AIMS For a better birth...

An interview with Dr Rebecca Moore from Make Birth Better (MBB)

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Interview by Alex Smith

Hello Rebecca, thank you for agreeing to answer some questions about your work with Make Birth Better. I wonder if you would start by introducing yourself and by saying why it is that you were drawn to this role.

Yes of course! My name is Dr Rebecca Moore. I am a perinatal psychiatrist and the Co-Founder ofMake Birth Better.

I have been working in perinatal psychiatry since 1999 and I love the field. It's a mix of psychiatry, obstetrics and paediatrics and it's an immense privilege to work with women through a pregnancy and the early part of being a parent.

It is a time of such unique vulnerability and one where women can get very mentally unwell very quickly but can also get better very quickly. It's so important women have specialist support around this time as maternal suicide remains sadly far too common in the UK, even in 2023, so this is a time where women and birthing people need intensive care and support.

I love psychiatry because in essence, for me, it's about hearing people's stories which are endlessly

fascinating and an honour to hear. I have always worked in London and this has meant that I have worked with colleagues from all over the world and worked with families from all over the world too. No one day is ever the same and it's an immensely rewarding career.

Can you tell us a little bit more about how MBB came into being? What was the trigger, who were the founders, and where do you come in?

Over the years as I sat with women and families after birth I heard increasing stories of birth trauma. What people really wanted to do was to debrief their personal experiences and to understand their birth and they often found there was no space for them to be heard.

At that time in 2007 there wasn't much known about birth trauma, and it certainly wasn't something I was taught about during my training. I felt I needed to learn more in order to offer more meaningful support.

So, in 2009, I planned the first annual birth trauma summit and we just had our 8th this year. It was a complete labour of love organised by me with no budget, but the positive power of social media meant that when I asked 'who knows about this?', I got lots of answers. The first conference had researchers, experts by experience, therapists, fathers and partners; over 200 people turned up on the day. It was the most amazing day of stories, tears, sharing about the ripples of trauma, and learning about how we can work together to make birth better.

Then I met Dr Emma Svanberg, a clinical psychologist and she was also looking at birth trauma and had done a thematic analysis of women's birth stories. We joined forces and Make Birth Better/MBB was born.

Since then MBB has grown into an amazing collective and we work via training, campaigning and activism.

We trained over 3000 NHS staff in 2022 around birth trauma and trauma informed care and I am really proud of the work we are doing.

We are part of the first All-Party Parliamentary Group (APPG) in Parliament with a focus on Birth Trauma, and we have just collaborated with PANDAS on a document for new parents to download for free to help facilitate those often difficult first conversations around our mental health with healthcare professionals.

I do a lot of the teaching and training with MBB and I love this aspect of the work. I really value hearing from colleagues about innovative practise and how services all around the UK are evolving.

Why do you suppose there is a need for MBB? What is going on?

Unfortunately we know that many women in the UK, around 30-40% in most studies are traumatised by some aspect of their perinatal experience and that means that large numbers of women, birthing people and partners are subjectively traumatised each year.[1]

We know that a smaller proportion, around 3-8 percent of all women who give birth per year, will go on to develop a clinical episode of post-traumatic stress disorder or other diagnoses such as Depression or obsessive-compulsive disorder (OCD) due to the experiences they had during pregnancy or afterwards.[2]

This might be due to one thing that happens, or it is often a combination of things that might happen antenatally, during the birth, or postnatally.

So here is the story of Kate, a first time mum who had no continuity of care through her pregnancy and saw a different midwife each time. One midwife told Kate the baby was large and this made her feel a bit worried about the birth but no one explored this. Kate was overdue and ended up being induced. it's not what she'd hoped for but she was not really given any options and she said it felt like she was suddenly on a conveyor belt that she couldn't get off. Kate said the induction was very long and she did not sleep for three days. At the very end she said there was suddenly a panic about the baby's heart rate. No one was talking to Kate directly but she could see the midwife's face change and look worried and she hit the emergency buzzer. Kate said she started to feel really panicked and the room suddenly filled with people and her partner was pushed further and further away from her into the corner of the room. Kate said the doctor said that the baby was in trouble, she did not know exactly what that meant and assumed it meant the baby might die. Kate said she felt completely terrified and helpless. She said her son was born and did not cry and then he was rushed off to NICU. She said she had not even seen the baby and so she assumed he had died. It was only after 45 minutes that Kate learned her baby was alive and she did not meet him for several hours.

This is a powerful story and you can see the layers of trauma that Kate experienced. She describes many of the key things that people find traumatic, she felt increasingly panicked and out of control, she did not feel people were talking to her or explaining what was happening. She felt lonely and separated from her partner and she feared her baby was going to die or had died[3]. People often start off by feeling very shocked and detached after such an experience and then over time go onto develop other symptoms of trauma, replaying the events, nightmares, visual images of perhaps the midwife's shocked face, feeling anxious and on edge, feeling something else bad might happen to them or their baby, for example. These are all classical trauma symptoms.

Have you thoughts about what would need to happen within (or without) the maternity services to make birth better?

This is a huge question!

> *What I know is that huge numbers of people each year are coming away from their perinatal experience significantly traumatised and this has to change.*

We need to think really systemically about this in my opinion and tackle this issue on many levels.

