Childbirth Trauma

Intervention by the perinatal mental health team at Wirral University teaching Hospital NHS Foundation Trust (WUTH) to address psychological trauma following childbirth.

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Background

The WUTH perinatal mental health team

The Service…

- The WUTH perinatal mental health team started in 2008.
- The service has developed significantly since this time.
- Our team currently comprises of…
- Perinatal Mental Health Specialist Midwife
- Perinatal Mental Health Midwife
- Consultant psychiatrist
- Staff grade psychiatrist
- Specialist nurse liaison psychiatry
- Obstetrician
- Specialist Health Visitor

What we do…

- Triage and assess
- Referral within team
- Multi agency referral
- Care plans
- Antenatal and postnatal mental health support
- Pathways
- Training
- Participate in local and regional special interest groups

Women referred to the team…

- Recent or current psychotropic medication
- History of mental illness
- Severe mental illness
- Family history severe perinatal mental illness
- Current mood or anxiety disorders
- Phobias
- Previous traumatic birth experience/surgical procedure
- Those women who make excess use of hospital resources
- Those whose mental health is compounded by physical illness
- Patients considered to be at risk
- HADS 11-14, on more than two episodes, two weeks apart
- HADS 15+

Prediction and Detection…

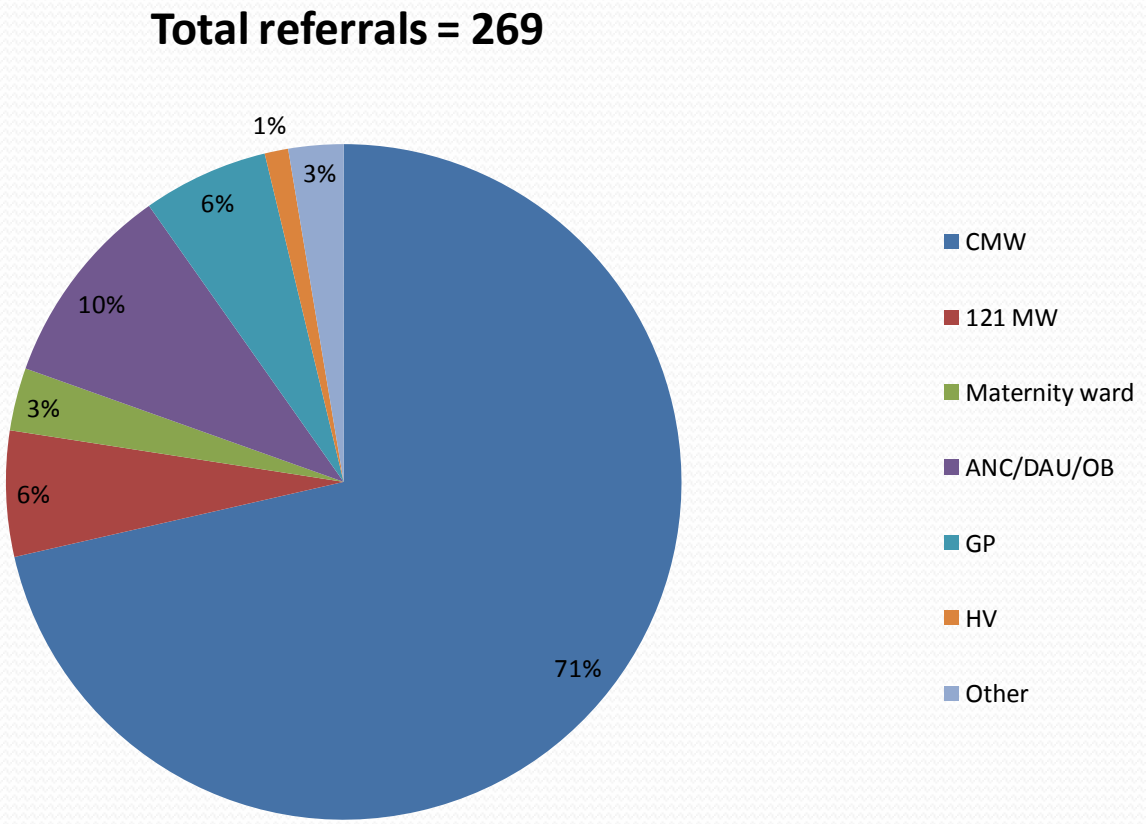
- **Questions to assess low mood depression (Whooley questions):**
- During the past month have you often been bothered by feeling down, depressed or hopeless?
- During the past month have you often been bothered by having little interest or pleasure in doing things?

- **Questions to assess anxiety (GAD questions):**
- In the past month have you felt nervous, anxious or on edge?
- In the past month have you often felt unable to stop worrying?

- **Questions to assess avoidance symptoms:**
- Do you find that you are avoiding people or places, which is causing you problems?

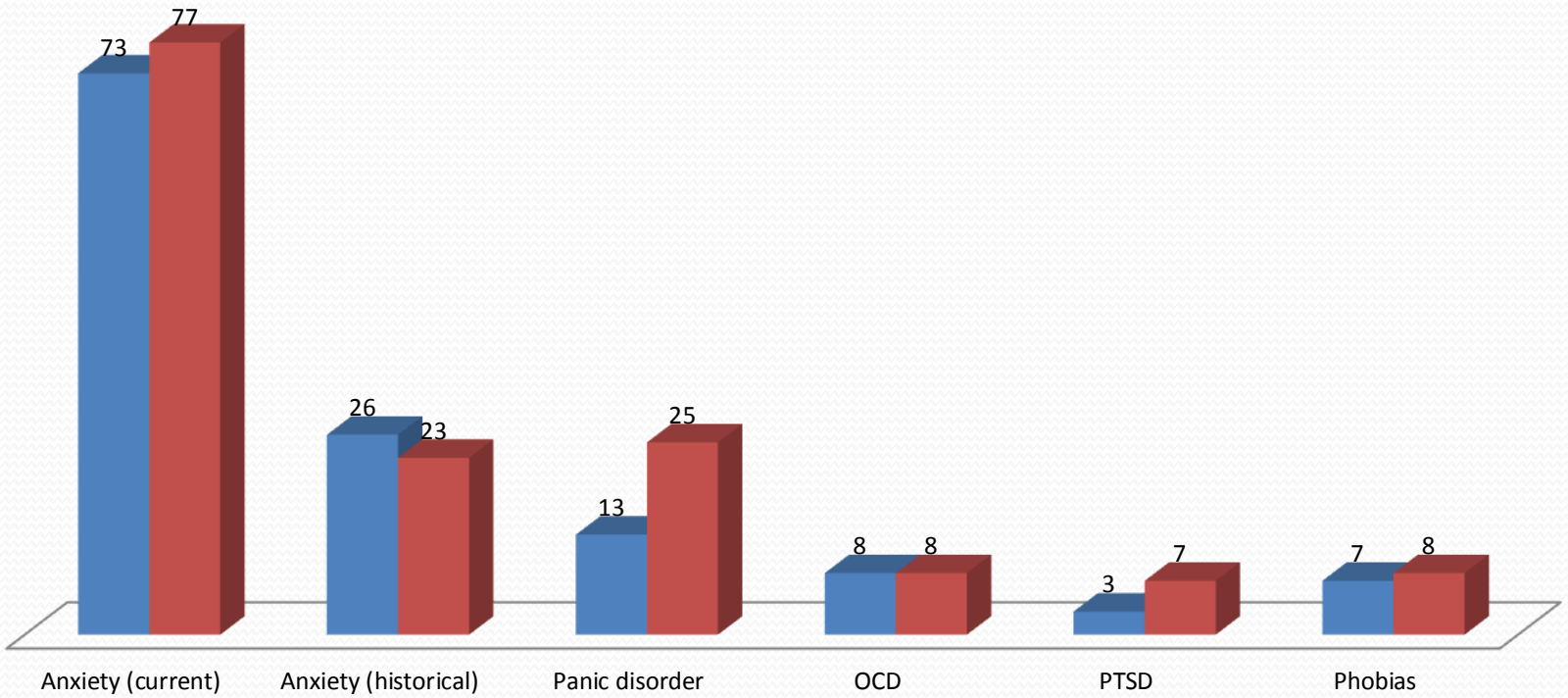
Is this something you would like help with?

