the birth trauma association

helping women traumatised by childbirth

BTA CONFERENCE

2nd June 2005

An Introduction to Post Natal PTSD

Internet: www.birthtraumaassociation.org.uk **Email:** enquiries@birthtraumaassociation.org.uk

I think that it is easy to forget how new and frightening it all is for us. To me it is like driving a car from London to Perth having never driven before and carrying the most precious thing you own - your baby. All you have is the person who is sat beside you to guide you (your midwife) who may or may not have done this journey herself but has guided countless people through it. You don't know what lies ahead and if you will all get through it alive. Who would you want - the bad tempered crotchety one or the supportive comforting one. They may do this every day but I only ever planned to do it 3 times in my entire life (and I am not sure that I will ever do the 2 other planned journeys). How many other things of this magnitude are you confident doing for the first, second or third time?

Kate

PART I

THE BIRTH TRAUMA ASSOCIATION

AND

POST NATAL POST TRAUMATIC STRESS DISORDER

About the Birth Trauma Association

A professional's view

Postnatal PTSD affects approximately 2% of women long term, which means over 10,000 women in England and Wales are affected each year. If treated early by psychotherapy it is usually very responsive to treatment. However, if untreated it can become chronic and has a huge impact on women and their children. Unfortunately, PN PTSD remains largely unrecognized. There is a huge lack of awareness, information, screening and treatment for it.

This is where the BTA have been incredibly influential in the last year. The BTA has been critical in pulling together clinicians, academics, and women who suffer from PN PTSD with many positive effects. For example, the BTA have increased media coverage of PN PTSD and therefore increased awareness generally. Their website is very well designed and a good source of information and support for women who suffer from PN PTSD. The BTA have recently set up telephone volunteers for women with PN PTSD to talk to, and they hope to expand this to provide a national helpline. In addition, the BTA has lobbied government organizations successfully to be involved in decision-making about relevant clinical protocols, for example NICE guidelines.

In summary, the BTA have undoubtedly helped pull together knowledge, provide support for women, and influence clinical practice – all in their first year. However, there is still a lot to be done. PN PTSD is still not routinely screened for and treatment is not routinely available. Public awareness still needs to be increased and there is a lot of preventative work that can be done in terms of training healthcare professionals.

Dr Susan Ayers,
Senior Lecturer in Psychology,
Sussex University,
March 2005

A woman's view

"I first came into contact with the Birth Trauma Association in autumn 2004. At that stage it was probably fair to say that, at times, I was near to suicide. My baby had been born in late February 2004, I had been misdiagnosed by my GP with post natal depression, and was not getting any help at all from any NHS services such as health visitors - my GP surgery no longer had a full time visitor - or from the hospital where I had given birth; I think they do not recognise the condition, and have failed to offer any assistance despite correspondence with them.

Quite simply I do not believe that I would be here without the BTA. Through the BTA I was able to find out more about the condition, identify a local hospital where I could get further support, and more than anything was able to regularly talk to someone who understood. The information leaflets have been useful to give to family as well as medical professionals who sadly generally fail to have much if any understanding of the condition. Despite a traumatic

birth my hospital offered no support at all, and if only they had been more proactive I could have been spared a very distressing 12 months.

Failure to identify or treat the condition has impacted all of my family; not least my husband and daughter. I felt so distant and removed from her at times that I wondered if I would ever feel the 'special bond' that a mother and child are supposed to feel. My greatest sadness is that I have missed much |of the important first 12 months; and have very limited memories of this.

The BTA fulfils a unique role in tackling a problem which unfortunately the UK has been slow to identify and yet affects a huge number of women. It has a critical role to play in promoting awareness, understanding and therapeutic treatment methods at all levels, national, regional and local. At the same time it is provides a literally lifesaving service to individual women and their families who are failing to receive support from their local NHS providers.

Unlike postnatal depression the need for support for suffers of PN PTSD goes on for years, as many find their child's birthday, and hence the anniversary of the birth traumatic, and for many more they need tremendous support in even considering, let alone attempting another pregnancy.

Sarah

History and Development of the BTA

The Birth Trauma Association (BTA) was established in 2004 to support women from ‘birth trauma’ as a result of their childbirth experience. This is a term which refers to both Post Natal Post Traumatic Stress Disorder (PN PTSD) and an acute stress reaction to birth. Research has shown that these problems can have an impact on the emotional well-being of children in the post partum period. Consequently, the work of the BTA supports the entire family.

PN PTSD is a clinically important condition but it is, as yet, under-recognised and under-researched. Symptoms of PTSD may occur in up to 30% of women in the UK following childbirth. In around 2% of women, these symptoms are of a severity to fit full DSM-IV criteria for PTSD[1]. For the remainder, trauma symptoms in three domains may be present; avoidance, arousal and ‘reliving’. In practical terms, a woman experiencing postnatal PTSD symptoms may avoid triggers which remind her of the birth, like hospital appointments, she may reject her new baby as a constant reminder of the traumatic birth and she may experience extreme levels of physiological arousal e.g. problems with eating, sleeping and concentration. This may impact on a woman’s ability to care for her new baby and on relationships at home and work. Women also experience the ‘reliving’ of the event in the form of recurrent intrusive thoughts, nightmares or dissociative experiences in which it literally feels as if the event is happening again

There is no other organisation in the UK which offers advice and assistance to women suffering these serious mental health problems and the BTA aims to fill this gap with work in three main focus areas:

[1] See Ayers and Pickering, 2001; Loveland Cook, 2004

(1) Raising awareness of birth trauma
(2) Working to prevent it
(3) Supporting families in need

The BTA has is currently a voluntary organisation but it is the process of applying to become a registered charity. It has 4 leading experts on its Board, a Board of Trustees and an Executive Committee of 9 committed activists. It has over 20 active professional and lay volunteers whose skills range from administration to obstetric and psychological expertise

The focus of its work is detailed in our work programme set out at The BTA provides direct help with internet information on its website www.birthtraumaassociation.org.uk, email contact, internet message board chat and advice, leaflets and publications and direct telephone or face to face support from its volunteers supporters. This work is not counselling, it is simply mothers supporting other women in a very effective way. Through all of these methods, the BTA has had contact with in excess of 1000 women since we launched.

