Perinatal Trauma

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Overview

Part 1:

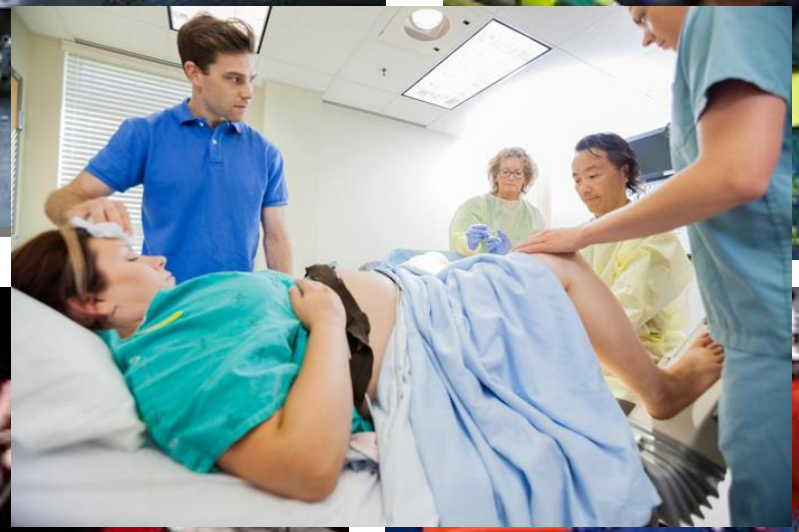
- Why do women get PTSD associated with childbirth?
- Preventing preventable birth trauma
- Interventions for birth trauma

Part 2:

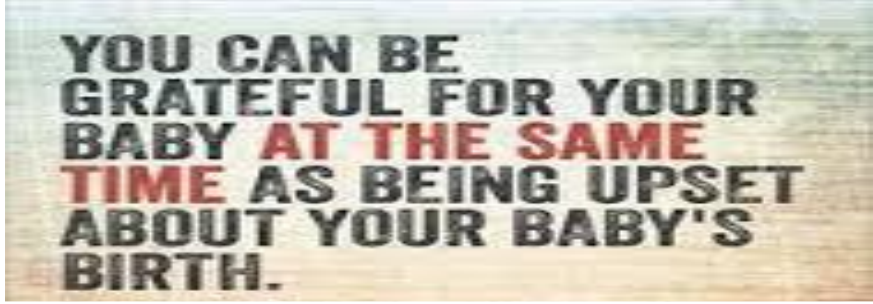
- Complex trauma and the perinatal period
- Stabilisation
- Working with parent and infant

Who will get PTSD?

Who will get PTSD?



Childbirth related PTSD



- PTSD reported in 3.17% of women following childbirth
- Postpartum PTSD found in 15.7%-18.5% of Mums who had a history of trauma prior to childbirth
- Almost 20% of women fulfill criteria of having had a traumatic birth i.e. their/their baby's life or physical health at risk during childbirth
- In a UK survey, 43.6% of women who experienced childbirth as traumatic reported 1 or more symptoms of PTSD (re-experiencing, negative cognitions/emotions, hyper-arousal and avoidance)

Childbirth related PTSD

We can predict that for some women childbirth increases the risk of PTSD

- High risk groups e.g. emergency c-section, history of abuse, pregnancy complications (e.g. HG, PROM, Pre-eclampsia), baby in neonatal intensive care more at risk of PTSD postnatally (Yidez et al., 2017).
- Black women x4 and women from Asian background x2 more likely to die in pregnancy and childbirth. More research needed to understand rates of PTSD in BAME women.
- Impact of covid

Childbirth related PTSD

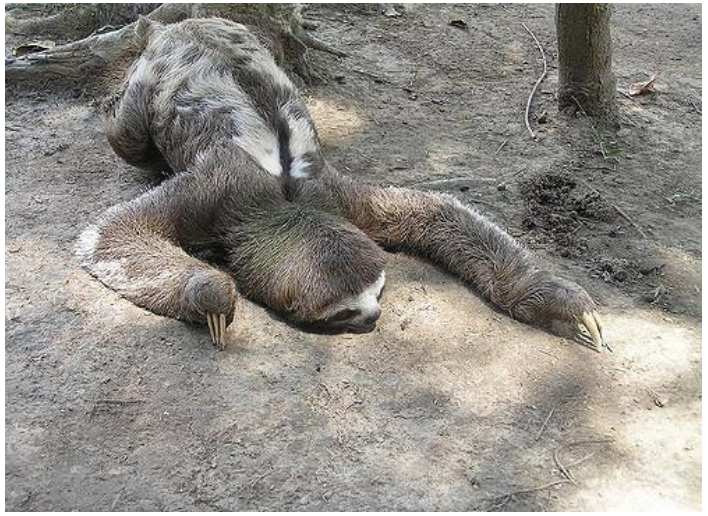
- If left untreated increased anxiety and exacerbation of PTSD in a subsequent pregnancy (Ballard et al., 1995; Thomson & Downe, 2010) and increased requests for c-sections (Ryding et al., 2015)
- 1st 3 months some spontaneous resolution. Shouldn't immediately pathologise symptoms