Total referrals to perinatal mental health team: January to June 2015



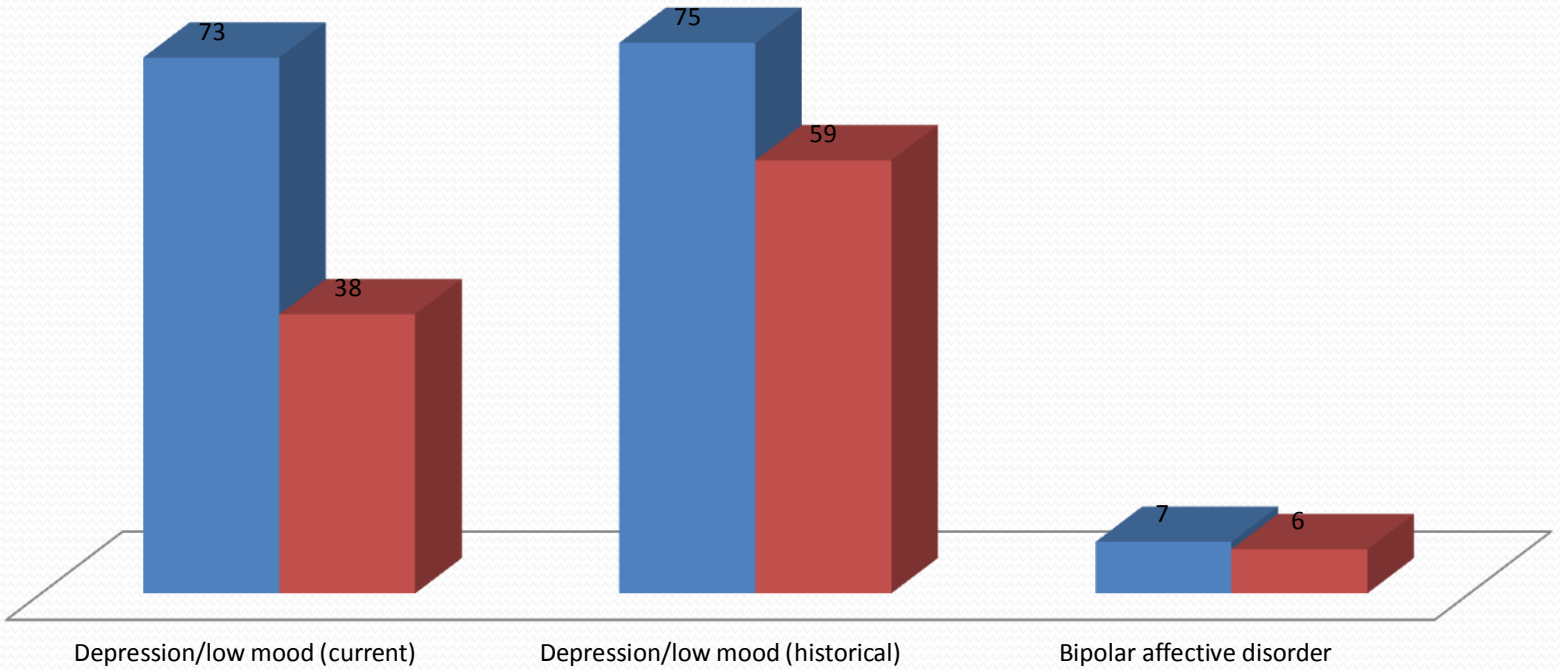
Reasons for referral: Anxiety disorders

Anxiety disorders: comparison of information on referral and findings following consultation with PMHM



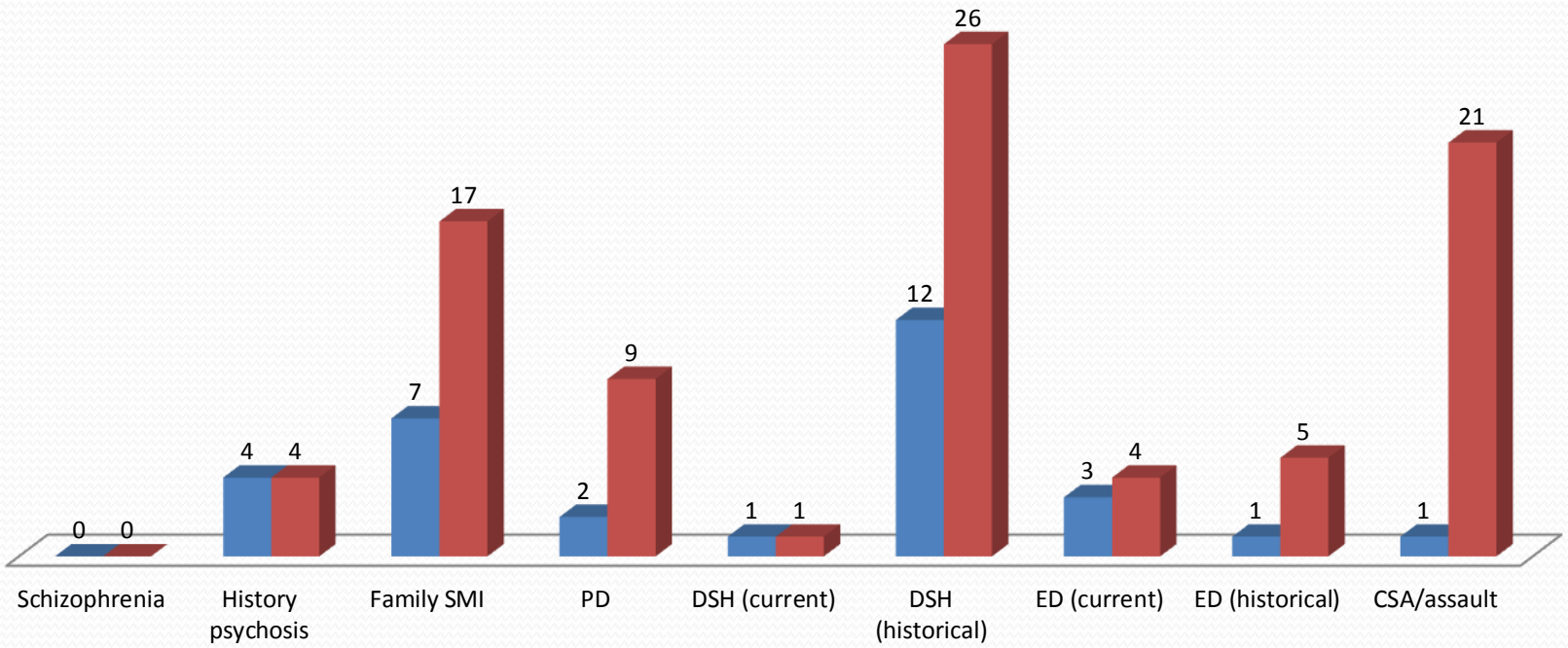
Reasons for referral: Mood disorders

Mood disorders: comparison of information on referral and findings following consultation with PMHM