The BTA is also working with relevant practitioners and researchers to identify the main causes of the development of these types of mental health disorders. By educating health care professionals about birth trauma, the BTA hopes to change any contributing health care practices.

The BTA runs seminars and is holding the first multi-disciplinary conference in the UK on this issue in June 2005. The BTA focuses on awareness raising as well as support because it is believed that this unique and innovative work will prevent the creation of cycles of dependency which may presently include the unseen perpetuation of mental health problems to the next generation

What is Post Natal Post Traumatic Stress Disorder?

A BTA Guide to research and the responses of women

The term Post Traumatic Stress Disorder (PTSD) is a relatively new one, but the condition has been around and written about for hundreds of years. Variously called 'railway spine' or 'shell shock', it was the experience of Vietnam veterans which led to the clinical classification of PTSD in 1980. At that point it was considered that to get PTSD, a person had to go through an event out of the normal range of human experience so it was originally taken to apply only to events (or 'stressors') like disasters or wars. Eventually, understanding of the concept was broadened enabling road traffic accidents and the like to be considered traumatic events but it was the re-definition of the diagnostic criteria in 1994 (with DSM –IV – see handout) that allowed a wider range of experiences to be considered as traumatic stressors.

The DSM IV criteria are as follows:

- The person has been exposed to a traumatic event in which the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and the person's response involved intense fear, helplessness, or horror.
- The traumatic event is persistently re-experienced
- There is persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness which was not present before the trauma
- There are persistent symptoms of increased arousal which were not present before the trauma
- The duration of symptoms is more than one month and
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

The re-defined criteria focus the definition of trauma on the subjective perception of the individual so that, now, any traumatic event which precipitates acute feelings of fear, helplessness and horror can be included. An examination of the role of health related events (cancer treatment, obstetric and gynaecological care) and trauma followed. Although studies had indicated, for many years, that women could be suffering PTSD type symptoms after birth, it has only recently become generally accepted that a birth experience can provoke a traumatic stress response and that women can go on to develop PTSD as a result.[2] Childbirth is now accepted to be both a possible primary trigger to PTSD and an experience which can re-traumatise those who have suffered previous trauma. PTSD following childbirth is known as Post Natal PTSD.

However, we must not limit consideration of the traumatic event to the birth itself as it has been shown that events during pregnancy, birth and post natal issues can give rise also contribute. It is also important to remember that PN PTSD is the term applied to **normal** reactions to a traumatic experience during pregnancy, labour and the post natal period, so it is important not to label women as mentally disordered.

[2] Wijma;Creedy;Ayers; Czarnocka and Slade.

Understanding the subjective nature of trauma is the key to understanding PN PTSD. In all situations of trauma, it is the person's perception of the event which causes PTSD and not someone else's perception of whether the event should be traumatising. However, the obstetric setting may be unusual because often the caregiver's perception of what can be traumatising can differ widely from the mother's and this can cause very real problems in the post natal setting.

An example of this comes from a woman who wrote to us about her experience. It included a relatively long labour and an episiotomy. This was not considered as traumatic' by any of the health care professionals she spoke to, but the woman did have PTSD which was diagnosed some 8 months after the event.

She writes;

"One of the worst pictures which replayed itself was of my episiotomy. I couldn't get the fact of my genitals being deliberately cut out of my head. I was in such pain after birth – for weeks and weeks. No one was interested. In hospital, no one explained what they had done to me or why and I had to chase them for pain relief. I spoke to my midwife, my health visitor and my GP but no one was interested. I could barely walk and I cried about it constantly as I felt I had been raped. It felt like my identity and sexuality had been brutally attacked. I asked the doctor about it at my six week check up and she said 'oh it'll never be the same again'. That just destroyed me."

Thus, it is essential to note that;

"Labour and delivery staff need to be aware that birth trauma lies in the eye of the beholder. What is important is how the mother perceives her delivery, not how the clinicians would view it."[3]

Clearly, it is not always the sensational or dramatic events that trigger childbirth trauma. Equally, it is important to note that not everyone exposed to a traumatic birth experience will go on to develop PTSD. Dr Susan Ayers distinguishes between those who appraise birth as traumatic, those who develop a traumatic stress response and those who develop PTSD and says we must be careful not to pathologise women's experiences.

The clinical presentation of PTSD

We have discussed the clinical criteria for PTSD. The condition usually develops between 3 and 6 months after the traumatic event and includes the following symptoms:

- Re-experiencing through images, dreams and flashbacks of the event
- Avoidance of cues which act as reminders of the event
- Difficulty recalling aspects of the event
- Numbing
- Increased arousal and anxiety when exposed to traumatic cues
- Depressed or irritable mood
- Difficulty concentrating

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[3] Beck

- Easily startled
- Social withdrawal

Treatment is deemed to have most chance of success if it is undertaken in the first year.