BUT screening/watchful waiting is required to aid detection and early intervention

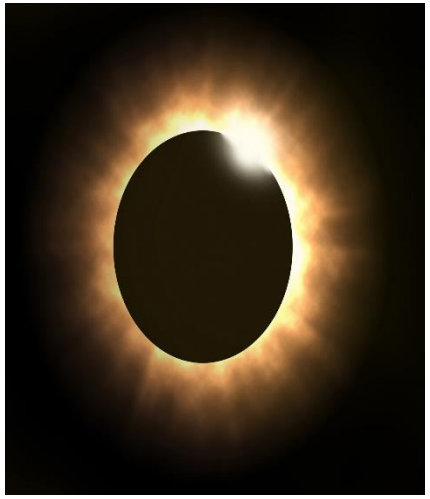
Why is birth trauma so important?

‘Myths and Old Wives Tales’

‘If you look at a sloth when you are pregnant the baby will look like one’



‘If you see something ugly during pregnancy your baby will be ugly’

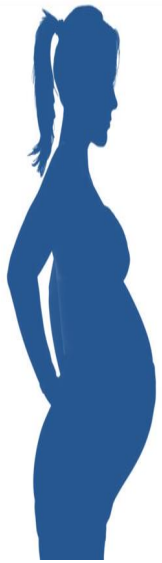


‘If you watch a lunar eclipse during your pregnancy, your baby will have a cleft lip’

‘At least you’ve got a healthy baby’

The importance of tackling birth trauma & Perinatal PTSD

- Women do not tend to spontaneously recover from PTSD without intervention (Soderquist, 2002). Additional problems include:
  - Depression
  - Loneliness
  - Feel weak and guilty they can't put it behind them
  - Avoidance of other medical procedures e.g. cervical smear tests, using tampons
  - Problems within relationships
  - Difficulties breastfeeding
  - Difficulties bonding with the baby
  - High levels of stress in Mother can lead to high levels of stress in baby



Impact of PTSD on the Child

- **Prenatal and Postnatal adversity can have long lasting effects**
  - PTSD during the perinatal period can negatively impact upon children's behavior, socio-emotional and cognitive development (see Garthus-Niegel et al., 2017; Cook et al., 2018 for recent systematic reviews)
  - Pregnant 9/11 survivors:- infant's displayed attenuated cortisol levels, and increased distress response when shown novel stimuli (Yehuda et al., 2005, 2011)

BIRTH IS NOT 'JUST ONE DAY' IN YOUR LIFE

We don't just leave our feelings about our birth at the hospital. The feelings we bring home about the birth can affect everything that follows. These feelings can infiltrate all areas of our lives as a new family.

THAT IS WHY BIRTH IS IMPORTANT.

