WHAT IS BIRTH TRAUMA?

Birth trauma refers to both Post Traumatic Stress Disorder and symptoms of trauma which do not meet a full PTSD diagnosis. Around 1 in 25 women experience PTSD following childbirth, while it is estimated that around 1/3 of women find some aspect of their birth traumatic but may not meet a diagnosis of PTSD. What is crucial is that birth trauma is 'in the eye of the beholder' - the traumatic experience is entirely subjective.

Common symptoms of birth trauma include: experiencing flashbacks, nightmares or intrusive thoughts related to the birth or the period around the birth; avoiding talking about the birth or avoiding reminders of the birth; feeling irritable, jumpy or agitated; noticing changes in mood.

For some, these symptoms are not noticed until some months after the birth - or are managed until they become too difficult to overcome, for example when planning a subsequent pregnancy.

Birth trauma doesn't just affect the mother or birthing person. It can also affect birth partners, family members, friends and healthcare professionals.

KEY POINTS

- Birth Trauma is not the same as Post Natal Depression and should be treated differently
- Current recommendations for treatment are are trauma-focused CBT or EMDR. Any treatment should begin with safety and stabilisation to help regain control over the symptoms of trauma. Medication is not currently recommended by the NICE guidance unless other treatment has been declined (although some do find it very helpful)
- Many people benefit from using a range of different approaches, which might include body therapies, medication, holistic techniques as well as psychotherapeutic approaches
- Birth trauma is treatable, and often preventable. Interpersonal factors, such as perceived support, are highly related linked to trauma after birth

WHY IS BIRTH TRAUMA DIFFERENT?

Most of us are now familiar with the diagnosis Post Traumatic Stress Disorder (PTSD). However, it seems that the idea that this can be related to a person's birth experience is a relatively new concept for some health care professionals. So, below are some of the main ways that it is different to PTSD in other contexts. Feel free to share this with care providers.

Unlike war or sexual assault, birth is seen by society as a 'normal' and happy event and thus many find it difficult to understand that someone might find it traumatic. Therefore, mothers, birthing people, fathers and/or birth partners can find it difficult to seek help or their experiences can be dismissed by others, particularly if they have been seen to have had a 'normal' birth. Trauma is subjective to the person, what one person will experience as traumatic, another will not.

Avoiding reminders of the traumatic event are near impossible after birth, given that parents now have their baby to care for. Having these reminders can trigger intrusive memories of the traumatic birth, resulting in feelings of fear and anxiety which can have an impact on the parents' ability to bond with their baby. Parents may also avoid routine postnatal and hospital appointments because they find them too distressing to attend.

Those with a previous trauma history (such as sexual abuse) and/or mental health difficulties are understood to be at a higher risk of birth related PTSD.

The evidence shows that for many, it is not the experience of birth per se that leaves them feeling traumatised but the way that they were treated by those caring for them, such as being ignored, their concerns being minimised or feeling criticised, judged or humiliated. This can leave parents feeling ashamed or angry as a result.

Witnessing a traumatic birth can also lead to birth related PTSD, so this can occur in birth partners, families and health care professionals too.

WHAT CAN I DO RIGHT NOW?

Acting with compassion, kindness and empathy is key. The way that you share information and care for women can make the difference between someone feeling that their birth experience was traumatic or not.

Listen to a person's experience of their birth. Support them to think about how they would like their next birth experience to be different. Many women, birthing people and their families say they felt ignored (for example when raising concerns or asking for pain relief) or that procedures were carried out without their informed consent. Even in difficult circumstances and tight resources, you can ensure that they feel contained and respected, not traumatised.

Take care of yourselves and your colleagues. Acknowledging that you have all had a difficult shift, have a cup of tea, do some mindfulness meditation, ensure that one another has a break, even if this is short! The kindness that we know you extend to women and their families applies to yourselves and your colleagues too.

FURTHER READING

- Birth Trauma Association www.birthtraumaassociation.org.uk
- McKenzie-McHarg K et al. (2015). Post-traumatic stress disorder following childbirth: an update of current issues and recommendations. Journal of Reproductive and Infant Psychology 33(3). April 2015. DOI: 10.1080/02646838.2015.1031646
- Bromley, P., Hollins Martin, C.J., Patterson, J. (2017). Recognising the differences between Post Traumatic Stress Disorder-Post Childbirth (PTSD-PC) and Post Natal Depression (PND): a guide for midwives. British Journal of Midwifery. 25(8): 484-490.

Books:

- How To Heal A Bad Birth
- Why Birth Trauma Matters

ASSESSING FOR BIRTH TRAUMA

One in three women find some aspect of their birth traumatic. This might be related to one or more events that happen before, during or after birth. It might be feeling out of control, fearful or powerless or fearing she or her baby was at risk. Partners, medical staff, friends and family members may also have symptoms of trauma. The crucial element is that, at some point, the person felt that they or a loved one was unsafe.

