in photography. After the initial shock started to wear off I was excited but afraid to have a third baby. I was still struggling at times with my two girls due to my health; I had chronic fatigue and some days it was hard to get out of bed. I was referred to a consultant due to my health conditions and two previous caesareans. I didn't realize I could decline consultant led care at the time, which is what I would have done.

At first I thought I had to have a repeat caesarean due to my history and I told my husband that is what I would probably do but a voice in my head kept nagging me and I knew I wanted to try again. I was afraid that I wouldn't be 'allowed'. At an early 8 week scan with a private consultant my husband voiced my desire for a VBAC and this consultant who I had never met before, who had not seen any of my notes and didn't know my history told me and my husband there was a good chance that the baby and I would die if I attempted a VBAC due to the risk of rupture. He also lied to us about the percentage of uterine ruptures. Driving home I was absolutely furious and my husband was obviously terrified and thus began my battle to get my VBA2C.

This time things were different. I started trawling the Internet for information on VBAC especially after 2 or more caesareans. I joined groups. I asked questions, I read books and I did research every day. I educated myself and tried to educate my husband. I sent him lots of links and tried to get him to read positive birth stories. It took him a long time to come around to the idea of me even attempting to VBAC as he thought it was safer to have a repeat caesarean. I gently tried to explain that for me, the risks of a third caesarean outweighed the risks of a VBAC and the very tiny percentage of a possible rupture.

There were many fights and many tears on my part. I so desperately wanted things to be different this time but he was afraid and traumatized by my previous birth. **The more I researched the more I became positive I could do this, or at least try. I read that having an independent midwife, even if I was birthing in hospital, would really give me extra support so I found one that my husband and I were both comfortable with. This was a turning point for me. As soon as I met Laura I immediately felt like I could trust her. She had a very gentle nature but also really knew her stuff and she totally believed in me from day one.** My appointments always lasted a minimum of two hours. Laura was never in a hurry to leave and we spent hours talking about any concerns I had and going over my previous births. The more we spoke, the more I realized that I could do this! When I met my second midwife, Kemi, we spent the afternoon discussing birth and laughing together, the three of us, and I remember looking around the room just knowing that these were the right women to help me have my birth. I felt excited for the first time. I had found my tribe.

By this time I was 32 weeks and had not seen my consultant yet at the hospital. I had seen a registrar at 20 weeks who at first had been open to me having a VBA2C but after a brief 5 minute chat with the consultant had told me they didn't advise I try to VBAC and would recommend a repeat caesarean section. I was disappointed but not ready to give up.

At my next appointment I insisted on seeing the consultant and I was prepared. She met me with her supervisor of midwifery and she was not friendly. She told me she knew that I was hoping to have a VBA2C but that she didn't recommend it as they didn't have research to support whether VBAC after 2 or more caesareans was safe.

I told her that I had researched and read many stories of women having a successful vaginal birth after 2, 3, 4

and even 5 caesareans she laughed and said what did I expect my chances were for a vaginal birth? I said 75%. She laughed again and said that it was much lower than that. I told her I would be having a VBAC either at home or at the hospital. We went back and forth. She told me I would need continuous fetal monitoring, I told her I would decline it. She told me I would need regular vaginal examinations, I told her I wouldn't consent to them unless there was an indicator that it was necessary for the baby's well-being. She told me if I was in hospital she couldn't guarantee which doctor would be on duty and whether they would support me to have a VBAC. So if I came to hospital in labour, the doctor on duty might hassle me and try to force me into another caesarean.

It was so frustrating but I was strong. No one would bully me with fear tactics this time, as I knew the truth. We agreed a letter would be drawn up to be handed out to the midwives on labour ward and to go in my notes, stating that I was aware of the hospital's policy on VBAC after two or more caesareans and that I would not consent to continuous foetal monitoring, regular vaginal examinations, a time limit on labour, a cannula, etc, should I decide to give birth in hospital.

I left that appointment feeling like crying and filled with doubt. I was so tired. Was I making a mistake? I was trying to be so strong but people kept knocking me down and telling me I 'couldn't' do it. Was this doctor right? After a few days I continued my research, reading positive birth stories and I started to feel confident again, although I was very worried about being in hospital and having to fight for my VBAC whilst in labour. I therefore decided the best place for me to be was at home where I could labour in peace and not feel threatened by unsupportive doctors. It is sad that I had to choose my home because I didn't feel safe in hospital, but this was how I had been made to feel by the system around me.

At first I told my husband and my parents that I would start my labour at home and then transfer to give birth. My parents, both medical professionals, had been projecting their fear onto me for months and I didn't need their reaction to me having a homebirth so I kept it quiet. My husband took a while and eventually, as I started preparing for my homebirth, he realised I was planning to do it at home and he basically surrendered. He told me that he realised it didn't matter where I did it as God had already decided the outcome. As soon as my husband was on board I felt a huge weight was lifted. It didn't matter to me what anybody else thought but it did matter to me how he felt. Finally he was supportive and excited for this birth. The day he told me he believed I could push this baby out of my vagina I cried with happiness.

My due date came and went, which I had expected, as my last baby had been born at 41+3 but then the exterior abuse began. On a daily basis I had texts, phone calls and comments on the school run about why I hadn't had that baby yet. I knew that until I was past 42 weeks I wasn't really 'overdue' but no one else seemed to understand that.

At 42 weeks I was finding it really hard and every day was a battle; I had been in prodromal ('stop-start') labour for a month and every day the contractions got more painful. I had been losing my mucus plug for the last week, which was exciting, so I clung on to the positive thought of having my VBA2C soon!

My husband started to worry that things could go wrong, after seeking advice from a doctor about going past 42 weeks and he voiced his concerns to me. I had already discussed everything with my midwife and researched the outcomes and felt safe that I was making an informed decision to wait for my baby to come when he was ready. My husband went along with my decision but I know he was worried because he had only been told of the things that could go wrong and was not informed that it is quite common to go past 42 weeks.

That day I sat in my car and cried. I was so close and still people did not believe in me. I went and had a scan to keep my husband and everyone else happy. I knew my baby was fine.

The next day **I went into labour and had a beautiful hands off homebirth where I roared my baby into this world in my own home surrounded by people I love.**

This journey taught me so much about myself and about other people and their perception of birth. Many people see birth as a scary, risky process that needs to be 'managed' by doctors and not felt by women. They look at the 'pain' of childbirth as a negative instead of a positive feeling, when in truth the 'pain' enables our bodies and minds to produce the exact cocktail of hormones that help us to birth our babies ourselves. Most women, especially with their first babies,

expect to be given care from their health professionals that will help them to achieve a natural birth. Unfortunately, I hear time and time again of women having a traumatic birth experience because they were led to believe by doctors or midwives that interventions such as induction, epidurals, pethidine, artificial rupture of membranes, continuous monitoring and time limits on the process of labour, are routinely necessary. It is usually not until women have their second or third babies that they realize they have a choice in how things happen and start researching and choosing how they want to give birth. Of course there are times when medical intervention is necessary and saves lives and thank goodness we have the doctors and the hospitals for these rare instances. Unfortunately far too often doctors are 'saving' babies after a cascade of interventions actually causes foetal distress or some other complication. The system needs to change. Instead of women relying on doctors to safely "deliver" their babies, doctors need to believe in and empower women to birth their babies themselves and only step in when needed.