birthtraumatruths.wordpress.com

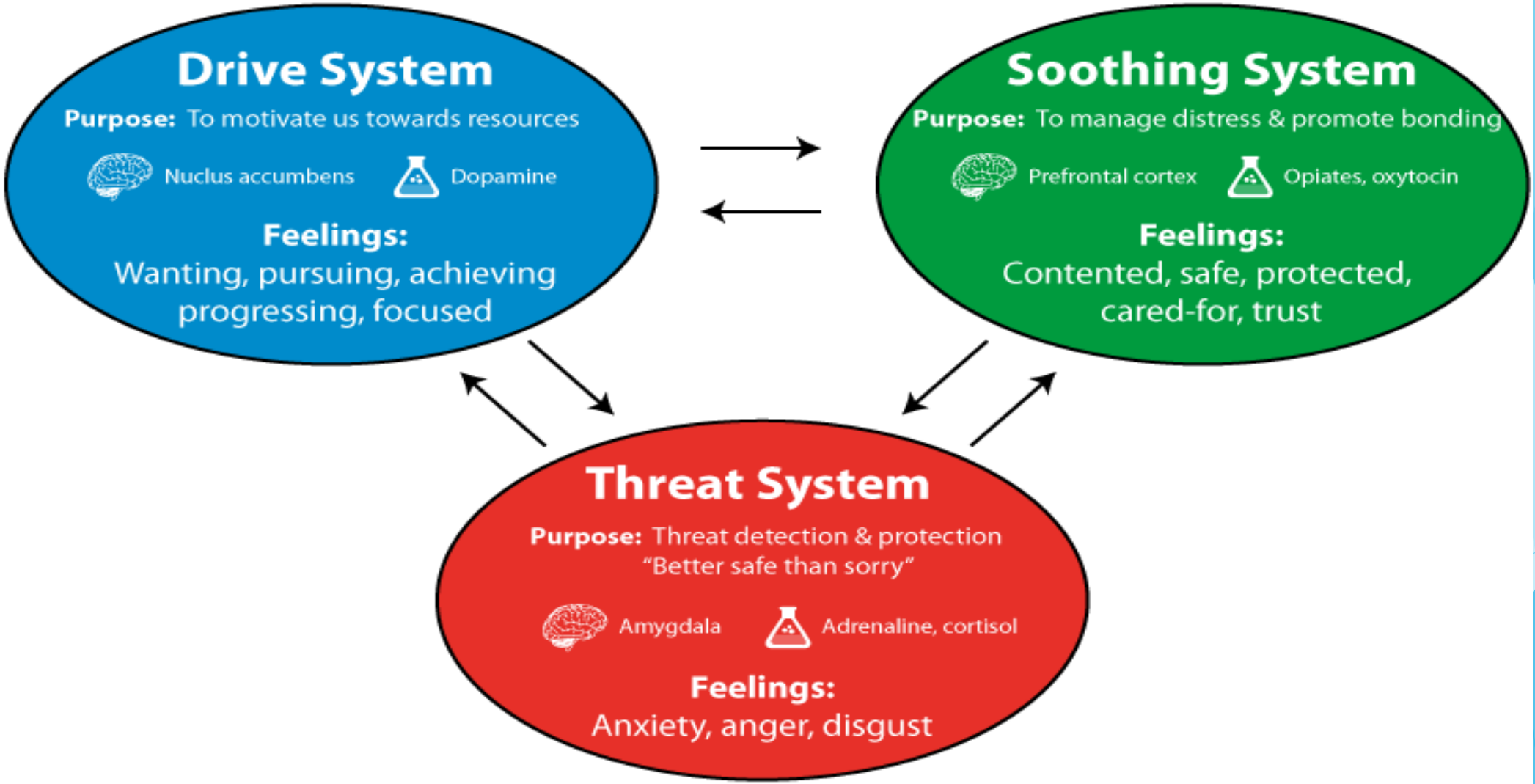
Why do women get PTSD with childbirth?

- Any new, unpredictable and uncontrollable experience is likely to be stressful
- Childbirth is so outside normal range of experiences, the brain cannot cope with it. Re-experiencing thoughts/images is the brains attempts to process it and remind us the threat is still present
- Actions of others around you really influence how you perceive that event
- Studies show a third of the ‘hotspots’ around a traumatic childbirth are due to interpersonal events e.g. feeling abandoned, being ignored, lack of support (Harris & Ayres 2012)

What helps women stay resilient through a traumatic birth?

- More support
- Less fear of childbirth
- Greater confidence in healthcare professionals
- Less anxiety and depression
- Sense of control over decisions

Emotional Regulation Systems



Two types of birth trauma

1. Objective trauma – trauma caused by potentially life threatening events

- Complications in the physical events of the birth e.g. postpartum hemorrhage

- Genuine threat to the Mum's or child's health/safety/life (e.g. stillbirth, disability resulting from the birth, stay in SCBU/NICU)