Those from marginalised groups such as BAME women, those in same sex relationships, with learning or physical disabilities & migrant women may face additional difficulties too. There are other factors before, during and after birth that might increase the risk of symptoms of trauma. You can read more about this in the MBB Training Manual.

A woman or her partner might be affected by these events for a day, a week, a month or even years. These symptoms can cause significant distress and affect the individual, their ability to be a parent and the relationship with their baby, partner, family and friends.

Birth trauma does not equal PTSD. One can be severely traumatised by birth but not have all the symptoms required to make a formal diagnosis of PTSD.

Birth trauma can cause depressive symptoms but it is not the same as postnatal depression. If a person's birth trauma is mislabelled as depression in the early weeks after birth, they may miss out on opportunities to access evidence-based trauma-focused psychological therapies and may develop unhelpful coping strategies that can contribute to the longer-term maintenance of the trauma symptoms.

The DSM-V (2013) has updated the diagnostic criteria for PTSD, and there are several simple screening and assessment tools that can be used to identify symptoms of post-traumatic stress including PTSD in a perinatal population.

FURTHER READING

- Ayers, S. & Ford, E. (2016) Posttraumatic Stress During Pregnancy and the Postpartum Period. In: A. Wenzel (ed.) The Oxford Handbook of Perinatal Psychology. Oxford: Oxford University Press.
- Beck CT. (2004). Post-traumatic stress disorder due to childbirth: The aftermath. Nursing Research, 53, 216–224.
- Blog by Clinical Psychologist Georgina Clifford http://www.babysleeprescue.co.uk/blog/item/are-you-still-dealing-with-your-birthing-experience.
- NICE PTSD NG116 Dec 2018

ASSESSING FOR BIRTH TRAUMA

KEY POINTS

The person's own perception of events is key: 'on paper' obstetrically straightforward deliveries may be experienced as traumatic. The meaning that was created during the traumatic event or events is the most crucial aspect.

An experience is considered to be 'traumatic' in psychological terms if thinking or talking about it evokes distress and fear in the person to whom it happened.

It is not necessary - and sometimes ill-advised - to hear the full birth story during an assessment. Instead focus on the symptoms that are remaining.

Get to know the symptoms of PTSD and trauma. You can learn more about this on the webinar on our website

Fathers and partners can also experience post-traumatic stress responses in the aftermath of a difficult birth as can the professionals that were in the room during birth.

For many, birth trauma will unfortunately not be the first traumatic experience in their lives. Their historical context has important implications for how care providers understand and respond to their psychological needs

The way we treat people after a traumatic event has a significant impact on their recovery and on whether or not they go on to develop full-blown PTSD. Validation and support really do make a positive difference to outcomes.

WHAT CAN I DO RIGHT NOW?

- Don't assume that a new parent is 'just' depressed. Ask gently and routinely about people's experiences of birth, remembering that their own perception of trauma is what matters.
- Take a whole-family approach to assessing for birth trauma.
- Consider using a dedicated and validated questionnaire to screen for perinatal trauma, such as the City Birth Trauma Scale (Ayers et al., 2018)
- Validate a person's distress about birth: avoid phrases that dismiss the value of their experience, such as "at least you have a healthy baby". Never forget the power of listening.
- Signpost to specialist birth trauma support services and resources (Birth Trauma Association, Make Birth Better, NHS evidence-based psychological therapies teams).

THERAPIES AND TREATMENTS

There are a number of therapies and treatments that can help alleviate the symptoms of trauma after a difficult birth. Some therapies have been shown to be effective. It is also important to find the right therapist to be able to engage, trust and build a relationship.

Therapy can help you process the memories of your traumatic birth in order to reduce the feelings of distress, fear and anxiety related to childbirth. If you are a parent this can help increase your sense of confidence as an individual in your own right and as a parent with your new baby. If you are a member of staff involved in birthing this can also help you in your work to regain your professional confidence.

Trauma focused therapies are not just about following an approach, but also about developing a strong relationship with your therapist to feel safe and secure. Some holistic approaches are also outlined below.

Speak to your GP, Health Visitor or other health professional who can refer you to NHS therapy services. If there are long waiting lists you may want to consider seeing a private therapist. Although this can be a large financial commitment many therapists will offer reduced rates. It is always important to check that therapists are properly qualified and registered. Trauma work usually requires weekly sessions over several months.