Of course, at the very heart of things we need women and birthing people to be able to come into NHS

services that are safe. Services need to be fully staffed and teams need to be trauma-informed and healthy so that they consistently provide kind, compassionate and women centred care.[4] We know that maternity services are in trouble in many places, not all of course, and that record numbers of staff are leaving the NHS. We also know that teams are working with members of staff being burnt out and thus providing poor care to women so we get a cycle of trauma going on.[5] We need the government to invest the money it promised into maternity services.

We need better antenatal care and this needs to provide a space where women can ask questions about birth and discuss all the ways birth might be. Women need to be better informed and to understand their real choices around pain control, instrumental birth and/or induction for example. Many women go into labour not knowing this and never having any real discussion and this becomes a trauma that could have been avoided with better antenatal care and discussion.

> *It's crucial that all people who support women and their families, in whatever setting, understand the importance of birth trauma and that many cases of birth trauma can be prevented.*

The words and language we use are important, we talk about this in depth in our Every Words Count Campaign which you can see on our website, with trauma phrases said to people are often a key part of their trauma that can stick and loop in their minds for months and years.

We need to provide culturally sensitive and dignified care to all. The ongoing MBRRACE results identify that we need to act now to improve outcomes for black and brown women, and we need to know about rates of trauma for the LGBTQIA+ community and how we provide bespoke care for them as a group. I think we need to come back to person-led, bespoke care that really listens rather than tick boxes and checklists!

We know that at least one third of the cases of birth trauma stem from a lack of interpersonal factors (including safety, kindness and respect), so we need to constantly teach, train, and model respectful interpersonal skills, and reflect on the care that we give. Personally I think we don't do this well enough at all in the NHS. We need to ensure that, as teams, we can reflect on our care, safely challenge poor care, and hear the voices of women and their families to learn from these in order to constantly improve and adapt. I think we need to involve peer support more often and to listen to the voices of Networking Maternity Voices Partnerships (MNVPs) and third sector groups.

We need to screen better for trauma during pregnancy and screen for trauma post birth and think about how we do this and when.[6] I would like women to be screened for trauma more at their 6-8 week postnatal check for example or at the eight month developmental check with the Health Visitor. So we need to ensure GPs and Health Visitors feel confident around trauma and work in a trauma-informed way as well.

It can sound daunting but change is happening, and I would say never forget what you as an individual can do in your own practice, to train others or to fight for change. If we hold in mind trauma and work with a set of internal trauma-informed practices - listening, kindness, reliability and advocacy - then each of us

can model what we want to achieve and cause wider change.

How can MBB help on an individual level, and how can it help bring about change for everyone.

I hope, for individuals, MBB offers lots of support and stories of healing. At our website, there are a lot of free resources; a supportive online community; and help for women to begin to find access to support. I also think for many, it offers a space to finally feel heard and be validated; we work very hard to be a space where all the stories of birth can be heard.

On a larger scale we work to spread knowledge with our amazing champions who work in their own geographical areas. We campaign and collaborate with lots of other groups to create broader change, and we of course train lots of different groups about birth trauma, trauma-informed care, trauma after loss, and how to look after ourselves when working with trauma. We hold an annual two-day online summit each May, which all can attend to share the amazing research and initiatives going on around the world to reduce trauma and support families after birth trauma.

Author Bio: Rebecca is a consultant perinatal psychiatrist based in London and the co-founder of Make Birth Better an organisation which seeks to reduce trauma for women and birthing people and those working in maternity settings by campaigning and training.

Rebecca is a medical cannabis prescriber and is interested in the use of novel psychedelic medicines for those living with and healing from trauma.

Rebecca believes kindness is a much-underused skill in medicine alongside fierce activism and challenging of the status quo. She is a mum and outside of work enjoys travel, watching trashy TV shows, seeing live music, long dog walks, eating a lot and sleep.

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1 Yildiz PD, Ayers S, Phillips L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. J Affect Disord. 2017 Jan 15;208:634-645. doi: 10.1016/j.jad.2016.10.009. Epub 2016 Oct 27. PMID: 27865585.

2 Ayers S, Wright DB, Thornton A. Development of a Measure of Postpartum PTSD: The City Birth Trauma Scale. Front Psychiatry. 2018 Sep 18;9:409. doi: 10.3389/fpsyt.2018.00409. PMID: 30279664; PMCID: PMC6153962.

3 Editor's note: As Rebecca explains, the experience of trauma is subjective and can follow an experience that on paper is recorded as being normal and straightforward. What trauma stories often share though are accounts of poor communication; lack of empathy, kindness and support; fear; helplessness and neglect.

4 Nagle U, Naughton S, Ayers S, Cooley S, Duffy RM, Dikmen-Yildiz P. A survey of perceived traumatic

birth experiences in an Irish maternity sample - prevalence, risk factors and follow up. Midwifery. 2022 Oct;113:103419. doi: 10.1016/j.midw.2022.103419. Epub 2022 Jul 9. PMID: 35930929.

5 Hunter B, Fenwick J, Sidebotham M, Henley J. Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. Midwifery. 2019 Dec;79:102526. doi: 10.1016/j.midw.2019.08.008. Epub 2019 Aug 12. PMID: 31473405.

6 Lefever-Rhizal D, Collins-Fulea C, Bailey JM. Trauma-Informed Psychosocial Screening and Care Planning: A Patient-Centered Improvement Project in a Midwife Clinic. J Midwifery Womens Health. 2023 Sep-Oct;68(5):652-658. doi: 10.1111/jmwh.13512. Epub 2023 Jun 7. PMID: 37283369.