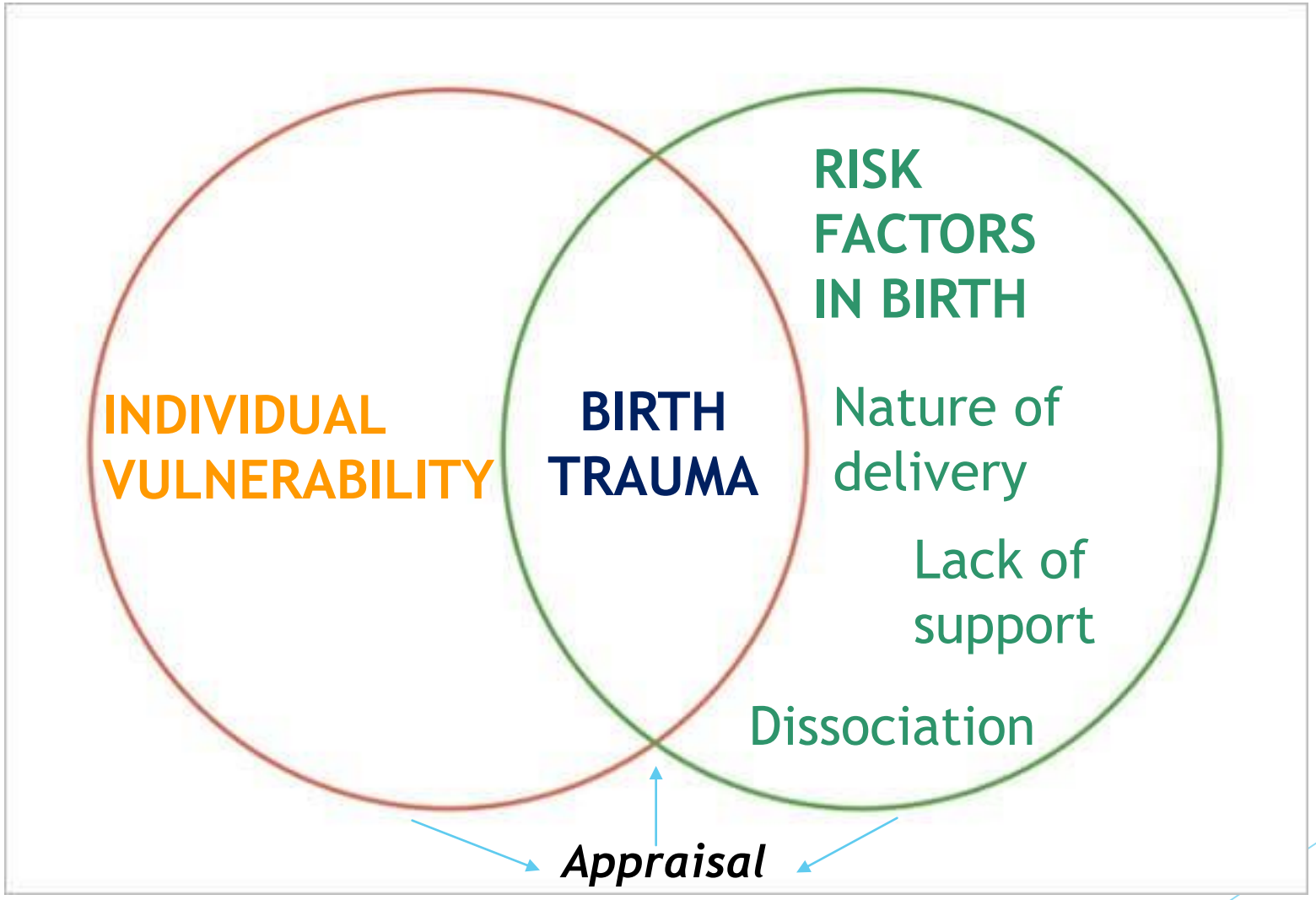
Two types of birth trauma

2. **Subjective** trauma

- Not caused by a potentially life threatening event

- Objectively a good outcome i.e. healthy baby, healthy mum but something about their labour experience has led to them feeling traumatised

Diathesis Stress model of birth trauma



Diathesis: Vulnerability factors in mother

- Anxiety and/or depression in pregnancy
- Fear of childbirth
- History of PTSD (including previous birth trauma) or psychological problems
  - More sensitive to how they are spoken to or cared for, due to life experiences
  - On greater alert to perceived threat
  - May not have coping skills to manage with the stress of labour and childbirth
- Complications in pregnancy

Stress factors: Dissociation

- Higher rates of postnatal PTSD in women reporting dissociation during childbirth
  - Dissociation often associated with previous trauma
  - Dissociative states may prevent women from expressing needs and preferences e.g. physical distance, touch
  - Difficult for health care providers to recognise and therefore may be failing to ask permission re physical distance and touch

Stress Factors: Nature of the delivery

Factors could lead to fear for own safety or baby's safety

- Lengthy labour or short and very painful labour
- Induction
- Poor pain relief
- High levels of medical intervention
- Emergency deliveries e.g. emergency c section