Here are some of the main forms of therapy available:

- Cognitive Behavioural therapy (CBT) – this is a NICE recommended therapy for PTSD and trauma which works by identifying and challenging negative thoughts in relation to the traumatic experience, processing memories and reducing unhelpful strategies/behaviours
- Eye Movement Desensitization and reprocessing (EMDR) – another NICE recommended therapy for PTSD and trauma which works by focusing on unprocessed memories in order to move them into long-term processed memory and developing coping strategies.
- Compassion focused therapy – to address feelings of guilt and shame experienced in connection with past trauma and to help clients to become kinder and more compassionate with themselves
- Short term or longer term psychoanalytic psychotherapy can be helpful to make sense of the trauma at a deeper level and why it has taken hold of you.
- Somatic therapies – More of a focus on how the body reacts during a traumatic experience and how to lower the body's arousal level when focusing on a traumatic event
- Antidepressants may be prescribed. The most common ones for PTSD and trauma symptoms are Paroxetine and Sertraline.

There are also a number of other strategies you might find helpful:

- Psychoeducation – learning about how birth trauma affects your brain and body and why you have the symptoms you do
- Grounding techniques – learning to bring yourself back to the present if you are experiencing a flashback or distressing images
- Learning relaxation and breathing techniques to help lower your body's reaction to the trauma
- Writing down your birth story, feelings or letters to key people in the process (midwives, partners, doctors) which can help make better sense of your experience
- Drawing or painting your experiences as a way of healing
- Speaking with empathic others about the birth
- Focusing on your wellbeing through such things as yoga, massage, eating well, going for walks
- Joining a birth trauma support group to be able to share your experiences
- Writing a letter of complaint to your hospital
- Taking advantage of a debriefing service at your hospital where you can review your medical birth notes with a midwife

FURTHER READING

Websites:

- Birth Trauma: Make Birth Better, The Birth Trauma Association, Unfold your Wings
- Psychoeducation and grounding work: getselfhelp
- Finding a psychologist or psychotherapist: The birth trauma association, The British Psychological Society, The British Association for Counselling and Psychotherapy, The Counselling Directory
- Support groups: The Birth Trauma Association has a facebook group

Books:

- **Birth Trauma (Kim Thomas), How to Heal a Bad Birth (Melissa Bruijn and Debby Gould), Trauma is Really Strange (Steve Haines), Why Birth Trauma Matters (Emma Svanberg)**

Finding a psychologist or psychotherapist: The Birth Trauma Association, The British Psychological Society, The British Association for Counselling and Psychotherapy, The Counselling Directory

WHAT CAN WE DO RIGHT NOW?

For this topic we will consider the immediate support we can offer a family, whilst bearing in mind the importance of professionals being aware of their own vulnerabilities and biases in the moment.

It is vital that we make it part of our everyday practice to look out for triggers for birth trauma. For example: Was the birth far from what had been hoped for? Is there a history of trauma or abuse? Was there dissociation or panic during the birth? Have negative attributions such as self-blame been said?

If you suspect a person is experiencing trauma, here are some ways to help:

- Acknowledge their distress
- Refer to any previous wellbeing plans (if available) for means of offering support
- Check how their partner is doing
- Create a sense of safety by providing privacy or facilitating opportunities to rest
- Help the person to feel 'mothered' but not 'smothered'
- Offer a referral to a birth reflection service if wanted
- Offer written material on emotional wellbeing in the postnatal period and signpost to any available support services
- Ensure good levels of communication with the multidisciplinary team (especially when discharging on to another team)
- Ensure that physical wellbeing is also followed up appropriately.

We must also be aware of the positive ways we can care for families during the perinatal journey to prevent trauma. Be aware of possible triggering behaviours in yourself and always strive to show compassion and respect. Think about your language and how you choose to communicate. Actively promote dignity, keep the person informed of any suggested plans and demonstrate a commitment to gaining fully informed consent.

It is also important that we look after ourselves, too. As professionals, we need to manage our own trauma, triggers and emotions. When it comes to your own wellbeing, try to incorporate the following to help you cope with your own potential trauma:

- Write a reflection on your experience with a trusted colleague
- Use your employer's debrief service
- See our document- Self-care for Healthcare Professionals

FURTHER READING

Susan Ayers: Birth Trauma & PTSD: the importance of risk and resilience

Twitter #PNDHour chat every Wednesdays 8pm on topics relating to mood and perinatal mental health
Managing anxiety self-help tools SMILE www.thesmilegroup.org Help and support managing anxiety & distress

WHAT CAN WE DO RIGHT NOW?

There are certain situations in which families are more likely to experience distress, here is some guidance on what to do:

Separated from baby?

- Facilitate earliest possible contact with baby, support mother to touch, hold, feed
- Maximise possible contact within constraints of health complications.
- Encourage partner to visit baby if in NICU, take photos, talk with the mother about baby using photos, video recordings, show partner having contact with baby, encourage partner to talk with baby about mother
- Encourage NICU/midwifery staff to give regular updates to mother if unable to see baby.

Disconnected from baby?

- Beware 'taking over' and disabling a mother who may already feel disempowered.
- Say "How can we help?" and offer support with feeding choices.
- Give encouragement about her abilities by role-modelling not disempowering or overwhelming with your 'professional expertise'.

Feels unable to care for baby?