I believe birth is a normal process, a bodily function as normal as breathing, that when left alone and allowed to happen undisturbed, can be beautiful and uncomplicated.

A birth against the odds

Frankie Jack born Sunday October 20th 2013 1.02am.

Home water birth, Unmedicated Home Water Birth After 2 Caesareans (HWBA2C)

Saturday October 19th I woke up feeling tired. I was 42 weeks and 2 days pregnant and every day I wondered when this little boy was going to be born. I had been having pre-labour for over a month, every day the contractions getting stronger. My midwife came and checked on me that morning and we decided to do a gentle sweep. I had not wanted to have one prior to this as I was afraid that she might accidentally break my waters but I was getting so impatient and feeling under immense pressure from the outside world to have this baby now that I had exceeded 42 weeks. I knew that everything was fine with my baby and that he was coming very soon, but the negative comments were starting to wear me down.

I carried on having mild contractions throughout the day, the same as the ones I had been having for weeks. I had been losing my mucus plug for the last week and some more of it came away making me excited that labour would soon begin. My husband, Frankie, and I went into town and had lunch together and did some food shopping. Even though I was exhausted and uncomfortable, it was really nice to have some time alone together without our other 2 children. That evening we had dinner and afterwards decided to make love (even though I really didn't feel like it!) I was still having mild contractions but we knew that it might just start things off.

It worked! Fifteen minutes afterwards I had my first strong contraction. I walked downstairs and had another it was around 9pm. I said to my husband "I think this is it!" and he smiled excitedly at me. He started bustling around and getting things ready for our homebirth. My contractions were about every 2 minutes lasting about 30 seconds. I texted my midwife, Laura, to tell her that things were happening. I then realised how strong the contractions were getting and called her to tell her. She advised me to call her when things progressed. I took a hot shower and went downstairs to the living room. Frankie was setting up candles and drinks ready.

I had to go to the bathroom and emptied my bowels a lot which was extremely hard whilst having such strong contractions. I then asked my husband to call Aini, our nanny and friend who lives with us. I was a bit afraid of the strength of my contractions and wanted a strong woman there with me. I knelt on the floor in the living room over the mattress we had prepared and Aini massaged my back for me. I called Laura again and all I remember saying was "Come". I knew things were moving quite quickly and really wanted her there. I was so in the moment I didn't even think about my sleeping children upstairs or the fear of rupture or anything going wrong I just went into myself automatically.

I was not comfortable on the floor so I stood up and held onto the back of the sofa and every time I got a contraction I swayed my hips in a circle and bent my knees almost like a dance. Aini was rubbing my back and I don't know how long we were stood there but I suddenly said "I can't do this" and my husband said "Yes you can" I realize now that this was transition but it appeared so quickly I wasn't even aware of it. Aini then said to me "Are you pushing?" and I

snapped "No" but actually I was! My body had just started pushing all by itself! I think Laura arrived at this point and I asked for a bucket to be placed under me so I could pass urine. I don't know if I did but with the next contraction and push there was a gush of fluid into the bucket and my waters went. I remember saying to Laura "What do I do? I don't know what to do?" and she just said, "Follow your body Hannah you are doing it!" Frankie and Laura were quickly trying to fill the pool, which was taking ages and I remember just longing for the relief of getting into the pool as I stood there. I started to roar through the contractions as I pushed and it felt very satisfying to grunt and roar as I pushed. I stripped off down to my bra as I was just so hot!

Finally I was able to get into the pool and I think I must have run and hopped into the pool as fast as my big belly would allow me. The relief of the hot water was instant and felt so good! From here I really went into labour land. I was completely inside myself and I kept my eyes closed almost the entire time. If I wanted a drink I just said "water" and my husband poured it into my mouth and he kept putting cold compresses on my face and neck, which felt amazing. I held onto the two handles of the pool every time I had a contraction and I pushed with everything I had! During this time the second midwife, Kemi, arrived. I didn't see her but I just heard her quietly in the corner, which made me feel more at ease. I roared like a lioness with every contraction and Laura told me to keep the sounds low, which really helped. Sometimes I would say "I can't" as a contraction started and I would then change it to "I Can!" and I would repeat this to myself and everyone around me said "Yes you can, Hannah" which really helped me to get through each one.

At one point I was pushing so hard and I shouted out "I am a warrior woman!" it was funny but also it was exactly how I felt. I felt like an amazing warrior woman pushing out this baby with all my strength I felt like I could do anything. The adrenalin was really pumping and my whole body was shaking with the strength of the contractions. With my consent, Laura monitored the baby's heartbeat frequently and every time it was great which made me feel relieved every time. Frankie stayed in front of me the whole time and he kept saying "I love you so much, I am so proud of you" and I then took hold of his hands and with every contraction I pulled with all my might and he held on. I took my strength from him at this point and I felt his love and strength flow into me through his hands. I started to feel the baby's head moving down and stretching me out. I pushed so hard and the head started to come out a little then go back inside. I said "It keeps going back in" but Laura reassured me this was supposed to happen so that the head would stretch me open gradually, stopping me from tearing.

I carried on like this for some time and then Laura told me we had been pushing for 2 hours but everything was progressing normally so she was not worried. She said we would review again in half an hour. To be honest this scared me a little and I started pushing with a renewed vigor and seemed to get the hang of pushing and holding the baby's head in place to stop it going back up again. I changed my position to squatting as I was on my knees and this with the harder pushing really started to bring my baby's head out. At one point I said "Is the head coming?" and Laura said "Yes feel!" and I did and I felt the head right there! It was amazing and I felt a spark of excitement and I said "I am going to see my baby soon!' and everyone around me said "Yes you are!" I felt a pop and my water went again, Laura told me there was meconium but it was only grade 2, which was not very thick, and baby seemed fine. She had told me before I went into labour that she would expect some meconium at this stage as most babies open their bowels in utero from 40 weeks. As I pushed out my baby's head it hurt but I knew if I kept going he would soon be here and I pushed through that pain barrier. Laura recommended me to stop pushing and breathe which was really hard and I squealed a bit with the pain and said I couldn't. However, Laura and Kemi strongly recommended I did as they could see the strength of my pushing and were afraid I would tear badly so I breathed the head out and I felt it slowly coming out. As his head emerged I went into myself so much that it was as though I could see inside myself and see the head coming out from the inside. I pushed hard and the head came out and I carried on with a scream and as the contraction was still there I pushed again and my baby's shoulders and body followed in the same contraction! At this moment I seemed to wake up from my labour trance and I heard the midwives saying "reach down and get your baby Hannah" I looked down and all I could see were his little

feet and curled up legs and I reached down and picked up my baby and held him against my chest. All I kept saying was "I did it, I did it" and my midwives smiled and said, "Yes you did it!"