Stress Factors: Lack of support

- Poor communication during maternity care e.g. not given enough information, conflicting information, or not listening to mothers concerns
  - Leads to unrealistic birth expectations
  - Fears and concerns are not listened to or not passed on/documented
  - Insufficient planning around woman's individual care needs/plan not read
- Lack of compassionate care
  - Staff are overworked, understaffed, burnt out, unsupported
  - Staff goals may focus on the process to ensure mum and baby are healthy but forget about how a Mum is perceiving what they are hearing and seeing
  - Woman might feel dismissed, unheard, uncared for, alone

Stress Factors: Lack of support

- Lack of privacy and dignity
- Lack of continuity in care
  - Caregivers could be ‘unknown, unnamed’ and have no prior relationship with the mother.
- Insufficient planning around woman’s individual care needs/plan not read
- Lack of knowledge and understanding of how to support women’s emotional needs in childbirth

Postpartum factors that maintain early PTSD symptoms

- Additional stress
- Maladaptive coping
- Poor support

(*Ayres, 2004*)

Postnatal checklist: risk factors for postnatal PTSD (The Birth Trauma Association)

- Lengthy labour or short and very painful labour
- Induction
- Poor pain relief
- Feelings of loss of control
- High levels of medical intervention
- Traumatic or emergency deliveries, e.g. emergency caesarean section
- Impersonal treatment or problems with the staff attitudes
- Not being listened to
- Lack of information or explanation
- Lack of privacy and dignity
- Fear for baby's safety
- Stillbirth
- Birth of a damaged baby (a disability resulting from birth trauma)
- Baby’s stay in SCBU/NICU
- Poor postnatal care
- Previous trauma (for example, in childhood, with a previous birth or domestic violence)

BIRTH STORIES FROM THE PANDEMIC

The Impact of COVID-19 on Birth Trauma

Main findings

- Overall, the literature suggests that COVID-19 has negatively impacted women's birthing experiences and led to a greater prevalence of birth trauma.
- One study found 5.9% of their sample met diagnostic criteria for PTSD and 57.9% experiencing trauma symptoms causing distress or functional impairment (Diamond & Colaianni, 2021)
- Factors associated with negative birth experiences were; a sense of reduced social support due to visiting restrictions, confusion over clinical advice, critical clinical care being missed, and reduced access to medication of choice.
- The most significant factor mentioned in the majority of papers was the impact of restricted visiting e.g., one visitor only being allowed to join their partner during active labour and reduced/prohibited visiting during the postpartum maternity stay.

Implications of COVID-19 as a stressor

- Mayopoulos et al. (2021) found that mothers giving birth in COVID-19 exposed communities reported more clinically acute stress responses to childbirth compared to matched controls and this was specifically associated with greater rates of birth trauma.
- Controls were matched on many factors including age, education, ethnicity, trauma and mental health history and delivery mode suggesting a unique impact of COVID-19 on birth trauma in the sample.
- The stress response in childbirth via the impact of COVID-19 was associated with other negative experiences including difficulties with bonding and breastfeeding in the early postpartum period.