Care must be taken not to pathologise women whose symptoms will naturally subside, thus 3 months is considered to be the best testing period as much less spontaneous resolution of symptoms will occur after that point[4]

Woman's experience of PTSD

It is one thing to discuss the clinical criteria of this condition, but, it is quite another to understand what this disorder does to women in the post natal period.

PTSD is a horribly debilitating condition. Following a traumatic event, sufferers of PTSD are left with a world view which has been altered profoundly and which often leaves them deeply afraid and anxious. The world is no longer considered to be a safe place and it can be difficult to trust the very individuals (e.g. health care professionals) who are supposed to be there to help. For those who develop PTSD, the future may look bleak as they struggle to liberate themselves from the images of the trauma they have endured. This can be particularly hard for women with 'birth trauma' because they often suffer these problems at a time when everyone expects them to be happy and positive. As a result, they often end up feeling guilty and this lowers self-esteem. Unfortunately, this situation is exacerbated by the fact that women are frequently struggling to articulate these damaging emotions in an environment which cares predominantly only for the physical outcomes of the birth experience and not the emotional ones.

In practical terms, a woman experiencing postnatal PTSD symptoms may avoid triggers which remind her of the birth, thus leading her to miss hospital appointments, GP visits, or meetings with midwives or health visitors. Some women reject their new baby as a constant reminder of the traumatic birth. Women may also experience extreme levels of physiological arousal affecting sleep, eating, concentration, memory and mood which may have an impact on their ability to care for their new baby and on relationships at home and work. Women may also experience 'reliving' of the event in the form of recurrent intrusive thoughts, nightmares or dissociative experiences in which it literally feels as if the event is happening again.

But we can best understand the experience of women by listening to what they have to say:

Here are some of the comments women have shared with us about their experiences:

- Suicide/suicidal thoughts

I'm still left with flashbacks, and horrible nightmares. I lay awake for hours at night despite sleeping tablets, and then wake up in the night soaked in sweat. Everything that happened goes over and over in my head. And I sometimes think about taking an overdose just so I can get some help, but I don't want to die, I want to get better.

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[4] Ayers

Louise

- Depression as future looks bleak

I felt as if I was in some sort of nightmare that I could never escape from. I was prescribed anti-depressants and I'm still on them now
Susan

- Videotape being played

I feel like every time someone is pregnant again I go into a rant, try to stop myself from telling them any information as if I am going on, but you're right, it is like a video on a tape. Two and a half years later still replaying.
Samantha

- Problems with bonding

It all felt surreal though. I felt as if she was not my baby and, because I connected her with the traumatic experience I had had, it took a while for us to bond.
Jane

- Emotional numbing

Afterwards, I was so shocked, I felt numb for along time. I knew I loved my son but I couldn't connect with the feeling.
Annie

- Anger and a constant anxiety about having questions answered

The questions that keep me awake at night are... 'Why didn't they just get me into theatre straight away?' 'Why did no-one explain fully to either me or my husband what was happening?' 'Why wasn't I offered pain relief during all this?' 'How can they justify that doctor doing that to me without my consent, or even telling me what he was going to do?'
Stella

- Feeling worthless as they are dismissed by professionals

My GP said to me" if you ask anyone in the street if they would like a massage, then they would mostly say yes, and it is the same for counselling, most people would like it if they could, but it doesn't mean everyone gets to have it"
Louise

Understanding of the effect of trauma on new mothers is generally very low. This can have other important implications. Many mothers have reported to us that their attempts to breastfeed were affected by their experience of birth. Sometimes women have felt that this type of attachment or closeness is too much to deal with. Unfortunately, lack of understanding of this issue can lead to insensitive or aggressive attempts by health care professionals to ensure women continue their breastfeeding efforts. Some women have

reported to us that the failure to understand the effects of their experiences on this process has just added to the guilt they feel.

- Isolation from the coveted world of motherhood

"My health visitor said I should get out more. I should go to the post natal group. But, I couldn't bear to be around these smiling perfect mums with their happy babies when my life was in tatters. The post natal environment is dominated with expectations and pressures. I hated those corny breast-feeding posters 'the start of a beautiful relationship'? Did they know what sentiments like that did to women like me? I had no one to turn to."
Melissa

- Overly anxious about child

I was in such a state of extreme anxiety when I left hospital that I couldn't sleep. I would cry every time he wouldn't feed. I counted his ounces religiously. The health visitor tutted when his weight dipped on the graph so I wouldn't' let anyone else feed him. I wanted to run away but I was terrified of leaving him with anyone else as I felt certain he would die.
Melissa

- Avoidance of doctors

I don't even like having to touch myself whilst having to wash etc. I recently had a coil refitted and couldn't sleep for days before and cancelled the follow-up appointment 5 times because I was so scared
Kate

Worryingly, this can include the investigation and treatment of abnormal cervical smears.[5] On a very basic level, women have also reported to us that they have found it difficult to use tampons or cope with the return of their periods.