I had lost quite a lot of blood so I got out of the pool and lay on a mattress and as soon as I lay down the placenta came on its own without any drugs less than 15 minutes after the birth. I carried on losing blood but it did stop and my uterus started contracting again. I lay and looked at my beautiful son and nursed him for the first time. I was so tired I couldn't move for the next 4 hours and lay having drinks and snacks. My husband took Frankie and had skin to skin with him giving me a chance to rest. I got up to try to pass urine before my midwife left and as I sat on the toilet I realized that I was bleeding heavily and I started to feel like I was going to pass out. My midwife got to work putting me on oxygen and giving me a shot of syntocinon and we called an ambulance. This was a scary time. I was trying not to pass out and could hear my girls outside the door and was hoping they couldn't see me. I was stabilized before I left in the ambulance and stayed overnight in hospital due to the volume of blood I lost. I had a few tears stitched up in theatre but my perineum was intact which was amazing. This was a hard part of the experience and my recovery was slower because of my bleed, but I still would not change a thing. I felt so much better than after both my c-sections. Frankie Jack was 8lb12.5oz, a big boy, and his head was tipped to the side, the same as his older sister, which meant I pushed a much wider diameter out – so much for being told my pelvis was "too small" and my vaginal arch "too narrow" to vaginally birth a baby. Labour was 4 hours from start to finish! I am immensely proud of myself.

I will never forget this birth for as long as I live. This was what I have been dreaming about for 7 years. 7 years ago I had my first emergency c-section. This birth has healed me in so many ways and empowered me as a woman and a mother. I know that this has changed me and I will see these changes in many areas of my life as time goes by. It has healed the trauma of 2 emergency c-sections and being told I could 'never' birth a baby naturally. It has healed the trauma of being sexually abused throughout my childhood and teenage years. I have taken my innocence back and am a strong, beautiful warrior woman.

Research Review

"Women's descriptions of childbirth trauma relating to care provider actions and interactions."

Gemma McKenzie reviews *Reed R. Sharman R. and Inglis C. (2017) Women's descriptions of childbirth trauma relating to care provider actions and interactions*. BMC Pregnancy and Childbirth, 17:21

Background to the study

The authors highlight that around one third of all women experience birth trauma. This can result in mental health problems such as post-traumatic stress disorder and post-natal depression. The consequences of this can include a disruption in family relationships, such as the mother-baby bond, which may potentially affect a mother and child's later emotional wellbeing.

What was the aim of the study?

The researchers aimed to understand women's experiences of birth trauma.

How did they do this?

The researchers created a survey which they promoted on social media. The survey contained a number of questions, but the research article was based solely on the responses given to one question in particular: "describe the birth trauma experience, and what you found traumatising." Once the responses had been collected, the researchers analysed them by drawing out the themes that appeared in the answers that the women had given.

Results

A total of 943 women responded to the survey, and, out of these, 748 (79%) completed the relevant question. The majority of women came from Australia and Oceania (36.8%), North America (34.2%) and Europe (25.5%). A very small number of women came from South America (2.1%), Asia (0.9%), South Africa (0.5%) and the Middle East (0.2%). Although some women described their trauma as stemming from events such as premature labour, haemorrhage or concerns regarding their baby's wellbeing, the majority (66.7%) described care provider actions and interactions as the traumatic element in their experience.

The researchers recognised four overarching themes that appeared in women's responses:

1 Care providers prioritised their own agenda over the needs of the woman.

The authors gave various examples of this, including obstetricians making it clear that they wanted the woman to give birth soon so that they could go home. In some cases, this desire to speed things up led women to experience unnecessary medical interventions such as caesarean sections.

Other women reported being used as a learning resource for staff, often without the woman's consent. One woman described "20 people in theatre and half were sitting down on phones and chatting away while I had someone train with forceps on me" (p.4). It appeared that women having unusual births were also subjected to this, particularly those attempting breech vaginal births.

2 Women's embodied knowledge (i.e. their understanding of what they could feel happening in their own body) was disregarded.

From the data collected by the researchers it appeared that care providers dismissed women's embodied knowledge. Instead, care providers relied on their own clinical assessments of events. This was particularly apparent when women complained of being in pain or in labour. Women's natural urge to push was also disregarded, with some women being told to stop pushing until care providers deemed it appropriate. In one example given, a woman reported her midwife spending an "hour yelling at me not to push and trying to talk me into an epidural" (p.4). Similar reports were given when women intuitively felt that there was a problem with their baby. When women attempted to inform care providers, their embodied knowledge was disregarded.

3 Women experienced lies and threats from care providers.

Some women reported being lied to by care providers in order to coerce them into unnecessary interventions. This frequently centred on lies regarding the risks to their unborn baby if they did not comply with medical demands. If women did not comply, threats of having their baby taken from them were also used. A common threat was the "dead baby threat." An example given by the authors was one woman who attempted to decline an intervention being asked: "Do you want a dead baby?" (p.5).

4 Women were violated by care providers.

The violation women described included feelings of being bullied and disempowered, with some respondents using language such as rape and mutilation. In addition to this, some women reported physical violence and assault, often to get them to consent to interventions. One woman described how during a cervical check the obstetrician "grabbed my cervix and pinched it. She would not let go until I consented to letting her break my water. I was in tears from the pain…" (p.6).

Some women screamed "no" as care providers carried out procedures, in particular vaginal examinations. Other women described being pinned down by maternity staff during procedures or tethered to the bed with equipment. Further examples given by the authors included women having their legs forcibly opened and being physically pushed onto their backs. Women who had experienced previous sexual abuse or rape described how this form of violation triggered previous distressing memories, with one woman reporting that the birth was more traumatising than her experience of sexual abuse as a child.

AIMS' response

It is impossible to know how many of these examples relate to women's experiences of giving birth in the UK. As the authors note, it is also impossible to know whether these examples are from births that took place last year or twenty years previously. However, from AIMS' experience from women who contact us through our helpline, these examples are not new, and sadly not surprising.

As the rates of induction and caesarean sections sky rocket, and as maternity services become stretched and overburdened with staff focusing on guidelines and policy, compassion and emotional support for women become side lined. Yet women's rights and individual needs should be central to all maternity care. Birth is not just a physiological process, but for many women an emotional and spiritual experience too. What this study highlights is that when maternity staff fail to respect a woman and her rights, or cater for her emotional needs, it can have a devastating effect on her later wellbeing. With the reports of physical abuse and violation it also raises questions about society's perception of pregnant women more generally, particularly with regards to staff's belief that it is appropriate to manhandle a labouring woman in such a way, and to disregard her rights to informed consent and bodily integrity.