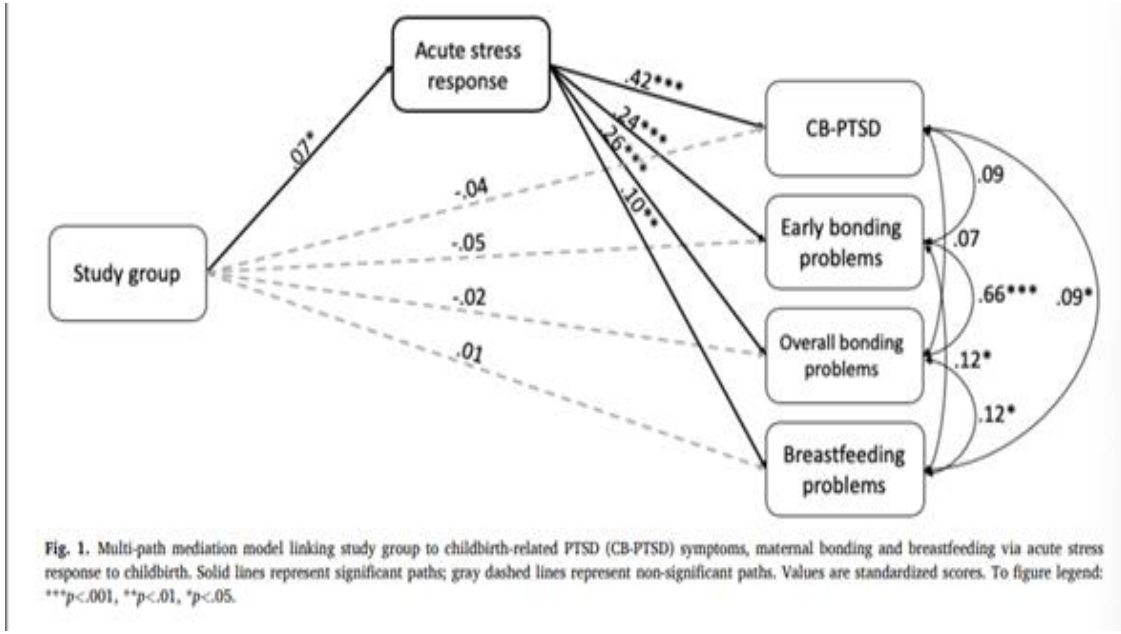


Fig. 1. Multi-path mediation model linking study group to childbirth-related PTSD (CB-PTSD) symptoms, maternal bonding and breastfeeding via acute stress response to childbirth. Solid lines represent significant paths; gray dashed lines represent non-significant paths. Values are standardized scores. To figure legend: ***$p<.001$, **$p<.01$, *$p<.05$.

Mayopoulos, G. A., Ein-Dor, T., Dishy, G. A., Nandru, R., Chan, S. J., Hanley, L. E., ... & Dekel, S. (2021). COVID-19 is associated with traumatic childbirth and subsequent mother-infant bonding problems.

Predictors of Birth Trauma (COVID-19)

- Diamond & Colaianni (2021) conducted a regression analysis to break down the impact of COVID-19 related perinatal healthcare changes on birth trauma.

- Identified the limited length of stay for a support person, only being allowed 1 support person who had to be the same, and mask requirements were significant predictors of PTSD after childbirth. Birth plan changes also predicted variance in PTSD symptoms.

Diamond, R. M., & Colaianni, A. (2021). The impact of perinatal healthcare changes on birth trauma during COVID-19.

Positive Birth experiences

- Karlstrom , Nystedt & Hildingsson (2015) – focus groups with Swedish Mothers 6-7 years after a birth they assessed as positive. Factors for a positive birth included:
  - Own ability and strength
  - Trustful and respectful relationship with their midwife
  - Trust and support from the father of the child
  - The feeling of safety promoted by a supportive environment was essential to gaining control during birth'

"For me a big part of the positive experience was that I felt seen and provided for, and that I was taken care of (second child, emergency C-section)"

"I soon felt a sense of cooperation with the midwife and the assistant nurse. This was something we would do together (Third child, vaginal birth)