- Distance from family and friends who don't understand

I don't know where to go from here. We had a narrow escape, but I am a pessimist, and think about what might have been. My mother and sister don't understand (although they try), and none of my friends, for all their big talk of traumatic births, don't understand. None of them thought twice about doing it again.
Lucy

- Tokophobia – abortion and C/S for future births

I love my daughter to bits now but I never sleep with my husband and I am sure he will end up having an affair. I would. The 1% risk of getting pregnant is too high
Sam

Further pregnancies may be more likely to result in elective caesarean sections as the women tries to remain in control[6] which presents its own problems in terms of a woman's post natal

[5] MENAGE, J. (1993). Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures. Journal of Reproductive and Infant Psychology, 11, 221 – 228.

psychological adjustment.[7] Sadly, such pregnancies may even result in a termination even if the baby was wanted[8]

Prevalence

Symptoms of PTSD may occur in up to 30% of women following childbirth. In around 2% of women, these symptoms are of a severity to fit full DSM-IV criteria for PTSD (Ayers and Pickering, 2001; Loveland Cook, 2004). This amounts to around 10,000 women developing PTSD. For the remainder, trauma symptoms in the three domains of avoidance, arousal and 'reliving' may be present . Research estimates that this level of trauma affects around 200,000 women in the UK each year.

We have noted that is important to realise that not all women traumatised by childbirth will develop PTSD – some will simply perceive their birth as traumatic but not develop any psychological symptoms. Others will develop a traumatic stress response but not have PTSD. The BTA aims to help all those women who have 'birth trauma'. We use this term to apply to all births that women perceive to be traumatic because we understand how the first few months of motherhood, together with their memories of birth, can be ruined by such experiences. Our focus, however, is undoubtedly on those women who develop the debilitating, and little understood, PN PTSD.

Causes of PN PTSD

It is clear from research, and from the feedback we have received from women, that the roots of PN PTSD lie in a complex mix of factors relating both to the intrapartum environment and the individual. However, all agree that research is in its infancy and more detailed scrutiny of the experience of birth and women's reaction to it is required before firm conclusions can be drawn.

What is clear is that although events can occur during labour that are truly terrifying for women and staff alike, it is not always these events which go on to produce a traumatic stress response or PTSD.

This is a summary of some of the main factors which have been considered to contribute towards the development of PTSD. As we have said, research is constantly developing our understanding of this disorder and the following list very much represents a current 'state of play'. Further, please note that we have combined academic research with our own empirical evidence and have separated the list into those factors which relate to the individual and those which relate to the environment of the birth experience. Where possible, we have punctuated our explanations with the words of women because it is only through their stories that the disorder can be properly understood.

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[6]HOFBERG, K. & BROCKINGTON, I. (2000). Tokophobia: an unreasoning dread of childbirth. British Journal of Psychiatry, 176, 83 – 85. This study looked at 28 mums electing caesarean section operations and demonstrated that all had traumatic memories of previous childbirth experience.
[7] SHEARER, E. (1991). Caesarean section: medical costs and benefits. Social Science and Medicine, 37, 1223 – 1231.
[8] GOLDBECK-WOOD, S. (1996). PTSD may follow childbirth. British Medical Journal, 313, 774.

The individual

Psychological research has begun to focus on the individual, both in terms of looking at the individual's subjective assessment of their birth experience and the role of their life stressors or previous trauma in the development of PTSD. This is not an easy task. For example, while it has been said that trait anxiety is linked to PTSD, there is no evidence of a causal relationship. [9] It could, however, reflect a vulnerability to the disorder.[10]

It is common sense to note that those involved in previous traumatic incidents such as sexual abuse, domestic violence, or serious accidents may be re-traumatised by their birth experiences. By considering the importance of previous trauma, researchers are not suggesting that we blame the individual for their response to birth but that we look at ways of identifying and dealing with women who may at higher risk because of high stress levels, previous trauma or lack of support which has been found to be an important protective factor against the development of the disorder.[11]

The birth experience

While research may suggest that some women could be more susceptible to the development of PN PTSD than others, it is clear that women would not develop the disorder without experiencing a birth that they perceive as traumatic. Thus, it is the woman's perception of trauma which is important.

Some common factors have been highlighted in research as possible triggers to PTSD. They are outlined below. We have also indicated additional factors which have been referred to time and again in our own work with women:

(i) Obstetric intervention

By this time it was nearly 18:00, coming up to 31 hours since my waters had broken. The registrar told me he was going to perform an episiotomy, which he did, then the forceps were inserted. Never in my life have I ever experienced pain like I did then, I was screaming out and arching my back in pain with my legs still tied in the stirrups, everything went white and I remember shouting out that I was going to faint. I really felt like I was going to die and was completely out of control of the situation. It was the most horrendous thing I have ever gone through and what should have been one of the best days of my life turned into the worst.
Emily

It has been noted that high levels of obstetric intervention are linked to PNPTSD[12] and that invasive procedures, like emergency Caesarean section and the use of forceps may increase the risk.[13] However, although women with instrumental deliveries perceived birth as more distressing, research has indicated that this has not meant that they necessarily developed PTSD. In fact, research findings indicate that women can perceive labour as traumatic

[9] Trait anxiety means "relatively stable individual differences in anxiety proneness . . ." and refers to a general tendency to respond with anxiety to perceived threats in the environment
[10] Czarnocka and Slade
[11] Joseph
[12] Creedy
[13] Ryding (98)

irrespective of the type of obstetric procedure conducted so there is no common agreement about the role of intervention and whether a particular type of intervention is more likely to lead to PTSD.

It is also important to note that, from our work, we are aware that it is not always the fact of intervention but the way in which it is carried out that is traumatising and it can be difficult to separate the intervention itself from the circumstances in which it takes place, e.g. long labour, poor pain relief, lack of trust. There is no easy linear connection between intervention and PTSD and more research is clearly required.