For maternity staff this study reiterates that they should be mindful of the words they use and the behaviour they display towards labouring women. They should also remember that appropriate emotional support may result in a much more positive birth experience for the pregnant women they work with. For those women who have experienced birth trauma, it appears that the problem is widespread. In short, you are not alone. And for the birth activist, it is clear that our work is nowhere near complete.

Conference Report

4th Annual Birth Trauma Event

by Maddie McMahon

When I became a doula nearly 16 years ago, the term birth trauma was largely unknown. There were certainly no conferences dedicated to the subject. It is heartening that the intervening years have seen a growth in awareness of the psychological impact of birth, both on the birthing person and their partner and wider family.

Along with a greater understanding of birth trauma has come an explosion in services tailored to meet the needs of traumatised families and a much greater interest in exploring this important topic. Part of this consciousness raising is due to sterling work by a few individuals, one of whom, Dr Rebecca Moore, perinatal psychologist, is responsible for the annual birth trauma event, which this year was in Chinatown in London.

Rebecca is part of The Make Birth Better campaign (makebirthbetter.org), a multi-disciplinary group of interested campaigners, including AIMS, working to raise awareness and understanding of birth trauma amongst birth workers. You can read more about the campaign and AIMS involvement here.

This year's conference was clearly designed to provide detailed information on birth trauma itself; its ripple effects and tools that can provide support and comfort to affected families. It was a packed menu, perhaps a little too packed, but I understand the temptation to include as many fine speakers as possible in this one-day event. The general theme seemed to focus on recovery from birth trauma, both physical and emotional, together with the potential knock-on effects of a traumatic birth.

We heard from Sakina Ballard, member of the Make Birth Better network and hypnobirthing teacher, who clearly explained the psychological causes of trauma and PTSD. Anya Hayes, pilates instructor, called for greater acknowledgement and treatment of pelvic floor damage and its impact on mental health. Susan Parker, 3rd year student midwife, shared her project around paternal postnatal depression, reminding us that 8% of fathers suffer from mental health challenges post-birth.

Alison Barker, nutritional therapist, introduced the term 'postnatal depletion': a term I found useful to sum up the potential impact of an unsupported birth and postpartum period and the impact good nutrition can have on a mother's experience. Next,

author and academic Diane Spier shared her postpartum wellness plan. This was followed by the talented women of WILD ABOUT BIRTH, a theatre piece that mixes narrative, comedy and audience participation to explore the notion that, perhaps we are telling the wrong stories about birth.

The day was completed by listening to the experiences of Deirdre Madden and Emma Sheridan, who recounted their experiences as traumatised mother and art therapist working together through Emma's tough feelings around her birth. The final session of the day was presented by Shweta Panchal who shared her wisdom gained from using yoga movements and breath work with traumatised parents.

There was much wisdom and practical information included in the day, notably the reminder that trauma is a complex topic and whilst we can't forget the attendant pain and suffering, trauma can also be an opportunity for growth and transformation, as the sharing of this Cynthia Occelli quote reminds us:

> *"For a seed to achieve its greatest expression, it must come completely undone. The shell cracks, its insides come out and everything changes. To someone who doesn't understand growth, it would look like complete destruction"*

Overall, I found the day useful and validating and I look forward to the Make Birth Better campaign further influencing maternity care in the UK. However, I admit to being a little disappointed at the lack of exploration of why birth trauma happens in the first place. Given the general acceptance that postpartum symptoms of trauma and PTSD are on the rise, it seems to me that any discussion of this topic should not fail to discuss the root causes, otherwise we risk falling into a fatalistic attitude of acceptance.

Even the talk of birth plans during the day centred around the need for women with previous trauma to plan for her next birth. I feel we need more discussion of preventative measures and an exploration of the evidence for birth care that may avoid trauma in the first place. I think it would be useful, therefore, to talk about NHS short staffing, lack of continuity of carer, the epidemic of induction and the case for improved social support from family, community and doulas.

In conclusion, thank goodness for the Make Birth Better network. It was heartening to see so many midwives at this event. I hope in years to come that more obstetricians will attend events such as this.

Born into Positivity – An Example of a University Midwifery Society Conference

by Katherine Minelli

Are you interested in maternity matters, but finding it difficult to develop or update your knowledge? Useful events can often seem too far away, prohibitively expensive or steeped in an intimidating level of jargon, especially if you're new to the field. However, if you live near a university, there may be accessible and cost-effective learning and networking opportunities right on your doorstep. Many university midwifery societies[1] now open up events (and sometimes membership) to the public.

One example is the UWE Midwifery Society[2] conference, 'Born into Positivity', which I attended recently. As well as students and prospective students, there were midwives, doulas and antenatal teachers in attendance. The theme of the conference resonated with me. As a mother, I have been asked a few times whether I had a normal birth, but never whether I had a happy birth. That's not to say that the mode of birth is irrelevant – a growing body of research suggests quite the opposite – but rather, there are other factors alongside the type of birth which also matter to the experience of women and their families. We know that negative birthing experiences can leave women traumatised and, in some cases, make it difficult for them to bond with their babies, so it is clearly important to identify factors that encourage positive birth experiences, and understand how to recover from negative ones.

After a brief introduction from UWE Midwifery Society's President, the first speaker, Mark Harris, came on. One of the hosts of Sprogcast[3] and the founder of Birthing4Blokes (*https://birthing4blokes.com*), Mark quickly engaged the audience with humorous anecdotes about his experience of being the first male midwife in Warwickshire in the early '90s and his more recent experience of working with fathers-to-be on how to support their partners. He claimed that midwives should stop talking about empowering women, and instead think about "pointing to the power" that women already hold within them. A great point, I thought. Even the most well-meaning professionals can forget that women are the protagonists of their birth story and should have the strongest voice. Pointing to the power of birthing women means listening to and respecting their choices and of course their right to make them.

The second speaker was Claire Nutt, a massage therapist, midwife and one of the founders of the Birth & Wellbeing Partnership and Fund (*www.birthandwellbeing.co.uk*), a community interest company offering a range of wellbeing services. Claire described how women who have experienced traumatic births and stressful pregnancies can still go on to have positive experiences, given the right tools and support. A strong proponent of the salutogenic model (promoting health and wellbeing), she spoke of techniques used to promote the three Cs – Calm, Comfort and Connection – which help people to deal with anxiety. She reminded the audience that the best way to understand how to help others was to practise self-care.

After lunch there was a Q&A session with Clemmie Hooper, midwife and author[4]. She was asked how young people could be better educated about pregnancy, birth and breastfeeding and how, as a society, we can encourage positive birth experiences to be communicated. Although there are no easy answers to these questions, I agreed with Clemmie's response which was that we should have more open conversations in general and, in particular, with school children.

