AIMS For a better birth...

After-birth service provision - An opportunity for resolution and renewal

To read or download this Journal in a magazine format on ISSUU, please click here

AIMS Journal, 2019, Vol 30, No 4

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.

References

1. Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. Psychological Medicine 2016;46(6): 1121–1134.

2. Andersen LB, Melvaer, LB, Videbech P, Lamont RF. Risk factors for developing posttraumatic stress disorder following childbirth: A systematic review. Acta Obstetrica and Gynaecologica. 2012;91: 1261-1272.

3. Beck C. Birth trauma: in the eye of the beholder. 2004;53(1): 28-35.

4. McKenzie-McHarg K, Ayers S, Ford E, Horsch A, Jomeen J, Sawyer A, Stramrood C, Thomson G, Slade P. Post-traumatic stress disorder following childbirth: an update of current issues and recommendations for future research. Journal of Reproductive and Infant Psychology (Special Edition) 2015;33: 219-237.

5. Better Help. Available from www.betterhelp.com/advice/stress/the-7-steps-of-critical-incident-stress-debriefing-and-how-they-support-trauma-recovery

6. Royal College of Obstetrics and Gynaecology. RCOG statement on the NHSLA report '10 Years of Maternity Claims'. 2012. Available from www.rcog.org.uk/en/news/rcog-statement-on-the-nhsla-report-10-years-of-maternity-claims/

7. Thomson G, Downe S. Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in North West England. Midwifery. 2016;40: 32–39.

8. National Institute for Health and Clinical Excellence. Postnatal care up to 8 weeks after birth: Clinical guideline [CG37]. 2015. Available from www.nice.org.uk/guidance/CG37.

9. Baxter, JD, McCourt C, Jarrett PM. What is current practice in offering debriefing services to post partum women and what are the perceptions of women in accessing these services: A critical review of the literature. Midwifery. 2014;30(2): 194–219.

10. Thomson G, Downe S. Changing the future to change the past: Women's experiences of a positive birth following a traumatic birth experience. Journal of Reproductive and Infant Psychology. 2010;28(1): 102-112.

11. Thomson G, Garrett C. Afterbirth support provision for women following a traumatic/distressing birth: Survey of NHS hospital trusts in England. Midwifery. 2019;71: 63-70.