(ii) Hostile or uncaring treatment

I had started to get involuntary pushes but was so exhausted (and drugged) that I didn't feel them or the urge to push. She told me to push on the next contraction (but didn't actually encourage me to push during the contraction) and I tried but I couldn't feel anything to push against. She went out of the room and said to her pals in front of hubby 'that she just doesn't want to push'(as well as calling the other woman in labour stupid). She then examined me (I wasn't even fully dilated so that would be why I didn't feel the urge to push)

Research has clearly indicated that quality of care can have a profound effect on a woman's experience of birth.[14] Cheryl Beck's work specifically considers the effect of care on the development of PTSD. Beck concludes that many traumatic experiences can be prevented with supportive care and good communication. She describes it thus;

"Women who perceived they had experienced birth trauma viewed the site of their labour and delivery as a battlefield. While engaged in battle, their protective layers were stripped away one at a time, leaving the women exposed to the onslaught of birth trauma. Mothers were stripped of their individuality, dignity, control, communication, caring, trust, and support."(Beck -Handout)

(iii) Loss of control

Closely linked to all other factors, in particular quality of care and supportive treatment is the importance of maintaining a woman's perception of control.

The importance of loss of control is that it links back to the whole idea of trauma being an experience where someone suffers overwhelming feelings of powerlessness. If a woman begins to believe that she has no control over her birth experience, because of high levels of pain, lack of information etc, she will feel powerless.
For example, Consultant Obstetrician, Helen Allott says:

"Sometimes there is a perception on the part of the woman that things are much worse than they really are. For example, women having an emergency caesarean section may fear that their baby will die or be born with brain damage, when in reality this very rarely happens. If the staff caring for a woman have not picked up on her fears and alleviated them, then it is not surprising that she will remain very frightened."(Handout)

[14] Ballard;Wijma;Menage

The word perception is important as we are not suggesting that women believe they can control the whole birth event but simply that they require information, trust and support to enable them to birth without being traumatised

To this end, Professor Slade's research has suggested that there may be opportunities for prevention of PTSD though providing care in labour which enhances perceptions of control. Ensuring that all procedures are carried out with a woman's full understanding (unless urgent clinical conditions make this impossible) is a basic pre-requisite. Once a woman feels that she is not consenting to intervention, she begins to lose control, she feels dehumanised and that things are being done 'to her' and not 'for her'. Feelings of violation often flow from failures to involve the woman in the decision-making process.[15] In this respect, it is vital to realise that women can be traumatised by interventions they feel they should not have had.[16]

(iv) Knowing what to expect

"As you give birth to your baby there may be a burning sensation around your vagina"

A well-known antenatal guide

Understanding the birth process, the risks and the facts empowers women. Research has concluded that feeling in control during labour and knowing what to expect were important protective factors against the development of PTSD.[17] Sadly, a recent survey showed that 75% of women say that their labour was 'more painful than they ever imagined'. A third said that their antenatal classes hadn't properly prepared them for the childbirth experience in Britain today and 43% had been encouraged by the classes to 'avoid pain relief'. In fact, 53% of mums say they found the whole experience of giving birth 'far more shocking than they thought'.[18]

Generally no one wants to talk about what could 'go wrong', or sometimes even the reality of childbirth. This is particularly unfortunate given the fact that many women undergo some form of intervention. Indeed, whatever people's views are on the appropriateness of current rates on intervention, and their causes, women deserve to receive a complete picture about birth as it is today.

The BTA believes that the failure to provide good quality information disempowers women and leaves them facing the challenge of birth at a disadvantage. This does not mean that they are traumatised as a result of poor antenatal education but that lack of adequate information may contribute to feelings of loss of control.

One woman her feelings this way;

I think the biggest thing to stop is the upholding of all the myths and fairy tales about birth. It is time to give out some true facts, like if it's your first you have X chance of forceps, X chance of ventouse, X chance of C/section, and about zero chance of being allowed in a

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[15] Green; VandeVisse
[16] GREEN, COUPLAND and KITZINGER J, Great Expectations: a prospective study of women's expectations and experience of childbirth. 1998. Books for Midwives, Hale, Cheshire.
[17] Lyons (98)
[18] See Mother and Baby magazine survey in handout

birthing pool........etc. They need to drive home that it's an unplannable, unknowable event that you're headed for and whilst they will do what they can to get you through it, in some ways you can't prepare yourself because there's no knowing how it will go.
Yvonne

(v) Fear for self/baby

When they finally got him out the staff in the theatre were absolutely silent - you could have heard a pin drop and all I could hear was the oxygen mask being used to resuscitate Tom. I now know that he was navy in colour and had an APGAR of 1 and that was for a heart rate of only 63 bpm. I turned to my husband who was crying and asked if he was dead. He couldn't answer because he did not know. After what seemed like an hour but in fact was 12 minutes we finally heard a cry. Tom was then whisked off to SCUBU.

It is not surprising to note that research has indicated that the delivery of an ill or stillborn child is a traumatising factor.[19] It can be a particular problem for mothers of premature infants.[20]

In addition, fear of losing a baby is a very significant factor. Consultant Obstetrician, Helen Allott has explained how many of the women she sees in her Post Delivery Counselling Clinic suffered problems with their pregnancy, suggesting that some women may already be suffering from high levels of stress before the birth itself.