- Affirm that she is the parent and has been for entire gestation, encourage contact with baby – look, touch, talk
- Reassure that baby already knows their voices and is wanting to connect with them, encourage and reinforce positive contact with baby and response from baby
- Help reinforce the developing relationship.
- At discharge, consider offering referral for further support with PIMH specialist services.

Heightened distress?

- Be patient and compassionate.
- Empathise with their experiences.
- Share information with other HCPs to ensure appropriate support and attitudes.
- Try to facilitate continuity of carer where possible and ensure prompt community follow up.

- Start with yourself- acknowledge areas that are highly emotive for you and if you are struggling consider support from you employer's debrief service.
- Remember that during the perinatal period people are extremely vulnerable and you, as a healthcare professional, are in a position of power. Therefore, always act from a place of compassion.
- If you suspect a person is experiencing trauma, take action. Start by simply acknowledging their distress and listening to what they are saying. Then begin to formulate a plan together, detailing where further support can be accessed and referring to specialist services where appropriate

WHAT HAPPENS TO THE BRAIN WHEN TRAUMATISED?

Individual responses to traumatic events vary between people, but there are several predictable effects of trauma on the brain that are important to know about if we are to understand the ways in which traumatic experiences can affect our thoughts, feelings, behaviours and bodies.

During and after a traumatic event, there are changes in areas of the brain involved in the fear response (the 'amygdala'), in storing and encoding memories (the 'hippocampus'), and in problem-solving, logical reasoning, planning and decision-making (the 'prefrontal cortex' or PFC).

The amygdala is a primitive brain region that operates outside our conscious awareness. It has one main job to do: it senses danger and activates the alarm. Evolution means that it will always override the more sophisticated and much slower PFC brain functions when survival is at stake. When the alarm goes off, the body is quickly prepared for action and all non-essential systems are switched off to maximise the chances of surviving.

The hippocampus's usual task is to code and store our memories in an organised way so you can retrieve them later when you want to - rather like a filing cabinet. But at times of danger, the hippocampus goes off-line and a very different sort of memory gets stored.

These trauma memories are made up of vivid sensory fragments that can be difficult to put into words, and which are involuntarily triggered by environmental reminders of the event.

People often try very hard to stop these memories from coming into their heads because they feel so frightening when they occur, but these efforts to block them out don't usually work very well, and they can slow down the brain's own natural attempts to convert the trauma memory into a 'normal' memory.

KEY POINTS

In a brain that has been traumatised, the thinking and memory storing systems are under-activated, and the fear centre is over-activated. This means that we get 'stuck' in fight-flight-freeze mode

You didn't choose for this to happen: it is a result of your brain and body's naturally evolved way of trying to protect you from harm

PTSD is an understandable reaction to a traumatic event: understanding what is happening in your brain can make it feel a bit less frightening

Just as the brain can change in response to past traumatic events, it can change again in response to future experiences: it is 'plastic' and continues to rewire itself

WHAT CAN I DO RIGHT NOW?

Talk to someone you trust about what you are experiencing: social support is key to recovery after trauma, and you are not alone

Please don't suffer in silence – ask for help from a qualified psychological therapist who is fully trained to work with the body and the mind after trauma

Practise simple grounding skills to help you feel safe in your body. Focus on your current environment and try to identify 3 things you can see, 3 things you can hear, and 3 things you can feel on your skin. This can help to anchor you in the here-and-now and remind you that you are safe

FURTHER READING

The Body Keeps The Score (Bessel van der Kolk, 2015)

London Trauma Specialists Brain model of PTSD: https://www.youtube.com/watch?v=yb1yBva3Xas

The Compassionate Mind Approach to Recovering from Trauma (Deborah Lee, 2012)

WHAT IS A TRAUMA INFORMED APPROACH?

There is an increasing interest across many settings to take a 'trauma informed approach' rather than looking at specific pathways or interventions. This is because we know that many people who have experienced trauma previously may not feel able to disclose their experience.

This is particularly relevant to current maternity settings where it might feel difficult to set up trusting relationships with healthcare professionals involved in birth, where normal practices in birth can be traumatising and re-traumatising for some, and because this is a particularly vulnerable period.

If we take a trauma informed approach for all women and birthing people, we believe we would see a reduction in birth trauma. A trauma-informed approach is across a whole service, changing the way that service is delivered down to our daily interactions with staff and patients/clients.

WHAT CAN I DO RIGHT NOW?

- Speak to your team leaders about how to integrate a trauma informed approach into your current practice
- Learn about trauma and the impact of trauma
- Print off the Make Birth Better Model to share with team members
- If you do one thing today, keep in mind that while we can't change the histories of the people we come into contact with, we can actively 'do no harm'
- Join us (alongside organisations the Association for Improvements in Maternity Services, Birthrights and the Birth Trauma Association) in campaigning for meaningful changes in maternity services.