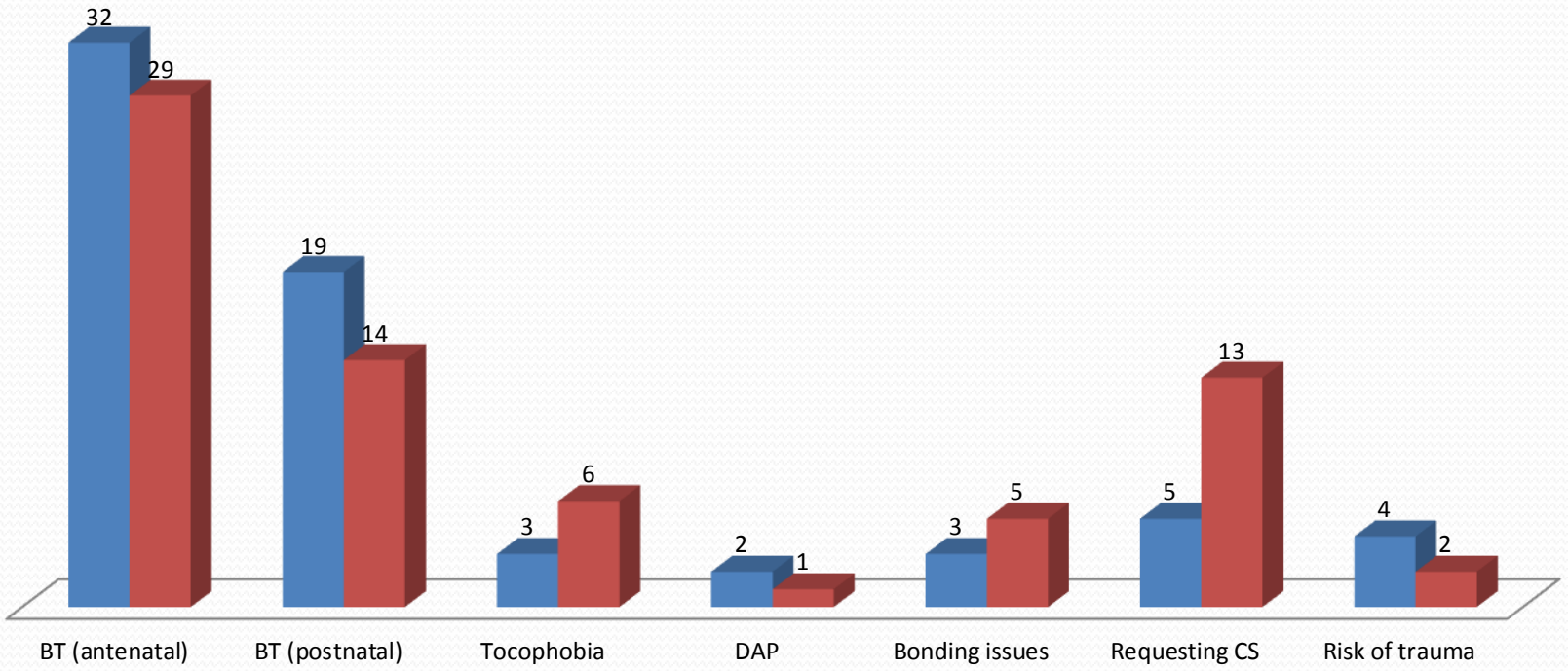
Reasons for referral: Other mental health related reasons

Other mental health related concerns: comparison of information on referral and findings following consultation with PMHM



Reasons for referral: Pregnancy related problems

Pregnancy related problems: comparison of information on referral and findings following consultation with PMHM



Psychological trauma following childbirth

Childbirth is a positive experience for many women, who recover quickly from the experience both physically and emotionally. However…

Others don't……

PTSD following childbirth….

Research has indicated that some women develop posttraumatic stress disorder (PTSD) as a result of childbirth.

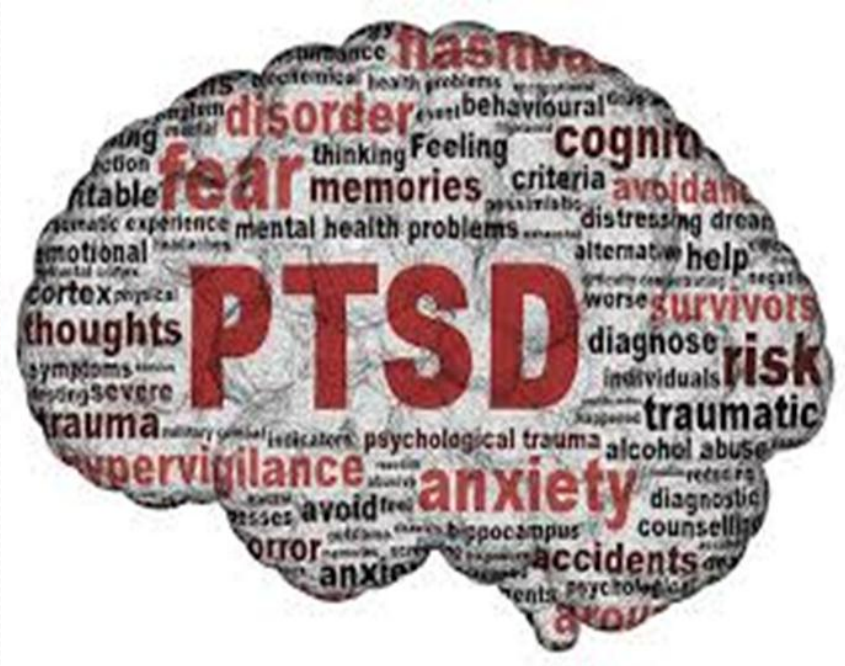
PTSD is not only detrimental to the psychological wellbeing of the mother, it can put strain on her relationships and can be damaging to the bonding process with her baby… which can affect the development and wellbeing of the baby.

What is PTSD?

The American Psychiatric Association [APA], in the Diagnostic and Statistical Manual of Mental Disorders DSM-V (2013) define a traumatic event as being exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence.

DSM-V diagnostic criteria for PTSD

- DSM-V focuses on four diagnostic clusters …



- Re-experiencing
- Avoidance
- Negative cognitions and mood
- Arousal.