Women need to understand what is happening and what the risk is to their unborn or newborn child to be able to retain their feelings of control and safety. As Consultant Obstetrician, Mal Dickson puts it;

"Pregnancy is a time when women, as never before in their life, feel so vulnerable - any minor deviation from the norm can cast such a chill of fear into their hearts. Things that wouldn't cause a midwife or obstetrician any worry if it affected their patient - such as a trace of protein in the urine, or a slightly raised blood pressure, can cause women (and I can assure you their Obstetrician husbands too!) to worry way beyond what they should."[21]

(vi) Pain

- *in childbirth*

When my healthy 8 pound 4 ounce son was born, it was discovered that an artery had been severed during the episiotomy. Blood spurted out in time with my heartbeat! The doctor in attendance began to stitch me up without any anaesthetic. I was so befuddled with gas and air I could not form any words to tell her the excruciating pain I was in but instead tried to grab her hand. She told me bluntly that she had to stitch me. I bit my own hand so hard to stop me screaming in agony that I drew blood. I wanted and hoped to die and was pleased when I passed out.

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[19] Ballard and Menage
[20] Affleck et al 91
[21] See handout

Most psychologists have pointed to pain as a traumatising factor. Pain in itself can be traumatising and only the woman knows how much pain she is in. It is not for others to tell her that her pain is not severe or to dismiss it with euphemisms such as 'discomfort'. Unless you are very lucky, childbirth is extremely painful and women need to understand this and make their own decisions about how to deal with it.

Further, the tailing off of epidurals at the end of the second stage is a common practice and women have reported finding this deeply traumatising. This can shock women who have had a painless labour and who suddenly face the most painful stage with no pain relief. Some women actually believe they needed a forceps delivery because the sudden shock of the pain makes it impossible for them to push.

Whether the epidural is allowed to wear off should be discussed with the mother antenatally and her decision (and her right to change her mind) should be respected. As with all pain relief, women should not be made to feel like this:

"The whole pain thing was a big issue for me, but sometimes I still feel like a wimp for not having been able to stand it without crying out in pain."
Patricia

- *after birth*

Pain from episiotomies and Caesarean sections can be traumatising.[22] An overwhelming 84% of mums say they were 'in pain after the birth' for an average of 21 days.[23]

(vii) Lack of support

Research has indicated that support may play a role in the development of PTSD and that it may be an important protective factor.[24] This goes further than immediate postnatal care, although this is vital. Social support networks are often lacking in modern society as women frequently live far away from families and sometimes friends. Health visitors could have an important role to play.

<u>BTA experience</u>

We have received many stories from women about their experiences and to the list above, we would add:

(i) Lack of respect for dignity, e.g. the use of lithotomy, internal examinations

"They kindly left me in stirrups with swabs hanging out of me while they scrubbed up and someone let the cleaners into the room, who complained bitterly about the 'bloodbath' they had to sort out. Stupid, but that memory is for me just so humiliating. Eventually one of the midwives put a sheet over me bless her but I felt by then that any dignity I had was gone." (Patricia)

[22] Ballard
[23] Mother and Baby survey
[24] JOSEPH, S. (1999). Social support and mental health following trauma. In: W. YULE (Ed.), Post-traumatic stress disorders: Concepts therapy. Chichester: Wiley.

This is profoundly degrading and humiliating to many women and contributes to feelings of violation. The psychological impact of this practice is misunderstood and underestimated. Stirrups should only be used when absolutely medically indicated and then *only* for the duration of the medical procedure.

Internal examinations can be very painful and, many women feel that they are degrading and violating. They should be kept to an absolute minimum. Many women find repeated examinations such as this one of the most traumatic parts of the induction process.

(ii) Trials of labour

If obstetric problems are predicted, it is for the woman to decide whether she wishes to try to for a natural delivery. The options should be discussed realistically. Women should not be forced to go through this if they would prefer an elective caesarean. Equally they should be able to attempt a vaginal delivery, where this is their choice and wherever this is feasible.

(iii) The use of syntocinon

My contractions started to slow down as I was exhausted. They decided to hook me up to a Syntocinon drip which speeds up my contractions. This was torture. I was terrified. It made my contractions even harder and more unbearable. I needed pain relief but I couldn't manage to ask for it as the contractions just took my breath away and it is all I could do to deal with them. I looked at the gas and air attachment on the wall behind me to my left and wished someone would pass it to me. I hadn't had any pain relief at all since I arrived in hospital.
Amanda

Syntocinon and similar drugs cause severe, sometimes unendurable pain. Women need to be informed of the benefits and effects of these drugs. Epidural services must be immediately available should these be required by the mother. Women frequently report to us that the continued use of such drugs after maternally requested epidural pain relief has failed played a large part in the development of their PNPTSD.

(iv) Attitudes to birth

I then asked for gas and air and was told by S "no I don't want you on that for that long!"

So my waters broke at 3am, and the midwife then consented to examine me - I was 9 cm dilated!!!! I went to the delivery suite and they called husband, who arrived in 5 minutes. I had asked for an epidural earlier, but the midwife had said it was too early. So I asked for one now, and she said it was too late, but why didn't I try aromatherapy oils?!

All staff need more understanding of different women's feelings about birth. This includes pain relief and the idea of natural or normal birth. A long, traumatic labour can take much longer to recover from than a planned caesarean. Traumatic labours that end in caesareans can be especially psychologically damaging. For some women the 'opportunity' to try for a natural birth is not an opportunity at all for others it is very important. Where there are potential obstetric problems, there should *not* be an automatic assumption that attempting

natural childbirth is what the woman will want. The woman needs to be listened to and her views respected.