What are the principles of trauma informed care?

There are six key principles to follow (Cuthbert & Seng, 2015):

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural and historical issues and gender awareness

While we at Make Birth Better try to use these principles in our work, we have slightly adapted these to encompass the core values of the Make Birth Better model. As a first step, individual professionals can reflect on these and instil them into their practice. However, to fully embed trauma informed care into maternity services will take top-down change to maternity services.

- Consent (offering informed consent regardless of protocol)
- Kindness (having compassion at the forefront of our interactions)
- Communication (considering language and tone, even in an emergency)
- Trust (creating a relationship where disclosure is welcome and will be acted upon)
- Safety (creating physical and psychological safe spaces, support for staff to process their own trauma)
- Respect (for physical and psychological autonomy, considering cultural, social, LGBTQI+, historical, physical, gender issues)
- Collaboration (considering collaboration between professionals, with the woman or birthing person at the centre of their care).

FURTHER READING

'Trauma Informed Care in the Perinatal Period' (Seng & Taylor, 2015)

Make Birth Better Training Manual (available online) and events

Weinstein, Ann (2019) 'Trauma-Informed Care Needed to Address Obstetric Violence', Psychology Today. https://www.psychologytoday.com/gb/blog/the-beginning/201903/trauma-informed-care-needed-address-obstetric-violence

Self care is learning how to nurture ourselves so we can boost our wellbeing, resilience and maximise our compassionate care. As rates of stress and burnout in healthcare professionals reach an all time high its even more important to look after ourselves.

We all need self-care to help us cope with and heal from life's inevitable stresses and we need to proactively engage in self-care to keep us resilient in the face of future curveballs.

Self-care becomes all the more crucial for those involved in healthcare. If we want to prevent burnout and offer compassionate care we must tend to our energetic bank balance.

Self-care needn't be grand, time consuming or expensive. It can be as simple as dotting 'micro moments of nourishment' through your day, like using a soothing mantra, feeling the sensations of your breathing, taking some shoulder rolls, standing tall to tap into a feeling of empowerment and remembering your professional 'why' to stay anchored in purpose.

KEY POINTS

Reflect on your current self-care practices - write them down and add to the list any activities you'd like to reclaim or new rituals or skills you'd like to explore.
Just the act of writing them down will help you get self-care on the radar.

Include in your list small actions that you can turn to throughout your day to release tension and re-energise.

As you move through your day, regularly check in, notice how you are feeling and take action to meet your needs. If there is an ache, take a short moment to stretch.

If you're feeling overwhelmed press the back of your hand to your forehead and feel how this soothes the nervous system.

If you've had a challenging experience at work, reach out for support and give voice to your feelings.

Even when there is no time to stop, extend towards yourself tenderness and compassion.

Ask at work what can your organisation do to support team health? Could you set up reflective practise groups, huddles or organise a team yoga class each week?

Self-care is health care and your health is of upmost importance too.

FURTHER READING

There is some wonderful self-care inspiration available from the Blurt Foundation and author Jayne Hardy

Suzy Reading offers Monday Micro Moment live Instagram sessions at @suzyreading on building the self-care habit and her book 'The Self-Care Revolution' provides a framework from which to build your own self-care toolkit.

https://blogs.bmj.com/bmj/2017/11/02/matt-morgan-poor-hospital-design-has-an-impact-on-staff-patients-and-healthcare/

WHAT CAN I DO RIGHT NOW?

Reflect on your current practice. Are there any areas where you are highly emotionally attached to a certain decision? Are there any particular memories from past experiences that cause you to unduly want to pressure a person into a particular decision? If so, can you think of ways to help you provide information in a more unbiased way?

Begin to utilise resources that help to convey information for common interventions such as '
Choices When Pregnancy Reaches 41 Weeks'

Think about communication strategies you could use, if you observe a colleague unknowingly trying to put pressure on a person to make a decision. What could you say to them in the moment? Could you ask them to step out of the room for a discussion? Could you act as an advocate for that person and open up the dialogue to give that person space to speak up? See e-Learning for Healthcare (2019) for further guidance.

FURTHER READING

- e-Learning for Healthcare (2019) 'Freedom to Speak Up'
- General Medical Council (2008) 'Consent: patients and doctors making decisions together'
- General Medical Council (2008) 'Consent: patients and doctors making decisions together'
- Birthrights (2017) 'Consenting to treatment'
- Nursing and Midwifery Council (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'
- Hall WA, Tomkinson J, Klein MC (2012). Canadian care providers' and pregnant women's approaches to managing birth

Coercion in healthcare is using one's position of power to pressure someone into making a decision they may not otherwise make.

Working with pregnant people means that we have the additional risk of using the health of the unborn baby to sway someone into accepting a certain plan of care. It can be easy to use emotive language, such as 'increasing your risk of stillbirth' or 'causing harm to your baby' to elicit a response that is in line with what we believe is the best course of action.