Trauma informed care

Empowerment, voice and choice

Safety

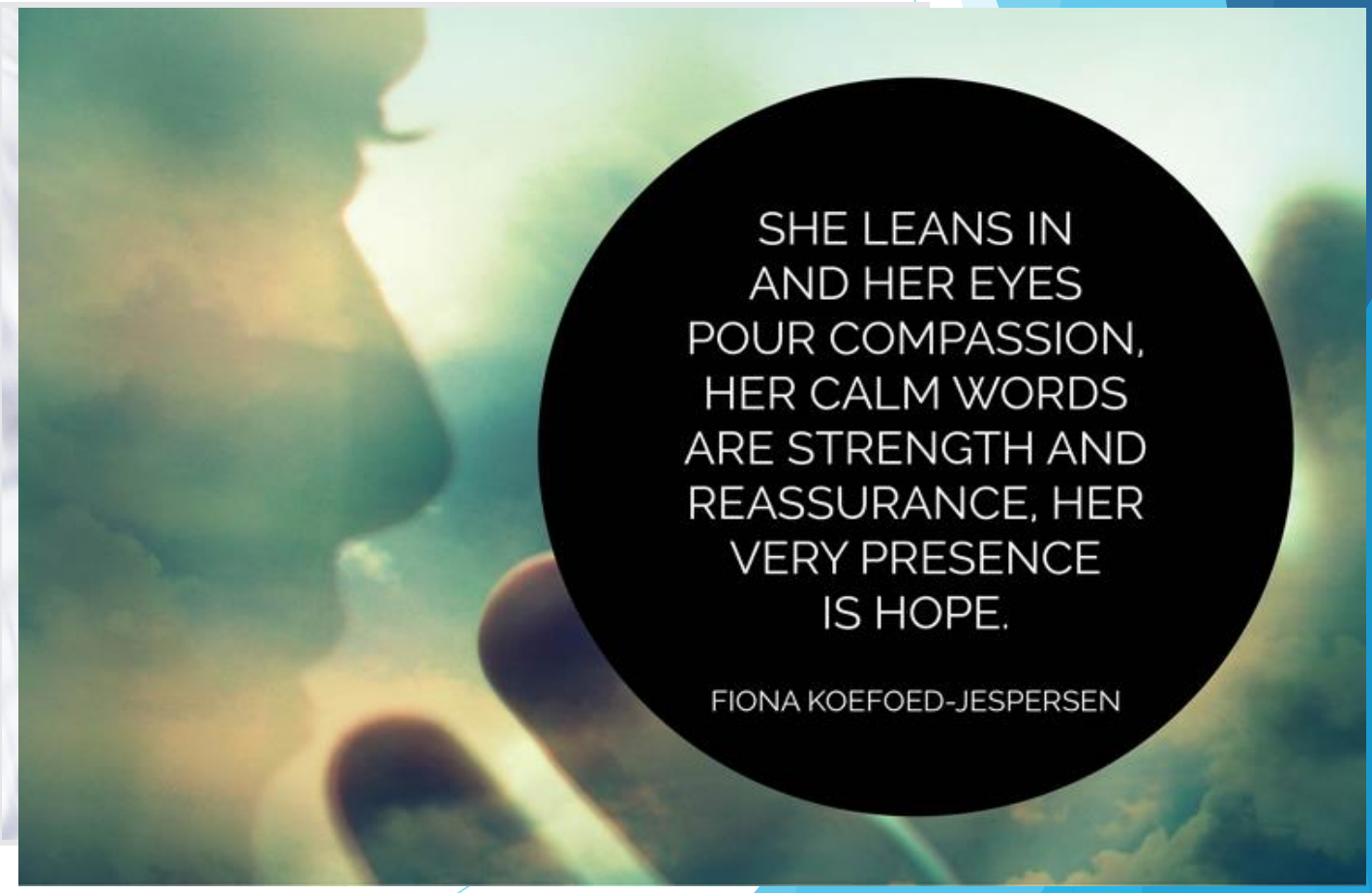
Collaboration and mutuality

Trustworthiness

Cultural, historical and gender awareness

Com·pas·sion [kuhm-pash-uhn]

noun : a feeling of deep sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering.



Supporting pregnancy following a previous trauma

- Ask early on about their mental health history and experiences of previous pregnancies (including miscarriages, terminations) and deliveries. How have they coped with these experiences?
- Work with the mother and maternity team to develop a birth plan. Support mothers to develop THEIR preferred birth plan AND caution to the need to be flexible as plans can need to change to ensure a safe delivery (psychological flexibility)
- When women are allowed to have an elective c-section a third will then choose to have a natural labour. Anxiety can get in the way of making a vaginal birth a choice.

C.A.L.M pack

- Keep **C**onnected with the people who matter

- **A**sk for what you want and need

- **L**earn ways to manage your thoughts and feelings

- **M**anage your environment

What to do if a woman has experienced a traumatic birth

- Watchful waiting in the month after childbirth
- Empathic and practical support can be far more helpful at this time.
- If the woman (or her partner) wants to talk about what has happened, listen empathically but do not probe for information.
- Pass on concerns to midwife/health visitor and GP and advise review after one month to see if symptoms are still present.
- Parents may request a birth reflections/discussion of their notes. This may help fill in the gaps but will not resolve PTSD. Could lead to additional problems if discussion not undertaken compassionately.

Interventions for birth trauma

- Stabilisation work e.g. empathic listening, coping skills, CFT/ACT approaches
- Limited studies on the use of trauma focused psychological therapies for women post-partum
  - NICE Recommended treatments:
    - Eye Movement De-sensitisation and Reprocessing Therapy (EMDR)
    - Trauma Focused CBT
- Coming soon – REWIND service improvement project for single trauma birth trauma

Reflections on using EMDR for perinatal PTSD

(Recent birth trauma/prenatal treatment)

- More complex work than you might expect for a ‘single trauma’
- Is it because in some cases the trauma is so recent?