Significance for postnatal women…

- Negative cognitions and mood, is new in DSM-V and is characterized by symptoms which include a persistent negative emotional state and persistent inability to experience positive emotions.

- These symptoms mirror those of postnatal depression, and if health professionals lack sufficient knowledge of trauma they may tend to focus only on these symptoms when it comes to diagnosis and treatment.

Factors which make some women more susceptible to developing PTSD following childbirth…

- A psychiatric history
- A family history of anxiety
- Anxiety sensitivity
- Fear of labour prior to the event
- A history of sexual abuse or sexual assault
- Instrumental delivery…as women can associate interventions with meanings that induce fear
- Some women experience obstetric interventions as physical assault

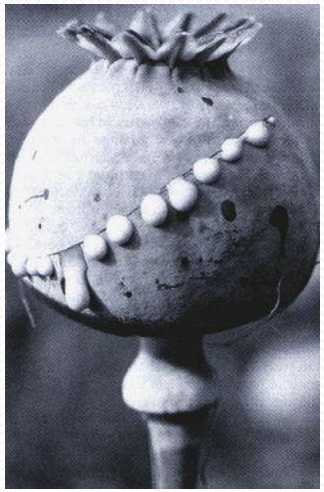
Why is childbirth traumatic?

- Sexual trauma survivors are twelve times more likely to find their birth experience traumatic compared with women without a history of sexual trauma
- Research estimates that 7 to 27% of women have been exposed to sexual abuse as a child
- Often we don't know a woman's trauma history; however for some women the themes which traumatise them during labour, mirror those of previous sexual traumas, in terms of childhood sexual abuse and sexual assault…

Comparing sexual trauma & labour do any of these themes sound familiar?

- Fear
- Lack of control
- Powerlessness
- Pain
- Genital injury
- Loss of dignity
- Belief they may die
- Being told to relax whilst something painful is 'done to them'
- Lying supine while the 'perpetrator' looms over them
- Losing control of bodily functions
- Having instruments and hands inserted into their vagina and sometimes rectum.

Also…



- Sometimes women are under the influence of substances which may affect attentional processes which may lead to fragmented memories and the inability to process information.
- The use of opiates during labour may effect cognitive state, leading to fragmented memory…a risk factor for PTSD.
- From this perspective, it is not surprising that some women are traumatised, whether they have a sexual trauma history or not.

Fear of labour…

- Influenced by the media & social influences.
- Pre-existing beliefs about childbirth are influenced by the beliefs and appraisals made by others.
- These can influence perceptions during labour, which in turn influence how the person thinks and what they pay attention to.
- These can result in women only attending to the information that is in-keeping with their pre-existing beliefs about childbirth.

Other theories…

- It has also been suggested that posttraumatic stress is due to the disruption of core assumptions about the self, the world and others…
- These being that the self is worthy, and the world is benevolent and meaningful.
- Therefore individuals who hold more positive beliefs are more vulnerable as their beliefs become 'shattered' following a traumatic event.
- Women who hold more positive pre-birth beliefs may require extensive mental reprocessing as they attempt to make sense of their experience, and re-evaluate their view of themselves and the world.
- This theory is pertinent for those women who have very rigid beliefs and expectations for the birth of their baby.

Prevalence…

- Studies have reported the prevalence of PTSD following childbirth ranges from 0 to 14.9% between one and fourteen months after delivery. Sample sizes varied from 47 to 1640.

- Most of the research tends to settle on a prevalence rate of about 2%.

Some women have mainly primary emotions relating to their experience, such as fear, with symptoms which can include avoidance and arousal.

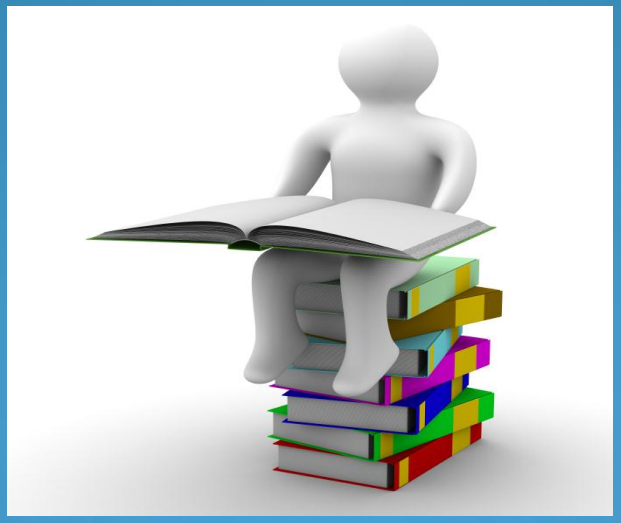
Others have mainly secondary emotions, such as guilt and shame, influenced by their appraisals of events, with symptoms which can include avoidance, anger, self-blame or strong negative feelings about themselves and others.

In summary…

- It is the subjective not the objective experience of childbirth that is significant for women.
- Procedures medical staff perceive to be normal and routine, are often experienced negatively by women during labour.
- Negative perceptions of care, in terms of communication, support and interventions have been associated with the development of PTSD.
- As does feeling out of control and powerless, feeling invisible, feeling trapped and being treated inhumanely.

The Research

An exploration of health professionals' knowledge, attitudes and beliefs surrounding the occurrence of childbirth trauma, using a convergent parallel mixed methods design.



Why?

There appeared to be a lack of research surrounding what health professionals who care for women during and following childbirth know about the causes of psychological trauma, or the barriers that may prevent them from responding to it…

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Rationale…

- An understanding of trauma would promote reflexivity in staff when caring for women in labour, with regards to how their own actions may be perceived.
- It would enable professionals who are involved in providing antenatal care to identify those at higher risk of experiencing labour as traumatic.
- It would equip those who encounter postnatal women with the skills to identify those who may be at risk of developing PTSD.

Hypotheses…

- Health professionals have insufficient knowledge of psychological trauma to enable them to respond appropriately to women who have experienced childbirth trauma.

- Barriers such as personal beliefs, attitude and workload exist which prevent health professionals from responding appropriately to women who have experienced childbirth trauma.

How…

- This study involved questionnaires being sent to all midwives, obstetricians, health visitors and GPs who work within the Wirral.

- The sample consisted of 484 midwives, health visitors, obstetricians and GPs. 180 of the sample responded to the questionnaire.

- The questionnaire made a series of statements on issues surrounding childbirth trauma, including personal views and beliefs, which the participants answered on a graded scale, ranging from strongly agree, to strongly disagree.

How…

- This allowed me to gather information in a statistical format, to answer the ‘what’ and ‘how many’ parts of the research question.
- Then they were asked to answer more descriptive questions, which aimed to answer the ‘why’ parts of the research question.
- I compared the information gathered from both kinds of data to check if both types of data confirmed the other.

Results…

- Results indicated that health professionals lack the necessary knowledge to respond appropriately to women who have experienced childbirth trauma though many are aware of the themes that contribute to the trauma.

- Perception of knowledge, within some professional groups, was incongruent with answers to questions relating to trauma theory and recommendations, which would suggest a barrier.

- Personal beliefs and attitude didn't appear to form a barrier to communication with this population of women, with most professionals reporting feeling comfortable talking about emotions and experiences.