We must also be aware that 'decreasing the risk' doesn't mean eliminating the risk altogether and we should always strive to share such information with adequate quantification (e.g. decreases the risk from 5 in 1,000 births to 2 in 1,000 births) and where possible pictorial representations of those figures to further help understanding.

This is not only important as it is part of both NMC (2018) and GMC (2008) guidance but it has a huge impact on patient experience.

KEY POINTS

- Both midwives and doctors are bound by their councils to tell the people under their care the benefits and risks of each proposed option, including the option of doing nothing. They must then respect the decision that person makes, even if they do not agree with it.

- In order to give consent the person must be well-informed and must not be pressured or bullied into giving their consent (Birthrights, 2017). This includes forcing repeat discussions of the risks, using family members in an attempt to sway the decision and suggesting a referral to social services. In these instances, informed consent would not be deemed to have been given.

- There is also a known but often unspoken-about culture within maternity care, whereby a healthcare professional may put pressure onto a pregnant person by "pulling the dead baby card" (Hall, 2012). This means simply stating that the baby could die, whether or not this is true or likely. This is never acceptable and must not be allowed within maternity care.

WHAT IS TRAUMA INFORMED ANTENATAL EDUCATION?

Having awareness of trauma in an antenatal class setting can help parents and practitioners to create safer environments and resources for antenatal learning
Make Birth Better follows seven core values of trauma-informed care, developed from our workshops and other research. These aim to enhance an approach to care which supports anyone who may have experienced trauma, and in turn to prevent trauma from being caused by us. You can read more about these in the MBB Training Manual. These are:

- Consent (offering truly informed, individualised consent)
- Kindness (having compassion at the forefront of our interactions)
- Communication (considering language and tone, even in an emergency)
- Trust (creating a relationship where disclosure is welcome and will be acted upon, but equally where disclosure is not necessary and universal precautions are used)
- Safety (creating physical and psychological safe spaces, support for staff to process their own trauma)
- Respect (for physical and psychological autonomy, considering cultural, LGBTQI+, historical, disability and gender issues)
- Collaboration (considering collaboration between professionals, with the woman or birthing person at the centre of their care).

KEY POINTS

Be aware that anyone you work with may have a previous trauma, either birth or non-birth related and those with previous trauma are more likely to experience trauma related to birth.

Consider the language you use. Is it open, non-judgemental and permissive. Consider materials used. Birth videos & images can be triggering, sending links can be easier than using in a class setting.

Connect with local Perinatal Mental Health services and midwives so you can signpost anyone who may need additional support before birth.

Keep education compassionate and fully informed. Choices and options should be explained using evidence based information.

Consider parents' needs and offer options, if there is trauma signpost to professional services, keeping the space safe for all.

WHAT CAN I DO RIGHT NOW?

It can be useful for practitioners to connect with their local MVP (Maternity Voices Partnership) to know who and where to signpost to locally.

Contact your local Psychological Therapies services and Perinatal Mental Health services to find out what is available near you.

Consider content of current education and how this can become trauma informed.

Be open to listening to people's birth experiences, with no judgement

Inform - birth trauma affects 30% of women & can affect birth partners, family members & staff

Refer – people to the free resources available on our site

Train – ask your local services if they need birth trauma training

Help – signpost people to health professionals, the Birth Trauma Association, Birthrights or AIMS

FURTHER READING

Please see also our crib sheet 'What is Trauma Informed Care?'

- If you are an NCT Practitioner, see the NCT Position Statement 'Trauma in Labour & Birth'
- AIMS UK offers books and a helpline plus online resources
- Birthrights
- Evidence Based Birth has online articles

- Books:
- Kathleen Kendall-Tackett 'Psychology of Trauma 101'
- Bessell van der Kolk 'The Body Keeps the Score'

Birth is a pivotal moment in a person's life, yet there are people who are experiencing traumatic births and finding it hard to understand the reasons why.

Birth trauma can occur after a long and painful birth, emergency treatment, unplanned c-section or difficult interpersonal experiences but trauma is subjective and is always in the eye of the beholder.

The experience can cause people symptoms including post-traumatic stress disorder and postnatal depression (Mind, 2019). It may also impact on the relationship with partners and the baby. The Birth Trauma Association (2019) report that 30,000 women experience a traumatic birth every year.

According to research, a third of midwives also experience PTSD symptoms. Research validates that there is a gap in service to support the wider team and that there are various challenges.

Below are examples of good practice that can support staff caring for the wider team after a traumatic birth.

Leadership and Management:

- The embedded organisational culture of caring for one another
- Speaking openly to learn from mistakes
- No blame/no bullying management

Personalized Policies and Procedures:

- Recognition of the emotional and physical impact of healthcare work
- Recognition of non-work personal context
- Work/life balance is respected
- Respecting the right to breaks
- Being treated well when unwell

Activities and Actions:

- Small gestures of kindness
- Provision of emotional support

WHAT CAN I DO RIGHT NOW?