(v) Post natal care

I was put at the far end of the ward, so no one passed by and I could see no one else. It was about 9.30am by now and it took until about 11am until someone came to check on me. They seemed surprised that I hadn't known to go and help myself to breakfast. My husband stayed with me from 8am until 11pm and even then I spoke to him on the phone for about 30mins when he got home. I didn't want him to leave me. I didn't know if the staff thought I was therefore OK and didn't need attention, as I hardly saw them. I had to ask for help to bath my baby, the following day, as no one had offered and he was still dirty from the birth. I asked to go home, but the staff seemed too busy to take much notice and said I'd be much better off in hospital. My bed sheets were stained from my discharge, but I was afraid to ask for more. The second day, I saw someone else's sheets being changed and felt isolated and uncared for. The night I spent in hospital was probably the most lonely in my life.
Celia

In conclusion, it is important to understand that a birth experience might be considered traumatic by the woman but not her caregivers, but equally that not all those women suffering traumatic births go on to develop PTSD and that a variety of factors are at play including:

- Actual experience
- Individual characteristics
- Recovery environment
- Post partum cognitive processes and adaptation[25]

Problems specific to PN PTSD

For those women who go on to develop PN PTSD, the post natal environment is a very difficult one for them to face. Socialisation and cultural stereotypes relating to motherhood as an overwhelmingly positive experience only increase feelings of failure and distress.

New mothers are under pressure to be happy and put their baby's needs and health before their own. This isn't easy for anyone let alone those struggling with PTSD.[26]
As a consequence, some women encounter problems with bonding with their baby which concern them deeply. Problems can involve avoidance of the child (as a reminder of the traumatic event) and higher levels of arousal may also mean new mums are more self-critical, less patient, and more anxious.

Unfortunately, many women report to us that their concerns are dismissed when raised as they are seen as being unfairly critical of their care.

[25] Soet et al
[26] Guerin-Weiss

Other idiosyncratic features of PN PTSD include sexual avoidance, tokophobia (fear of childbirth which may even lead to requests for the termination of subsequent pregnancies) and an increase in requests for Caesarean sections in subsequent births.[27]

Confusion with PND

There is clear symptom overlap with Post Natal Depression. Similar symptoms include:

- Irritability
- Anxiety
- Sleeplessness
- Change in behavioural patterns, e.g. appetite
- Psychological arousal
- Over anxious for baby

However, the two conditions are not the same. Czarnocka and Slade identified several women with PTSD in their study but at least 25% of them did not have depression which was detectable on Edinburgh PND scale. The conclusion is a significant number of women will remain entirely unsupported after birth because their symptoms will not be recognised.

In distinguishing PND and PN PTSD, the crucial thing to note is that the essence of the PTSD is the continuous intrusive thoughts, flashbacks or nightmares. This does not occur with PND and is more than ‘ruminating’ or ‘reflecting’ on a person’s birth experience. Women with PTSD can’t ‘snap out of it’ or ‘move on’ because they have a psychological disorder which requires specialised treatment to effectively‘re-programme’ the experience. Otherwise, the desire to prevent these intrusive thoughts may develop into seriously damaging and life altering patterns of avoidance behaviour and depression.

This confusion between the disorders might account for the failure to diagnose. But it is also attributable to a lack of understanding on the part of some health care professionals who remain unaware that PTSD may develop after birth. Childbirth is considered a normal function so PTSD is frequently misunderstood or worse women are blamed for being too weak or expecting too much

For example, one woman told us that she went to her GP about her concerns but when she raised the possibility that she might have PTSD *“he stared blankly at me and then upped my prescription for anti-depressants”.*

Another said:

“At my lowest, I felt suicidal. I don’t think I would have ever done anything, but every day was a black hole. I felt gutted, broken, like I’d been brutally attacked and the world simply didn’t care. I knew this wasn’t depression. It was like a pain in my heart that wouldn’t go away. I knew the GP would give me pills as that’s what they do with women who’ve just had babies. I felt cornered because no one would take my pain seriously. As a mother, I felt dismissed. I was a non- person.”

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[27] Ryding et al - all 28 mothers studied who had requested Caesarean sections had had previous traumatic birth experience

There are several other reasons for difficulties with diagnosis and they include:

1. There is no specific screening tool available for PN PTSD (although one is being developed)
2. A woman's story has to be listened to in order to be diagnosed and there is a misunderstanding about the subjective nature of trauma which is exacerbated by problems with accepting women's concerns about the care they've undergone
3. There are also problems in locating psychologists able to treat this

Treatment

In discussing treatment, it is important to distinguish between appraisal of birth as traumatic, a traumatic stress response to birth (where symptoms often resolve within 3 months) and PTSD. Some of the work to date on the nature of the traumatic response of women has suggested certain factors might aid recovery, although it is to be remembered that those with actual PTSD will require psychological help with it.

Allen's work has shown that those with social support fared better. There may also be a link to individual coping strategies

Psychotherapy

Psychotherapy may in particular help reduce feeling of self-blame, and guilt which are characteristic of PTSD. In particular, Cognitive Behavioural Therapy (CBT) has been shown to be effective and is therefore the treatment of choice. It usually involves 6 to 10 sessions of up to an hour over the course of two or three months.

A few hospitals in the UK do offer psychotherapy as a part of their Obstetric service but more commonly women have to go to their GP and ask for a referral to a clinical psychologist for PN PTSD. This is where problems can arise as women often report that their GP did not understand what they were talking about.