Results…

- Midwives particularly reported that restricted time and heavy workload impedes their ability to provide emotional support to women, this was a lesser theme with the other professional groups.

- Qualitative data suggests that exposure to women's childbirth trauma narratives can evoke emotional reactions, which prompt actions, and desired actions based on their own beliefs and feeling the need to 'do something'.

Recommendations…

- The results indicate that education and training in relation to trauma needs to be addressed for all professional groups.
- The introduction of care pathways and simple assessment tools to help professionals identify women at risk of PTSD following childbirth and facilitate appropriate referral and interventions.
- Further exploration of the needs of women who have experienced childbirth trauma, perhaps in the form of focus groups may promote a richer understanding of the needs of this population.

Debriefing

Why….?

- In 1999, the Department of Health recommended the use of postnatal debriefing for women following a traumatic delivery, and this practice has been interpreted differently by maternity providers since.

- Some studies have suggested that debriefing following traumatic birth may be a useful intervention for reducing the risk of PTSD.

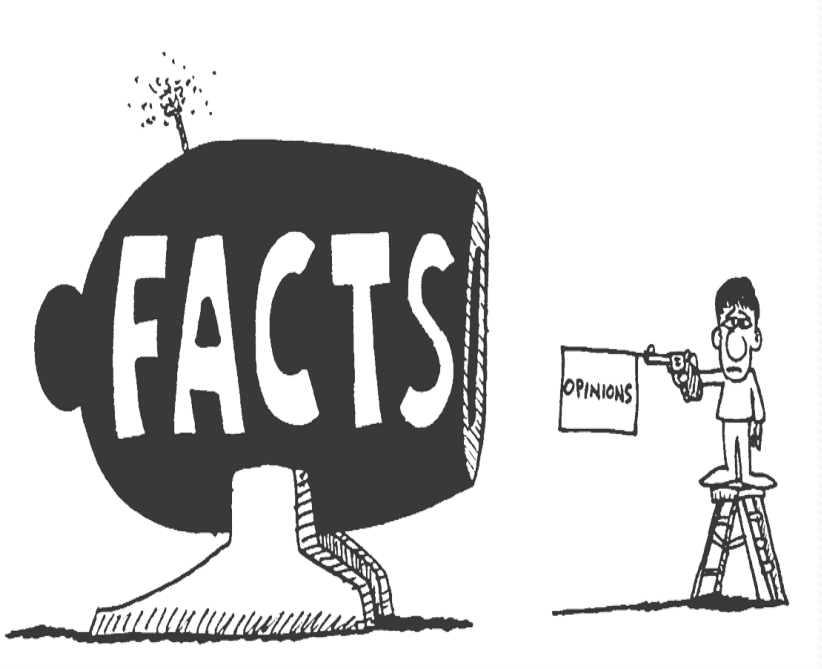
- However, other studies found these interventions had no significant effect on reducing PTSD…

- …or even had detrimental effects, as it is believed debriefing may interfere with natural coping responses.

- Postnatal debriefing occurs in 94% of hospitals in the UK for women who have had difficult births.
- 78% of these services are led by either a midwife or obstetrician .
- These interventions are usually offered to those women who are perceived by medical staff to have had a traumatic experience.
- Research suggests it is the interpersonal experiences that traumatise women as much as the medical adverse events…
- Therefore it is possible that many women are not being identified as at risk, as they have in the eyes of the health professionals had a ‘normal’ delivery.

- By offering a debriefing service, professionals may believe they are providing an effective intervention.

- However midwives and obstetricians don't typically have training in trauma, or counselling skills, which may mean that the woman is only provided with an explanation of 'the facts' from a medical perspective…



- …but the meaning of the experience for the woman, and her emotional needs may not be addressed.


THERE IS NO TRUTH
THERE IS ONLY PERCEPTION

NICE guidelines for antenatal and postnatal mental health

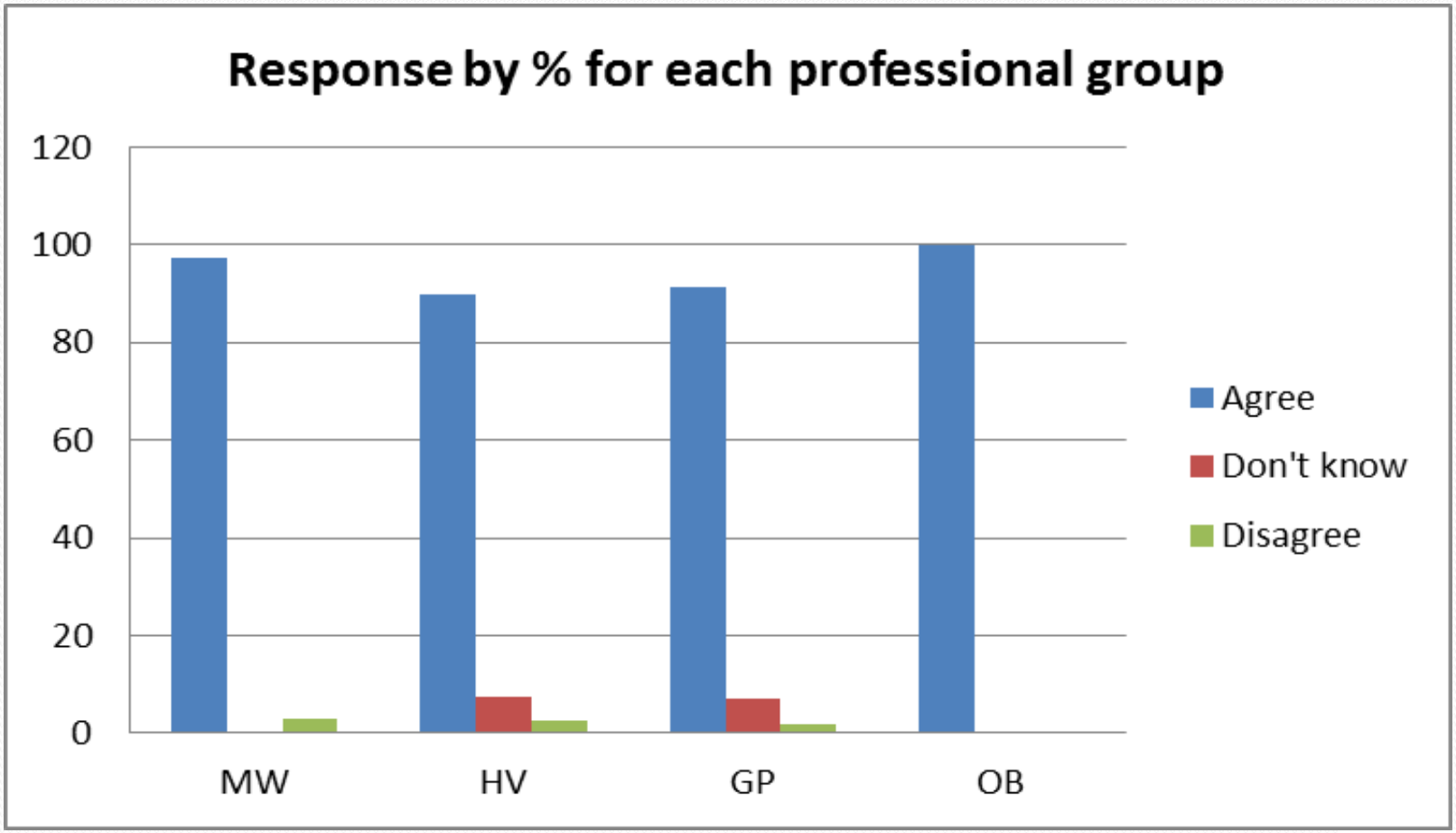
- 2007 guideline…
- *"Do not routinely offer single-session formal debriefing focused on the birth to women who have experienced a traumatic birth"*

- 2014 guideline…
- *"Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth"*

- Recommendations made within the new guideline reference the 2005 NICE guideline for PTSD.
- This guideline was based on systematic reviews of RCTs of individual psychological debriefings.
- It concluded that there is unlikely to be a clinically important effect on subsequent PTSD, following single session debriefing, with one study suggesting evidence of harmful effects.
- The guideline concludes that single session debriefing may at best be ineffective.