The final speaker, Siobhan Miller, described herself as "a mum on a mission". She recounted how she was inspired to set up her hypnobirthing company, the Positive Birth Company (*www.thepositivebirthcompany.co.uk*), after she had a fantastic birth experience with her second child following a difficult first birth. Siobhan explained how overcoming fear, positive thinking and the right environment can produce biological effects which facilitate birth. Arguing that every birth has the potential to be positive, she asked midwives to consider how to prepare the room to make it more homely, demonstrating her point with an amusing Failure to Progress YouTube clip[5]. I am sure that she inspired a lot of the audience to reflect on their practice.

Siobhan also spoke about the effect of language, as had most of the speakers before her. In fact, this was one of the common themes throughout the conference. Here are some of the points that came up:

- The language professionals use can both reveal and actually sustain unconscious bias. I've already mentioned Mark's point about "empowering women". There was also an example from Clemmie. She recounted how a colleague had spoken about a woman "refusing" a particular intervention rather than "declining" it.
- The use of negatives is unhelpful. For instance "don't panic" will always have the effect of making someone think about panicking.
- We should talk about power rather than pain – e.g. "how powerful?" rather than "how painful"? Siobhan even suggested referring to "contractions" as "surges" due to the different connotations the words conjure up.
- Although orders such as "just hop up on the bed" may seem clear and helpful when given to a woman who is in a state of vulnerability, they should be avoided as they infantilise the woman and, once medical professionals adopt this tone, it is easy for them to stop explicitly asking for consent.

I gained so much from attending this conference and by the end my head was buzzing with all the new ideas. If you enjoyed reading this, I would encourage you to look up your nearest university midwifery society. Who knows what you could learn?

Notes

1. A list of university midwifery societies can be found on the MIDIRS website: *www.midirs.org/midwifery-societies/*
2. For more information on UWE midwifery society, please visit their Facebook page: *www.facebook.com/UWEMidwiferySoc/*
3. Available at: *soundcloud.com/pinterandmartin/sets/sprogcast*
4. Clemmie has written How to Grow a Baby and Push It Out and the How to Grow a Baby Journal. For more information, please see *www.penguin.co.uk/authors/1078354/clemmie-hooper.html*
5. Available at: *www.youtube.com/watch?v=lpkgWyJKn8I*

Being a birth activist: An interview with Virginia Hatton

Virginia Hatton (currently an AIMS trustee) has been active in national birth campaigning since 2012 when she started volunteering for AIMS. Virginia has also volunteered locally with the York Home Birth Support Group, Healthwatch and the Treasure Chest Breastfeeding Group. In this interview we have asked Virginia about her life as a childbirth activist and her role as a childminder supporting her local birthworker community.

1 When did you get involved in birth issues, and why?

I am American, and I've always been interested in birth and women's health, particularly throughout history. At university I took a class on 'Gender Science and Culture' where we read Robbie Davis Floyd's "Birth as an American Rite of Passage". I also interviewed my mother about her birth experiences. My MA research was on archaeological evidence for maternal mortality in the past, and I concluded that our modern bias towards the medical model of childbirth colours how we interpret birth history.

I had my first child 6 years ago, in the UK, and it was my first experience of the NHS. Though I was delighted that home birth and midwives were part of the system rather than on the fringes as they sometimes are in America, I was disappointed that the care on offer still seemed to follow the 'medical model' rather than the 'midwifery model' that I had expected. I had a home birth against medical advice and this started my journey towards birth activism.

2 How did you get involved with AIMS?

I had written to AIMS when I was first planning a home birth and found the response very supportive. After I watched the documentary 'Freedom for Birth', I knew I wanted to get involved in some kind of birth activism and my doula recommended joining AIMS. I went to my first AIMS meeting in 2012 and the focus on action, instead of complaining how bad things were, was so refreshing. I was hooked!

3 Can you tell me about some of what you've achieved within AIMS?

I have really enjoyed supporting the AIMS publications. When I was pregnant I found the AIMS book on induction to be extremely helpful and reassuring. When I had the opportunity to help with the rewrite of the book, I was thrilled to help continue to make this resource available to other women.

4 I understand that you are a childminder for birthworkers. Can you tell us a bit more about that? How did you get into this line of work?

I trained as a doula in 2013. This was excellent preparation for my birth related volunteer work, but unfortunately I was not able to work as a doula due to limitations on childcare that I had at the time. The same year I registered with Ofsted as a childminder. Since I couldn't work as a doula myself, I wanted to offer the kind of childcare to other birth workers that I needed myself. And there turned out to be a great need for it in my area.

5 Can you help us understand how midwives working in a Continuity of Carer model of care might be able to get their childcare needs met, especially with the overnight on calls that are a key part of that care model? What needs to happen in terms of childcare options to facilitate that new way of working?

Having a relationship with the childcare provider is really key. Since I am involved in birth work in my area, local doulas and their families and children know me already. So even if I only look after a particular child occasionally while their parent is at a birth, I'm already a familiar person, and they know me and my children. I make an effort to be available for families to get to know me (for free), by meeting at the park for playdates, etc, and this is mutually beneficial. I am registered with Ofsted to provide overnight care and I have special rates which apply to overnight stays. I have a clear fees policy, but I am happy to work with families to meet their needs during on call periods. At the moment, I do not charge for the time that I am on call, but my fee for if I do look after the children during the on call period is higher than that of an average childminder. I am usually only one of a combination of childcare options that birth workers use, for example I may be on call for them during the week or weekend only, and the other times someone else is on call for them. Communication is really important, as is planning and booking childcare well in advance.

6 What changes have you seen in maternity care - for the better or worse?

In my area, support for home birth by our local trust has increased which is really positive. The number of closures of the service have significantly decreased since we started putting in Freedom of Information Requests on the number of closures every year. (a campaigning tip I learned from AIMS!) However despite the reduction in closures, there are still a lot of issues to resolve in order to make home birth accessible to everyone in our area who wants one.

7 What has been your biggest frustration in your time as a birth activist?

I had a very challenging experience as a volunteer for our local MSLC. It taught me how much volunteers need to be valued and supported.

8 What do you hope for the future of the UK's maternity services?

In the future I wish we could get rid of the word 'choice' when it comes to maternity care. I think it is tempting to come up with individual solutions to the challenges we face in maternity care, such as being 'informed' or 'prepared'. But in order for all women to have the high quality care they deserve, it is not and should not be down to individual choice or preparation. The problem is the system, not women's choices. We need to work together to create a new system that provides Continuity of Carer to all women.

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Place of birth: What are my options?