Key Themes

- Ongoing uncertainty over their health and health of baby
- Baby’s first birthday also the anniversary of the traumatic incident
- Women tend to blame themselves for not giving their baby the ‘perfect start in life’
- Often several targets within one trauma memory e.g.
  - Multiple admissions to hospital and different episodes of health deteriorating/concerns about baby
  - Multiple invasive procedures
  - Separation from baby due to Mum or Baby’s health
  - Adjusting to becoming a Mum following trauma e.g. impact on breastfeeding
  - May be worth addressing these as separate targets rather than trying to process it all at once

Reflections on using EMDR for Perinatal PTSD

- Often not obvious what might be ‘historically’ contributing to trauma memory until start processing
  - Timeline approach might not generate contributing beliefs. Sometimes women do not report any previous difficulties prior to birth trauma or do not see previous events as relevant
  - Using floatback technique to access blocking beliefs

- Might be unanswered questions around why these events happened (and whether they will happen again) which are blocking processing
  - Liaising with maternity to help them understand what happened
  - Helping them accept uncertainty around the ‘why’s’

Reflections on using EMDR for Birth trauma

Experience might clash with:

- Beliefs of being ‘in control’, ‘strong’
  - Working with parent to accept their own vulnerabilities
- High standards
  - Working with parent to accept ‘good enough’
- Lack of understanding from support network/professionals
  - Educating others of PTSD following birth
- Supporting parents where they are both traumatised
  - Fathers may be expressing their distress in different ways e.g. anger/alcohol
  - Joint meetings
  - Helping partners access support

Reflections on using EMDR for Birth trauma

- Pre EMDR work: Safe place, and compassionate/wise/protective figures: who would have made a difference, if they had been present at key points during your birth experience
- Finishing each EMDR session with imagery of being safe with their baby
- As EMDR progresses:
  - Gratitute: Noticing who helped them and appreciating small acts of kindness
  - Noticing own strengths
- In some cases targeting birth trauma can be enough to resolve other presenting problems including difficulties bonding with baby. Where it isn't parent may also need parent-infant intervention.

EMDR: Working with parents where their baby has died

- As with any EMDR work for grief unrealistic to reach a point of no distress around the memory
- Complicating issues
  - Their time with their child being taken away from them
  - Loss of their imagined future with their child
  - Lack of understanding from partner/family/friends (especially if the trauma is a miscarriage)/other people moving on with their life where they cannot
  - If mistakes were made that resulted in the baby dying
- Helping the parent work through the pain of their grief and accept the reality of their loss
- Helping parent access positive memories of their time with their child e.g.
  - moments of feeling close with their bump in pregnancy
  - holding their baby's hand
  - how the love for that baby has enabled them to love a new baby
- EMDR might be more successful if they have gone on to have a healthy baby

For and Against EMDR in pregnancy

- EMDR can increase stress levels. Elevated stress hormones can be harmful to pregnant woman and her baby.
    - Leeds (2013) received a small number of reports from women complaining of unstable pregnancies following EMDR – believing EMDR to be a factor
- However PTSD has negative effects on maternal and foetal health
    - Stramrood (2012), case series with 3 pregnant women where EMDR led to stress reduction, fewer PTSD symptoms and increased confidence about up and coming birth. All had positive outcomes of their 2nd birth.
- Baas et al (2017) are undertaking a RCT to look at whether EMDR is a safe and effective treatment in pregnancy for birth trauma and fear of childbirth
- Current view that risks on stability of pregnancy are low and high probability EMDR will improve maternal stability, however there is an absence of research trials to confirm this (Leeds, 2013).

AT ASSESSMENT DISCUSS POTENTIAL BENEFITS AND COSTS OF TREATMENT WITH THE SERVICE USER WHEN CO-CONSTRUCTING THE INTERVENTION PLAN

For and Against EMDR in pregnancy

- As there is insufficient evidence of the risks and benefits of EMDR in pregnancy important to:
  - Weigh up the pros and cons of using EMDR on a previous trauma with the client. Important to consult with obstetrician to ensure mother is physically well enough to cope with the therapy
  - Minimise harm when using EMDR on previous trauma
    - Good preparation stage. Using EMDR resources, drawing on other coping skills e.g. mindfulness
    - Therapist needs to be active in using containing exercises to reduce the amount of re-experiencing symptoms
  - Use EMDR to prevent future problems (e.g. Divitus & Luber, 2016 protocol)
    - Building resources
    - Instilling positive cognitions to enhance confidence of childbirth
    - Future template
- Preferably undertake EMDR prior to becoming pregnant again.
  - Important for clinicians to recognise symptoms of PTSD and provide interventions in a timely way.

ANY QUESTIONS?