So why are so many maternity providers offering “debriefing” to women following a traumatic birth?

"I believe if a woman is complaining of difficult emotions following childbirth, it is important that she is debriefed"



- Results from the qualitative data from the study suggest that health professionals believe knowing 'the facts' will reduce the psychological distress associated with traumatic birth.

- As results from the quantitative data suggest that health professionals have insufficient knowledge of how individuals process trauma, this would suggest that their beliefs and actions are not based on knowledge of trauma or recommendations, but based on their own emotional reactions to the situation and the need to 'do something'.

The WUTH Perinatal Mental Health Team response

Our plan to address childbirth trauma…

How our service has developed…

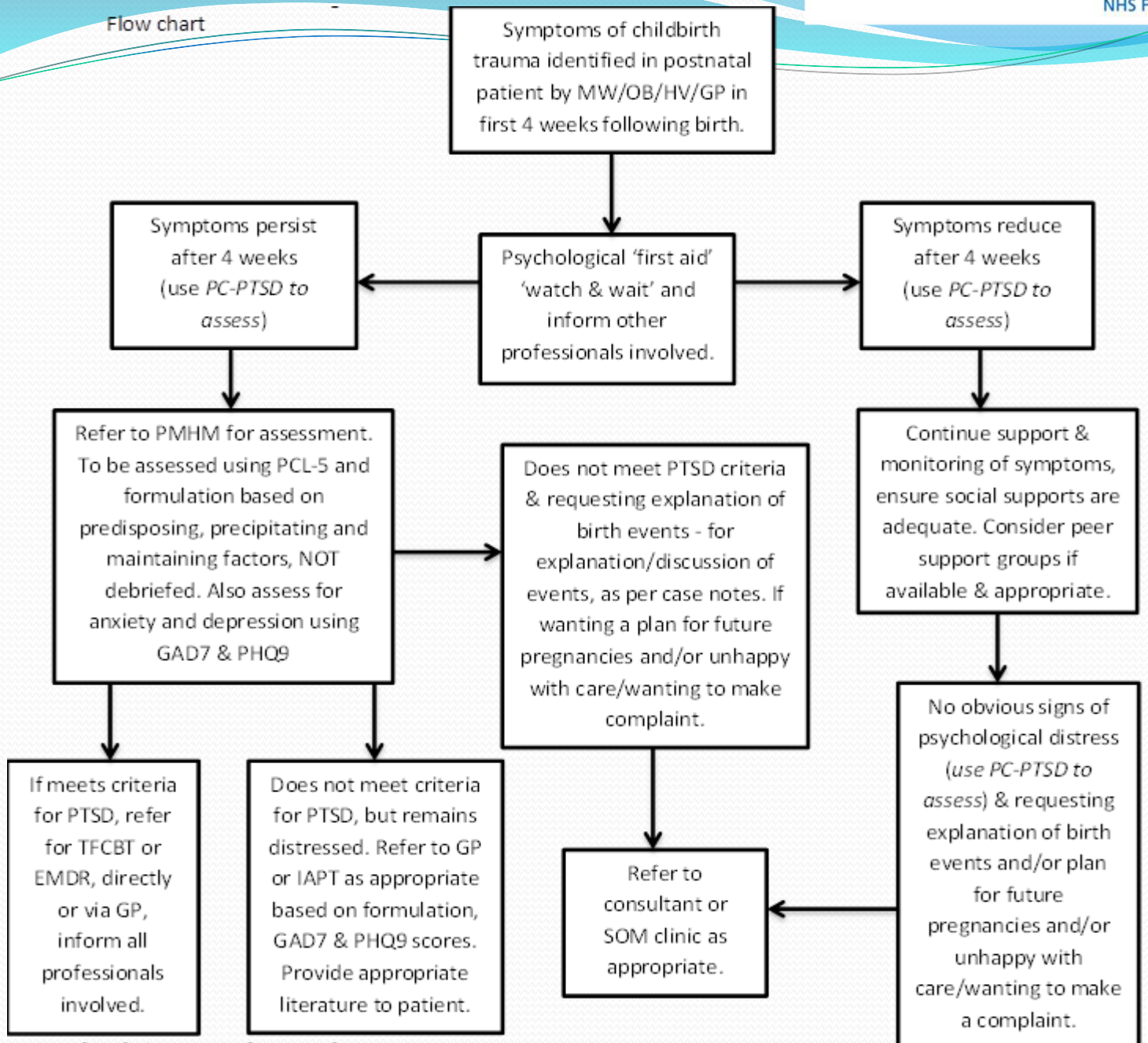
- Until February 2015 supervisors of midwives were holding a monthly 'debriefing' clinic.
- From March 2015 the perinatal mental health midwives have taken over this service and approach the problem very differently.
- We offer assessment for PTSD, depression and anxiety, and referral for psychological therapy if appropriate.
- Psycho-education on trauma.
- The opportunity for the woman, and her partner to explore the meanings they have attached to their experience.
- And only if required, an explanation of events as per the medical records.

Referrals…

We are receiving referrals from:

- Community midwives
- Health visitors
- GPs
- Obstetric consultants
- Self referral
- We are also receiving referrals from ward based midwives in relation to women who have had a difficult delivery and who may have higher risk of developing PTSD.

Flow chart


Symptoms of childbirth trauma identified in postnatal patient by MW/OB/HV/GP in first 4 weeks following birth.
Psychological 'first aid' 'watch & wait' and inform other professionals involved.
Symptoms persist after 4 weeks (use *PC-PTSD to assess*)
Symptoms reduce after 4 weeks (use *PC-PTSD to assess*)
Refer to PMHM for assessment. To be assessed using PCL-5 and formulation based on predisposing, precipitating and maintaining factors, NOT debriefed. Also assess for anxiety and depression using GAD7 & PHQ9
Does not meet PTSD criteria & requesting explanation of birth events - for explanation/discussion of events, as per case notes. If wanting a plan for future pregnancies and/or unhappy with care/wanting to make complaint.
Continue support & monitoring of symptoms, ensure social supports are adequate. Consider peer support groups if available & appropriate.
If meets criteria for PTSD, refer for TFCBT or EMDR, directly or via GP, inform all professionals involved.
Does not meet criteria for PTSD, but remains distressed. Refer to GP or IAPT as appropriate based on formulation, GAD7 & PHQ9 scores. Provide appropriate literature to patient.
Refer to consultant or SOM clinic as appropriate.
No obvious signs of psychological distress (*use PC-PTSD to assess*) & requesting explanation of birth events and/or plan for future pregnancies and/or unhappy with care/wanting to make a complaint.