Any woman, whether she is expecting her first baby, second, third or more, has the right to choose where she wants to give birth. Depending on where you live it may be easier to access some options than others. The main options are:

A Homebirth. Women giving birth at home are usually cared for by either NHS or Independent midwives. Mothers can hire a birth pool and use whatever methods they want for managing labour. Midwives usually carry Entonox ("gas and air") and sometimes opiate drugs if wanted, but if a woman decides to have epidural analgesia she needs to transfer to a hospital obstetric unit.

A Birth Centre (sometimes called a Midwife-led unit or MLU) where all care is provided by midwives. They focus on maximising the chances of a straightforward birth, and usually have a homelike setting with birth-pools in all or most rooms. Normally all forms of medical pain relief are available apart from epidural analgesia, and some offer alternative therapies such as aromatherapy. They usually have a homelike setting to encourage relaxation and the flow of hormones that help labour to progress. There are two types of Birth Centre - to learn more see https://www.aims.org.uk/information/item/choosing-place-of-birth

An Obstetric Unit (OU) is a maternity unit within a hospital where doctors are available to provide medical care if needed. Doctors will usually only be involved if there are medical complications. Otherwise, women who choose to give birth in an OU will be cared for by midwives...

Read more about the different options here:
www.aims.org.uk/information/item/choosing-place-of-birth
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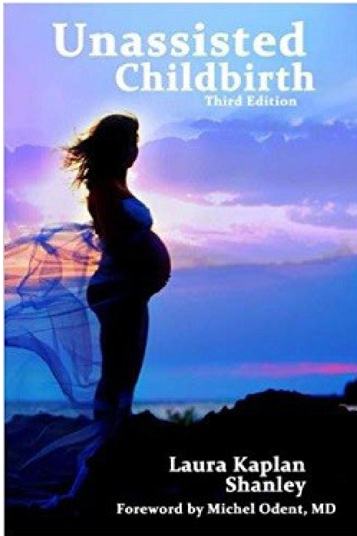
Book Reviews

Unassisted Childbirth

by Laura Kaplan Shanley

CreateSpace Independent Publishing Platform
(3rd edition, 2016)
ISBN 978-1-49915-203-6
206 pages

Reviewed by Gemma McKenzie



This is a book about the much maligned and often misunderstood world of unassisted childbirth. An unassisted birth (or freebirth) occurs when a woman intentionally gives birth out of the presence of health care professionals. This is usually at home with those close to her, such as her partner, friends or family. A book on this subject therefore looks at pregnancy and birth in an unconventional way - as a non-pathological and natural female physiological process. However, its content remains important to those working to improve the maternity system, as it challenges accepted norms and provides an alternative perspective on how some women prefer to approach birth.

The book is not a 'DIY delivery' type of book, nor does Shanley advocate unassisted birth. It is also not an academic hard read. Instead, it is an explanation of an alternative way of birthing, and an account of Shanley's own spiritual and birthing journeys.

Shanley begins with exploring the ease with which animals and 'tribal women' give birth, highlighting anthropological accounts of how women in other societies appear to have experienced few complications. She also highlights the role of intuition and the reliance of internal authority, arguing that Western women have become reliant on external authority to tell them how to behave and are therefore quick to dismiss their inner selves. In contrast, the current practice of highly medicalised birth is condemned, and Shanley gives a bleak outlook with regards to maternal and infant outcomes relating to the use of medical interventions.

Throughout the book, there are some insightful snippets of wisdom for both pregnant women and those working within the maternity system. For example, Shanley argues that "the insistence on pushing in labour is simply a reflection of our cultural attitude that force and haste are superior to trust and patience" (p.25). There is also an interesting discussion on pain, in particular that birth can be pain free if women approach it without fear and let go of the negative messages around birth that society often bombards us with. While I'm not entirely convinced of this argument (for example, I think some pain may be the body's way of telling the mother to be that the birth is imminent), I do think that there is some truth in what Shanley is saying. In particular, it is interesting to consider whether childbirth is more painful if women are filled with fear and anxiety, and it is certainly arguable that a woman's state of mind may play a role in how complicated or protracted her birth becomes.

The book has frequent religious (Christian) undertones, which may be great for some readers, but was not really to my taste. Some sections of text also seemed a bit far-fetched for me (for example that people could regrow their teeth using the power of their minds). Having said that, there is a lot of positive energy in the book, and some truly magical birthing stories. My favourite chapter was Shanley's own account of her life. Written with humour and honesty, it took the reader from her middle-class Jewish childhood through to her rather unconventional early adult life via spiritual texts, unassisted childbirth and topless dancing.

While not written specifically for a British audience, the book does provide an alternative way of thinking about birth, and I would recommend it to women interested not necessarily just in freebirth, but also to those who want to try and make their births as natural as possible. Equally, for those engaged in the maternity services, the book provides an opportunity to challenge one's own understanding of birth, and serves as a discussion point for ways in which the maternity system can be improved to better support women's needs.

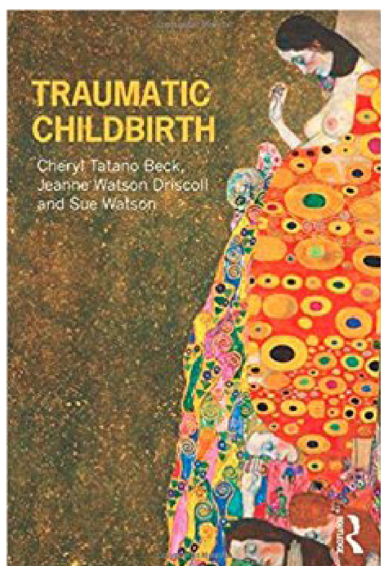
Gemma McKenzie is an AIMS volunteer and is currently undertaking doctoral research at King's College, London on women's experiences of freebirth.

Traumatic Childbirth

by Cheryl Beck. Jeanne Driscoll, Sue Watson

Routledge, 2013
ISBN 978-0415678100
272 pages

Reviewed by Mari Greenfield



This book comes from a collaboration between an academic researcher, a psychotherapist, and a mum who runs a support group for people affected by traumatic birth in New Zealand. All three have a long history of working with women who have had traumatic births, and have previously worked together as researchers.

This book focuses mostly on post-traumatic stress disorder (PTSD) as a result of childbirth, but much of the book is also relevant to those who experienced a traumatic birth without a diagnosis of PTSD. The book takes the reader through a journey, discussing first what a traumatic birth looks like from the point of view of someone experiencing it, then looking at the links between traumatic birth and PTSD, and then examining the systems within the brain that lead to PTSD. Cheryl Beck's other research on related issues is then presented, including the links between traumatic birth and breastfeeding, why birthdays can be so hard after a traumatic birth, and what happens in subsequent pregnancies. I found this research really useful, as these consequences of traumatic birth are often not talked about.