Supporting Staff

Make sure that the following concepts are embedded into teams:

- Feeling Valued
- Being Heard
- Enjoying work
- Being Engaged at work
- Use of caring language

The Make Birth Better model describes the factors involved in the cause and prevention of birth trauma. It was developed following analysis over over 70 birth stories, workshops held with parents and professionals, as well as feedback from our Network .

The model describes the impact that birth trauma has on every part of the system, and our belief that birth trauma cannot be prevented without addressing each different layer. We believe that small changes at any layer can make a huge difference.

There are many different opportunities to prevent birth trauma, and support those who have experienced a difficult birth - at the moment we are missing many of these opportunities.

There are many examples of good practice in the Make Birth Better Training Manual.

Our key message is that trauma can be prevented by using the core values which surround the model. If you would like to hear more, please contact us for training and consultation

FURTHER READING

- The Make Birth Better Training Manual (available from our website)
- Top tips on how to make a difference to the wider team include NHS England's "Towards commissioning for workplace compassion: a support guide" document (NHS England 2018).
- Ayers, S. (2017) Birth trauma and post-traumatic stress disorder: the importance of risk and resilience Journal of Reproductive and Infant Psychology VOL. 35, NO. 5, 427–430.
- Mind (2019). Accessed January 2019. https://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression-and-perinatal-mental-health/ptsd-and-birth-trauma/
- NHS England, 2018. Towards commissioning for workplace compassion: a support guide. 08058.
- The Birth Trauma Association (2018) Accessed January 2019. https://www.birthtraumaassociation.org.uk/

At Make Birth Better we believe that regular reflective practice can support professionals to contain the inevitable difficulties that arise through work. Here are a number of ideas, but we are happy to offer personalised consultations to your service and are currently working on developing the MBB model as a tool for reflective practice. Please get in touch if you'd like to know more.

Working with parents and infants who have experienced birth trauma is both rewarding and emotionally challenging.

Practitioners are exposed to high levels of distress and are required to manage clinical complexity and risk on a regular basis. The vulnerability of babies and the dynamics of a caring relationship can resonate with practitioners, evoking feelings that are difficult to understand (Neath and McCluskey, 2019).

Without support staff may experience distress themselves and develop unhelpful, defensive ways of coping.

To grow and develop and deliver quality services practitioners need to feel contained, listened to and understood. Reflective practice groups can provide this containment, offering a safe space for shared learning and understanding.

Practitioners also need to feel held in mind by a compassionate organisation with effective leadership (Marks, 2017), so all layers of the service need to support the need for reflective practice.

WHAT CAN I DO RIGHT NOW?

- Think about the culture of the organisation you work in - how is this impacting on staff wellbeing?
- Throughout your working week where are the opportunities for thinking and joint reflection - what could you do to introduce these? Daily team huddles? A weekly or monthly meeting?
- Reflective practice doesn't just happen in a group - you can build this into individual supervision and management and try to be more reflective daily at work.

KEY POINTS

Are staff enabled to attend a Reflective Practice Group? How can this be supported?

What is the work context and organisational culture practitioners are working in? Does work need to take place with service managers?

Key questions for Reflective Practice. What work situation did I find hard that I want help with? How can we understand what went on and why things became difficult? What might I do next time? Explore internal and external, systemic factors

Key Components of Reflective Practice Groups should be curiosity, collaboration and joint exploration, tolerating difference

It is impossible to learn and reflect unless staff feel safe, so boundaries and confidentiality are important, as well as having a skilled and trusted facilitator