Psychological first aid…

- …is an approach used to provide early assistance to those who have experienced trauma, the aim being to reduce initial distress and maximise the likelihood of a natural spontaneous recovery.
- It ensures basic needs are met, providing practical and emotional support and information, and promotes adaptive coping; encouraging engagement with social supports.
- It aims to ensure a sense of safety, calming, self-efficacy, connectedness and hope.

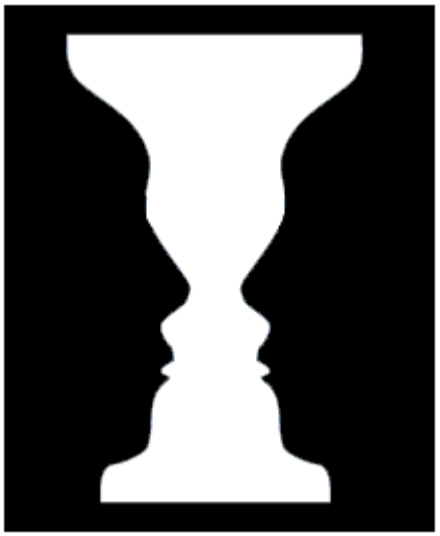
Basic trauma assessment tool: PC-PTSD…

- In terms of the experience; in the past month have you:
- Have had nightmares about it or thought about it when you did not want to?
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or you surroundings?
- PC-PTSD should be considered “positive” if a patient answers “yes” to any three items.

PCL-5: used by PMHM

- This is a 20 item, self-report measure which assesses the symptoms of PTSD as outlined by DSM-V
- It is a validated measure which has been revised to meet DSM-V symptom criteria and it can be scored in different ways.
- Its predecessor, PCL, was found to be a reliable measure for the assessment of female trauma victims.

Trauma assessment…



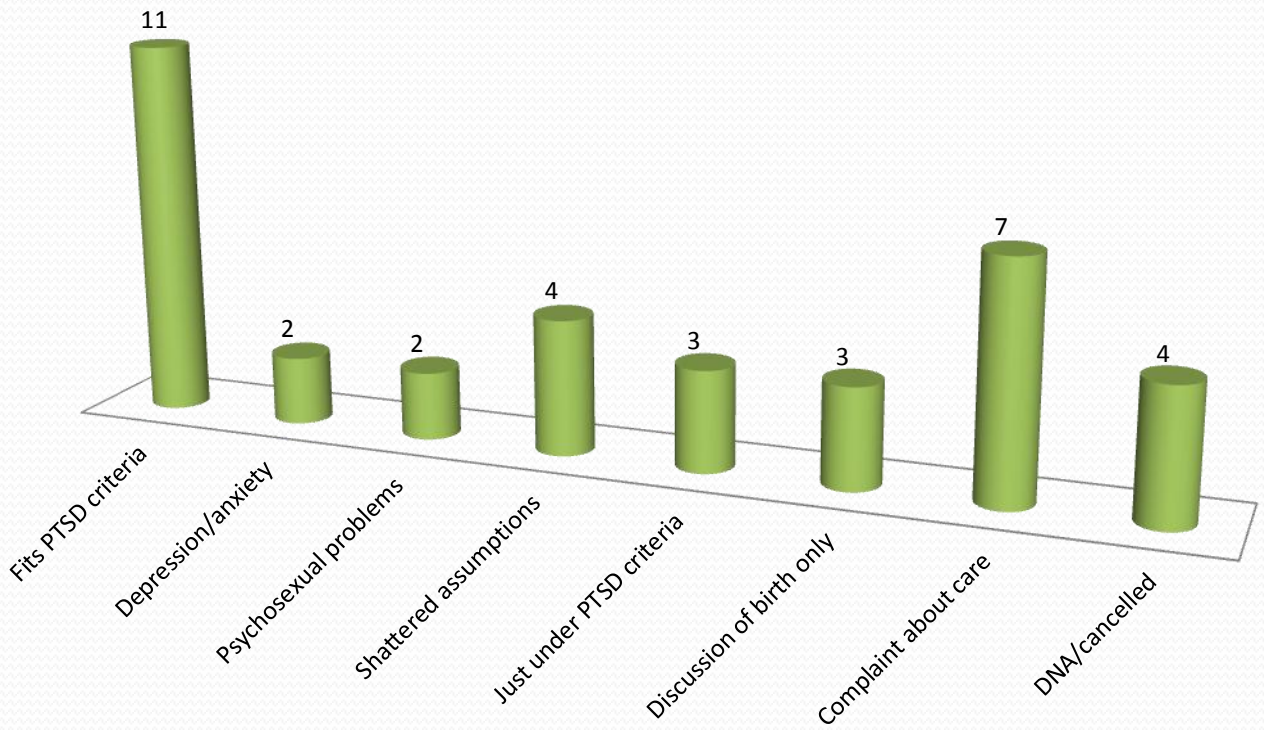
- Focused on the woman's perception of her 'truth'. Not the medical 'facts'.
- Use of the PCL-5, GAD7 and PHQ9.
- Formulation based interview of the woman, with discussion of predisposing, precipitating and maintaining factors, using themes identified in the existing research on childbirth trauma.
- Indicates who to refer for treatment for PTSD and who may have symptoms of anxiety and depression.