Treatments for PTSD are then discussed, and the book ends with a roundup of what was known in 2013 about the effects of traumatic birth on fathers and midwives/ intrapartum nurses. (There is no research so far on lesbian partners, doulas, obstetricians, or others who might be present at a birth). The book offers a brief introduction to a number of treatment methods includes debriefing, cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). With the NHS in England announcing more help for men whose partners experience health problems last year, and with more interest in the issue of traumatic birth generally, this chapter is very useful. As the chapter makes clear, these treatments are not interchangeable or equal, and getting access to the wrong treatment can make problems worse.

I really liked how much women's voices are 'heard' in the book, both directly as short birth stories, and indirectly as case studies from the authors' professional experiences. However, the book is not an easy read. The academic and medical sections are presented in a way that is understandable for the lay reader, but require attention to properly grasp. The birth stories and case studies are so important, but are a difficult read for anyone who has been affected by a traumatic birth themselves. They are also frustrating, as stories from 20 years ago and the present sound so similar, and so many of the experiences related could have been so different with better, more compassionate care. For me, this was perhaps the most important message of the book: there is still so much that we as parents, birth workers and campaigners have to do.

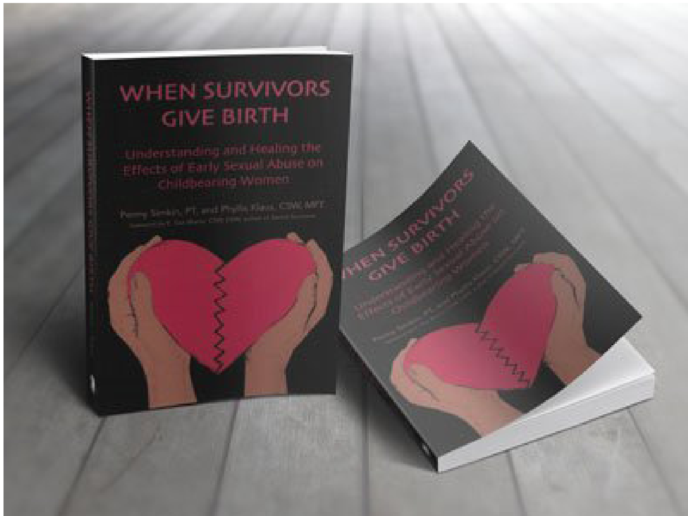
Mari Greenfield is an academic researching maternity services, a doula, and a doula mentor.

When Survivors Give Birth

by Penny Simkin and Phyllis Klaus

Quality Code Pub (2004)
ISBN 978-1594040221
450 pages

Reviewed for AIMS by Kicki Hansard



So many light bulbs went off in my head when I first got my hands on this book and it all made so much sense! This book is written for both survivors of childhood sexual abuse (CSA) as well as for those of us who care for them during the childbearing year. Penny and Phyllis are doulas and childbirth educators and Phyllis is also a psychotherapist. The combination of all their knowledge as well as their experience of working with CSA survivors makes this the go-to book for anyone who is a CSA survivor as well as anyone who wants to educate themselves on things to consider when supporting CSA survivors in the childbearing year. Penny and Phyllis are also two of the founders of DONA (Doulas Of North America) and created the very first official training courses for aspiring doulas. It took them 8 years to write this book.

The book is divided into four different parts, each focusing on different areas. In part one we get to read about the long-lasting impact of CSA on the child, the adult and also how this impacts on a woman during pregnancy, labour and birth and in the postnatal period. The authors' knowledge is interwoven with stories from survivors. This part of the book is very helpful to get an overall idea of possible triggers, how survivors can protect themselves from a traumatic birth experience, as well as all the clinical challenges for survivors and how their caregivers can support and help to ensure a positive experience. Statistically we know that 1 in 4 women are survivors so the chances are great that if you are working in maternity you will definitely be supporting survivors.

The second part of the book is all about communication, with some great examples of how birth workers can ease communication and give the space for survivors to disclose and talk about their abuse. There are even scripts showing how some phrases and word choices could make it more difficult for everyone involved and how to really consider how we talk to women to prevent a break-down in communication. Penny and Phyllis also talk about the power differences between women and caregivers, unhelpful ways of reacting to a woman who discloses as well as practical solutions to ensure the promises caregivers give are kept. There is also a section on self-help methods for survivors to prevent and manage distress during childbearing and suggestions for good communication with the caregivers.

Section three is specifically about clinical challenges and solutions, and here a few other authors have contributed towards the book. A midwife gives a detailed explanation and scripts for supporting survivors through pelvic examinations. We have another midwife who gives suggestions on how to prepare and follow through on a care plan for survivors. Finally, an obstetrician has contributed with a chapter on how to support informed decision making and advocacy. This section is mainly for medically trained caregivers but also gives survivors a really good idea about what practical steps they can take to feel more in control of the care they receive.

In the final part of the book you will find appendices and resources to use in your work as a birth worker or as a survivor. Most of the forms and questionnaires can also be found on-line and they are really useful to have access to and use in your work, especially the trigger form, which will really help you to pin-point areas that might be more difficult for a survivor and then plan how to deal with those situations.

Overall, I would go as far as saying that anyone who works with women during pregnancy, childbirth and in the postnatal period should have this book on their bookshelf. The care and considerations talked about in this book for

CSA survivors makes so much sense, and as you read it you will keep coming back to the fact that ALL women should be supported and cared for in the sensitive and kind way this book describes. The book is full of stories from survivors, outlining how the care they received helped them or how some things that happened to them during their maternity experiences traumatised them more.

It's an easy to read book in terms of how it is written but it is also hard to read at times, when you learn what survivors endure and get an understanding of how the smallest things can make the biggest difference for a woman's birth experience.

The book might appear a bit pricey but I would say it is worth every penny. It's the kind of a book that you will keep going back to and as there is nothing else really on the market that comes close to this book, it's well worth the investment.

Kicki Hansard is a doula, doula course facilitator and AIMS supporter.

Obituary

Mary Cronk, 1932-2018

Mary Cronk's family announced that Mary had passed away on the morning of 21st December 2018. She was known nationally, and internationally, as an expert midwife and breech birth specialist. I first met Mary at an Association of Radical Midwives (ARM) meeting about 18 years ago. I was impressed then that this famous midwife was very down to earth, and had faced similar challenges to all of us in her long career. I was also privileged to have later worked with Mary as an independent midwife, and taught workshops with her over a 9-year period. What set her firmly amongst the greatest midwives of our time was not just her 50 years' experience as a midwife, but who she was as a person.