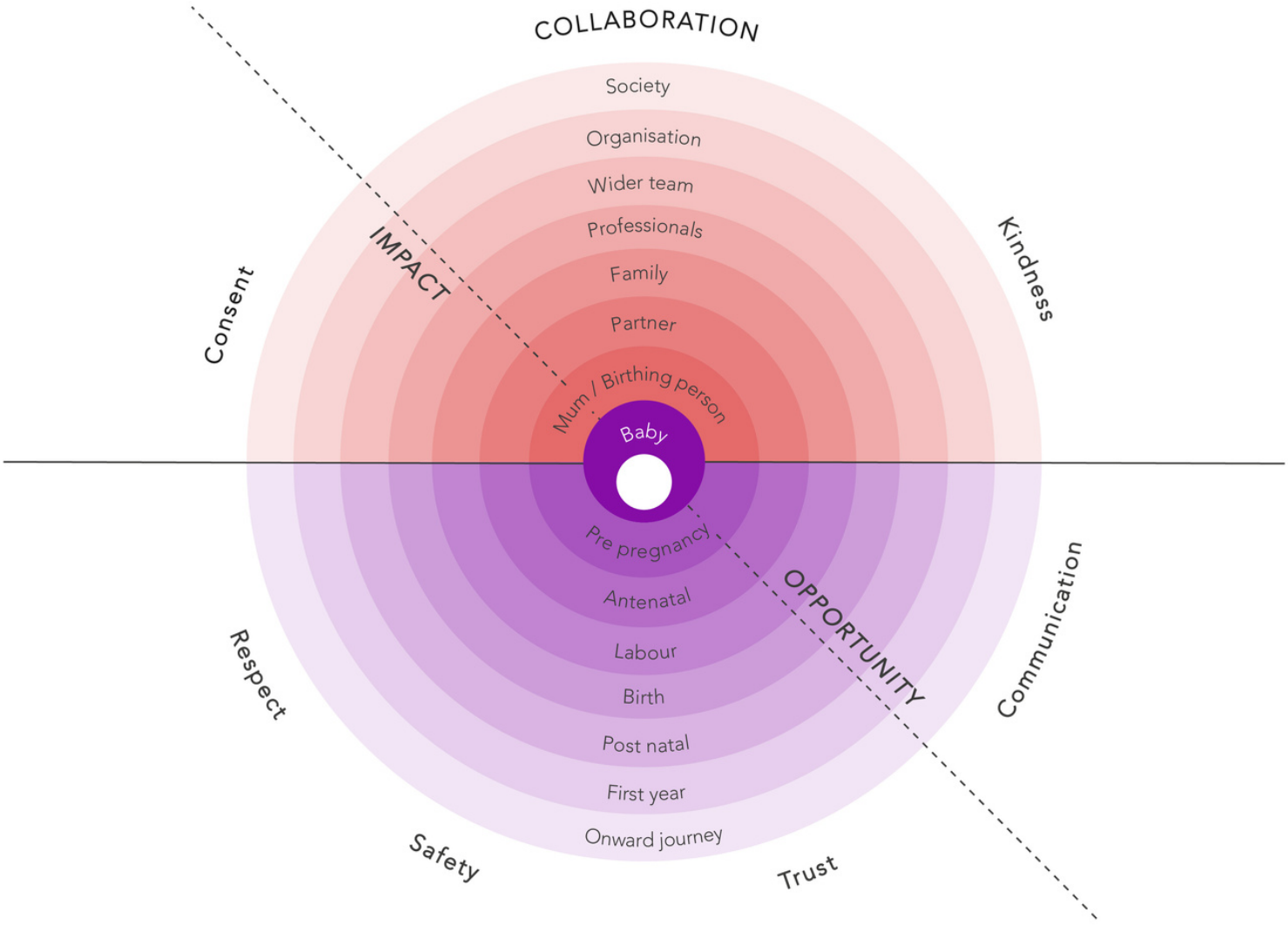
In order for a reflective practice group to work- a safe space must be created with an experienced facilitator. You could ask your local psychology department if they are able to offer this.

FURTHER READING

Neath, N. and McCLuskey, U. (2019) 'To Be Met As A Person At Work: The effect of early attachment experiences on work relationships' . Routledge

Marks, L. (2017) Overview of challenges to implementation of good practice in perinatal mental health promotion and management, in universal primary care and community services, Journal of public mental health, Vol 16 No. 3, pp 100 -103 'Breakdown or breakthrough? How to support parents affected by mental health problems in the perinatal field' (2012) This is a DVD produced by NSPCC featuring 5 short films, one of which details how communication can break down when staff are faced with high anxiety

THE MAKE BIRTH BETTER MODEL



Thanks to Limor Guerabli

WHAT IS IT?

This conceptual model describes the factors involved in the cause and prevention of birth trauma. It was developed following analysis over over 70 birth stories, workshops held with parents and professionals, as well as feedback from our Network .

The model describes the impact that birth trauma has on every part of the system, and our belief that birth trauma cannot be prevented without addressing each different layer. We believe that small changes at any layer can make a huge difference.

There are many different opportunities to prevent birth trauma, and support those who have experienced a difficult birth - at the moment we are missing many of these opportunities.

Our core message is that trauma may be preventable, using the core values which surround the model.

HOW CAN I USE THE MODEL?

Professionals are welcome to use the model to consider their own practice, or can attend a Make Birth Better training day to learn more.

Individuals and Services are welcome to speak to us about consultation and reflective practice using the model to promote trauma-informed service development.

Parents can use the model to think about the care they would like, and are welcome to share it with care providers to help them think together about birth planning. It may also be used to think about what may have influenced a difficult birth experience, and highlight areas which you may wish to explore with a trusted supporter.

IF YOU USE THE MODEL IN YOUR AREA, OR USE IT FOR RESEARCH, WE WOULD LOVE TO HEAR HOW YOU ARE USING IT!

Our goal is that birth can become a collaborative experience between families and professionals, who all feel held in a system that values its parents, children and those who care for them.