Trauma assessment…

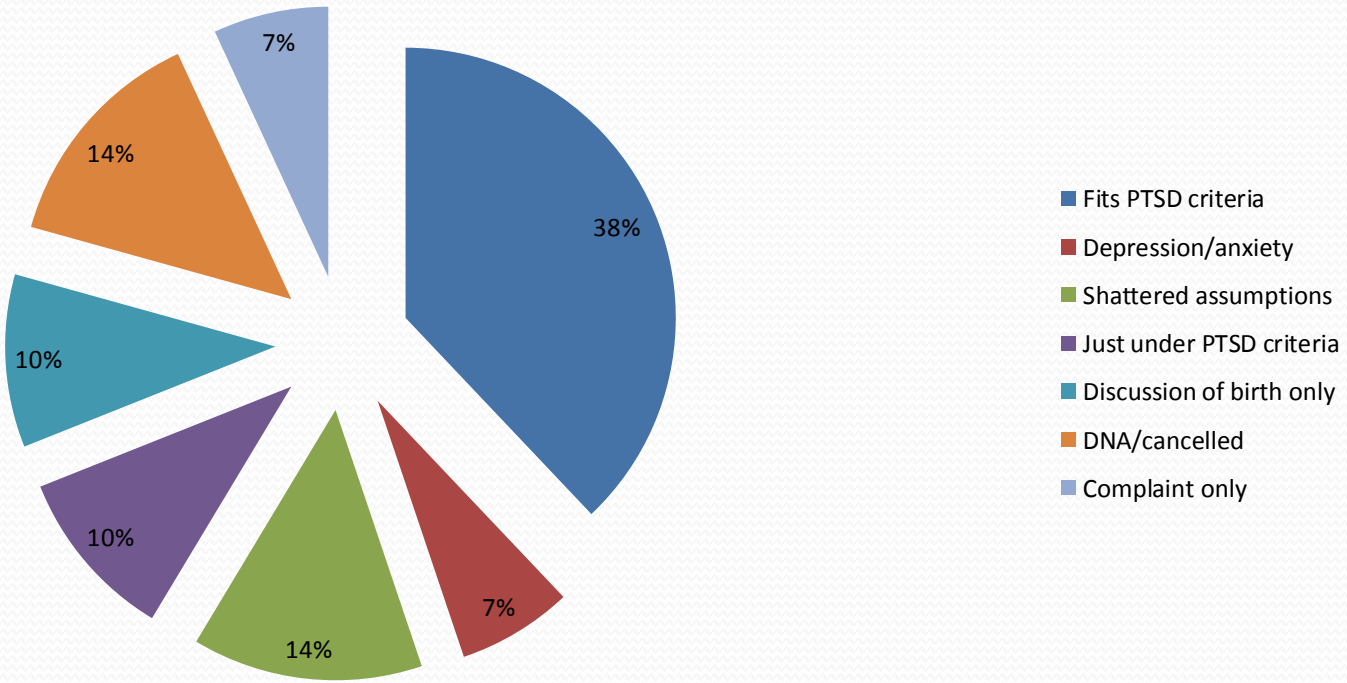
- For those who don't fit PTSD criteria, but wish discuss their delivery, or who have a complaint about their care; it may then be appropriate for a discussion of labour events.
- If the woman needs reassurance for a future pregnancy; then this can be provided, or referral to a consultant obstetrician may be appropriate.
- If wanting to complain about care, referral to a supervisor of midwives may be more appropriate, or details given on trust complaints procedures.

Statistics are for a 6 month period from March to August 2015

Postnatal referrals (total = 28) findings following consultation with PMHM

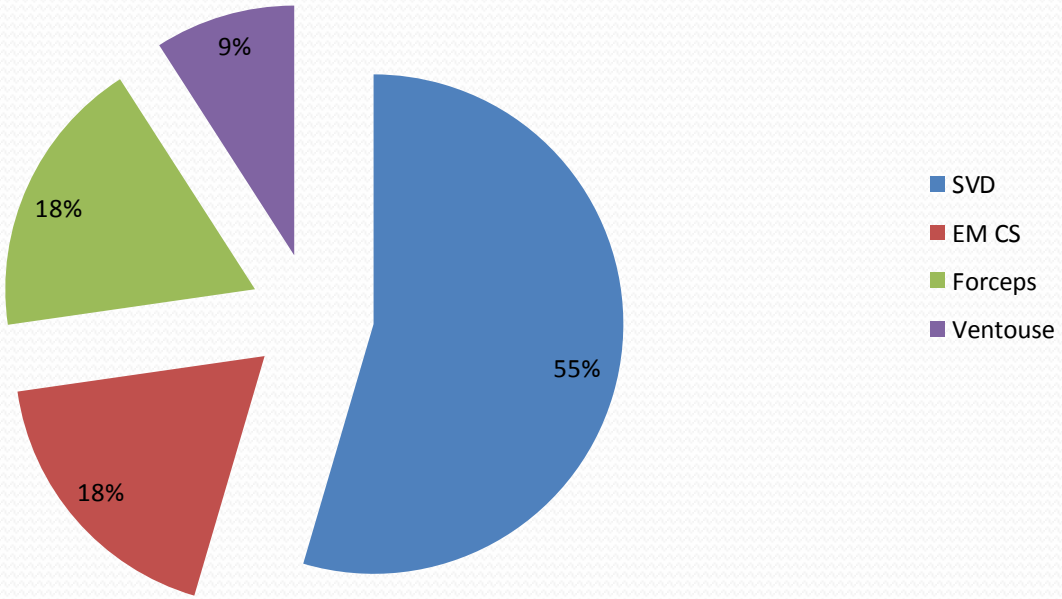


Statistics are for a 6 month period from March to August 2015



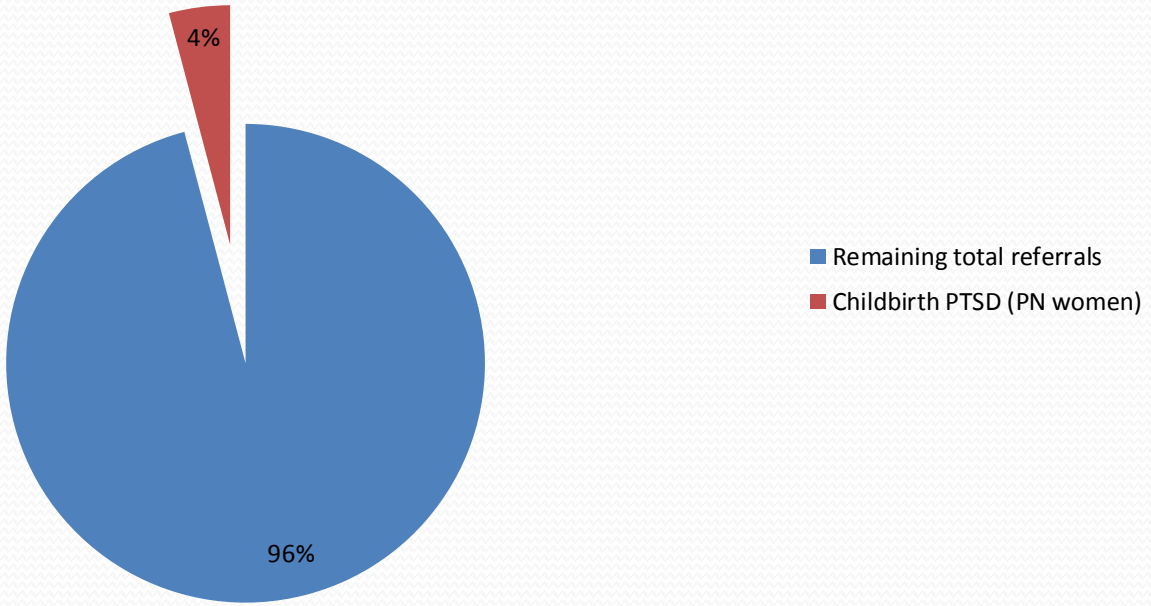
Statistics are for a 6 month period from March to August 2015

% of women who fit criteria for PTSD following childbirth by type of delivery



Childbirth related PTSD: Statistics are for a 6 month period from March to August 2015

% of total referrals to the PMHT who meet criteria for childbirth related PTSD (postnatal only). Total referrals to the service for these dates 267



Developments…

- Expanding the team - a third part-time midwife.
- CBT training – PMHM to commence PG Dip in CBT September 2015
- Training – PMHM to develop training in psychological trauma and childbirth trauma to offer to all health professionals who come into contact with perinatal women.
- Focus groups - to attempt to establish what good support for this population of women actually looks like?

Contact details…

To enquire about training or for more information on the research study, please contact me on:

emmamathews@nhs.net

Questions…?