I often wondered what made her such a great midwife, and I am sure her formative years were instrumental in moulding the strong woman I knew and loved. Mary was born in a time when formula milk was being sold to mothers as "The Food of Royal Babies". Mary told me how her own mother had informed her midwife that she would certainly not be using formula milk, and she would be nursing her baby (Mary). Mary grew up with stories about her mother's midwife, who must have made quite an impression on Mary as she remembered her by name. At this time all families had to pay for services from a midwife or doctor. Mary's father was a Clydeside ship worker. In her chapter in Mavis Kirkham's book "The Midwife-Mother Relationship"[1], Mary says,

> *"My father had great difficulty paying doctors' and midwives' bills and welcomed the NHS. I have often wondered what he would have thought about the changes in the relationships between professionals and their clients since its inception."*

She described midwives as 'professional servants'. This was an idea she knew would not be popular with many midwives, because a servant may appear to have less power over a woman, but Mary was no stranger to people disagreeing with her. In The Midwife-Mother Relationship, Mary goes on to say,

> *"I believe that our assumption of power over the women for whose benefit we practise at the beginning of their parenting can begin their disempowerment as parents and take from them the feeling of responsibility for their children on which good parenting depends."*

Mary had had a period of very ill health in her youth meaning she spent a long period as a patient in hospital. Her experience of being on the receiving end of care must have given her great insight into the nursing profession. Mary embarked on a nursing, then midwifery career, which spanned a period of five decades. Even when Mary retired from clinical practice (she worked well into her 70s) she continued to share her skills of breech birth using the oral and visual traditions of storytelling and sharing pictures of the women she'd cared for.

Whilst a nurse, Mary suffered a back injury and spent the last half of her first pregnancy in hospital on traction. She was separated from her baby but demanded that he should be brought to her immediately. The love of her family further emboldened her spirit, and in a blog by Midwife Gloria Lemay she described the fierce protectiveness that parenthood can bring.[2]

Mary's strong independent spirit was echoed by her love of sailing. She and her beloved husband, Joe, built a boat in which they sailed the Mediterranean with 3 young children.

Mary says she learnt to be assertive at the very first ARM meetings in the 1970s, through roleplay, 'sharing the skills' sessions, and through solidarity with a sisterhood of likeminded midwives and students. Her assertive phrases are now well known by women and midwives alike. Mary's strength as a midwife enabled her to encourage other midwives and service users to find their own inner strength. Filmmaker and former midwife Bernadette Boss captured Mary talking about her assertiveness phrases.[3]

With the advent of the NHS Mary went from working autonomously as a community midwife to working "under the hospital" and sometimes struggled with hospital policies. She describes her training, and how she reconciled a hospital policy of performing an episiotomy on every woman, with her own experience of helping women give birth with an intact perineum.[4] We can learn a great deal from stories like these.

Mary was a feminist, an activist, who fought tirelessly to improve maternity services through her work with ARM, AIMS, the RCN and the NMC. She educated families as well as her sister midwives, so they could make informed choices. As an independent midwife she cared for many families that NHS care failed to serve. Women expecting breech babies, planning VBACs or twin births, at home and sometimes in hospital. Whenever her clients needed to give birth in hospital Mary ensured they got the very best NHS maternity care, because as she put it "Women shouldn't have to give birth at home to give birth in peace."

Mary Cronk is perhaps best known for facilitating, and teaching about, physiological breech birth. Her article published in 1998 by AIMS5 helped equip a new wave of midwives with the skills to safely support vaginal breech births. She taught workshops called "A Day at the Breech" and "Once More unto the Breech" in venues across the UK. She also shared her skills with the midwives who were lucky enough to work with her (myself included). She made me promise to share the skills of breech birth, and I'm sure she made other midwives to promise likewise. Mary loved sharing her stories and was a great story teller. This oral tradition deserves to be valued much more than the much-maligned anecdotal evidence. So many midwives have gained confidence to safely attend breech births because Mary's stories and photos provided solid evidence that breech babies can be born safely.

What made Mary a great midwife rather than just a good midwife was her integrity, compassion and her humility. Her ability to stand with women and their families even in the most difficult of circumstances, by freely sharing her midwifery knowledge, and answering queries from midwives and members of the public well into her final year of life. We can all learn lessons from Mary's way of being with-woman, and pass on the legacy of her work through story-telling, as well as the written word. It is our job now to take up where she left off in the fight for human rights in childbirth.

Mary is survived by her husband Joe, her two living children Maggie and Peter (Mary's other son, John, sadly predeceased her), four grandchildren and two great grandchildren. She will be sadly missed by all who knew her and her work.

Joy Horner RM

Further reading and other materials:

1. Kirkham, Mavis 'The Midwife-Mother Relationship' (2000) [Palgrave-Macmillan] and also see AIMS' Book Review of Mavis Kirkham's book, "The Midwife-Mother Relationship": https://www.aims.org.uk/journal/item/book-reviews-22-3#2

2. Gloria Lemay's blog with Mary Cronk. "The first time that the iron entered my soul" *http://wisewomanwayofbirth.com/the-first-time-that-the-iron-entered-my-soul-by-mary-cronk-mbe/*

3. Mary's Phrases: *www.youtube.com/watch?v=kxGBEwFAGho*

4. Mary Cronk and hospital policies: *https://youtu.be/zkssfpuVjpAJoy*

5. "Hands off the breech": *www.aims.org.uk/journal/item/keep-your-hands-off-the-breech*

Implementing Better Births

Continuity of Carer statement

Bringing the woman's perspective to the fore

Commissioners and providers across England, guided by their MVPs, are working across the country to implement sustainable Continuity of Carer models of care, initially for at least 20% of the women registering for maternity care from March 2019 onwards. To support this work, the AIMS Campaigns Team has developed a series of statements (below) to illustrate what AIMS believes the successful implementation of this initiative should feel like to women accessing maternity services. We hope that it will be useful in ensuring that women's experiences are kept at the centre of all ongoing implementation and evaluation efforts.

1. I have a midwife who is responsible for coordinating all of my pregnancy, birth and postnatal care.
2. I am able to contact my midwife directly.
3. My midwife provides the majority of my pregnancy, birth and postnatal care.
4. Any midwifery care that is not provided by my midwife will be provided by one of a small number of midwives who work closely with my midwife, and I will have the opportunity to meet these midwives during my pregnancy.
5. I can expect my midwife to attend all pregnancy-related appointments at my invitation, for example meetings and consultations with obstetricians, anaesthetists or other specialists.
6. My midwife will be with me during labour, at the birth and immediately afterwards, even if my midwife is not the only care provider present.
7. Any midwifery care during labour that is not provided by my midwife will be provided by a midwife who I know and have met before.
8. Where a large part of my care is undertaken by maternity care professionals other than a midwife, for example an obstetrician, I can expect to see the same professional at every appointment.
9. I have the option of changing my midwife or any other healthcare professional.
10. These statements hold true regardless of what is happening in my pregnancy and my chosen place of birth.

AIMS hopes that these statements, written from the woman's perspective, will prove useful, as services across England develop their models of care and start to communicate to women what their expectations should be of a Continuity of Carer model of care. They should also be helpful as services seek to evaluate their service provision with respect to meeting the Better Births vision and the national Continuity of Carer expectations.