Debrief

Some hospitals offer midwife-led services, which usually involve an appointment to go over the events of the birth with a midwife or doctor who has the medical notes available. This can be useful in terms of understanding why particular decisions were made or particular interventions occurred. However, it is unlikely to resolve established symptoms of PN PTSD.

Debriefing is a controversial area for trauma patients. Indeed, the recently published NICE guidelines have come out against this technique. However, most psychologists who have written in this area suggest that more research needs to be done using standardised techniques (relating to time, place and method – e.g. having more than one opportunity for discussion) before final conclusions can be drawn

Research is continuing but a recent paper (Birth, March 2005) suggests that counselling in the first few days after birth and subsequently – an informal birth debriefing – can be effective. This secondary prevention could limit the numbers who progress from being traumatised into

developing PTSD but more research is required. Sensitive handling in the early weeks after birth is critical. Some women find it helpful to go over their medical notes with a member of the midwifery team to understand more clearly what happened. For this to prove successful it is essential that the primary objective is the psychological care of the patient, rather than litigation minimisation. Where this birth debrief is done sensitively, ideally by a healthcare professional appropriately trained, this can be very therapeutic.[28]

Medication

Medication can also help in some cases, in the form of selective serotonin reuptake inhibitors (SSRI's). There is some evidence that psychotropic medications (SRIs) can assist the patient in the short-term but they do little to challenge the traumatic experience itself.

What can be done?

An essential component in the diagnosis of PTSD is that a woman found herself faced with a situation to which she reacted with helplessness and powerlessness. Thus, the maintenance of control is an essential protective factor.

The key to maintaining control may be to provide an environment in which the woman feels she is supported irrespective of her personal experiences or past traumas. After considering the causes, we can see that the reasons women develop PTSD after birth are complicated but it is clear that amending or improving some facets of current maternity practice could assist in the prevention of birth trauma generally, and consequently PTSD too. This can include taking the following basic steps:[29]

- Providing good quality antenatal education and information
- Ensuring informed consent is obtained
- Respecting choices
- Providing supportive and validating care
- Providing post natal acknowledgement of experience
- Improving pain management which is dictated by the woman's choices[30]
- Providing opportunities to discuss the birth experience post partum[31]
- Considering both the physical and psychological consequence of intervention[32]
- Ensuring women do not feel as if the end justifies the mean at any price, so she is left feeling that her worth is diminished and her needs and concerns are unimportant[33]
- Supporting women post natally[34]
- Respecting a woman's body and dignity
- Treating the woman as you would want to be treated or as you would treat your sister, mother or daughter

[28] Creedy
[29] Crompton;Beck
[30] Soet et al
[31] Beck;Soet et al
[32] Soet et al
[33] Beck
[34] Soet et al

- Being vigilant to a stress reaction after birth, for example in women who may seem, dazed, withdrawn, disorientated or anxious[35] Being aware that the partner can be traumatised too

For those dealing with women after birth, there are various ways in which assistance can be offered. For example, it may be helpful to:

- Allow women the opportunity to speak about their birth experience in a validating, non-judgmental environment
- Assist women with obtaining copies of their medical records (without forcing them to get caught up in hospital bureaucracy or making them pay a fee)
- Take their concerns and anxieties seriously and consider practical ways in which they might be addressed, e.g. referrals to paediatricians to relieve concerns about their baby's health
- Raise awareness of birth trauma with local GPs so that they will be able to understand the seriousness of women's concerns
- Establish a referral path for suitable help – counselling/cognitive behavioural therapy
- Let women know about the BTA and that we are happy to offer support to women wherever possible. It helps for women to know that they are not alone

Dealing with subsequent births

Terror prevails for many women contemplating a future birth. There is no "one size fits all" solution to this dilemma. Each woman needs to be treated as an individual and helped to find a solution which is right for her. In discussion between the woman and appropriate health professionals, a clear plan needs to be made, preferably in advance of the next pregnancy, to avoid further stress and worry.

In a subsequent pregnancy, any admission history should address whether any of these previous deliveries were perceived as traumatic by the mother. Identification of any possible contributing factors to birth trauma can alert labour and delivery staff so that special care can be taken regarding these factors.[36]

The element of choice is very important and where possible a woman should be offered a series of options to cater for different eventualities. It is important to emphasise the choice ultimately rests with the woman herself. Professional staff should give advice to aid informed choice rather that tell the woman what to do and women should be helped to realise that they do have control over choices that need to be made.

[35] Beck
[36] Beck

PART II

BIRTH TRAUMA

ARTICLES BY PROFESSIONALS

An Introduction to Birth Trauma

The best intervention for PTSD is to prevent birth trauma in the first place. In addition to providing safe care during the birthing process, the basic skills that all health care providers are taught need to come to the forefront with each and every laboring woman: to be caring and to communicate effectively. One mother in my birth trauma study (Beck, 2004a) shared "I am amazed that 3 ½ hours on the labor and delivery room could cause such utter destruction in my life. It truly was like being the victim of a violent crime or rape".

What could have happened to this woman and others to turn the delivery process into a rape scene? Perceived lack of a caring approach during such a vulnerable time was one of the core components in this scenario for a traumatic birth. The women reported that feeling abandoned and alone, stripped of their dignity, lack of interest in them as individuals, and lack of support and reassurance all contributed to their traumatic births. Lack of communication with women was another core component contributing to birth trauma. The women perceived that the labor and delivery staff failed to communicate with their patients. During a traumatic birth, women often felt invisible. Health care providers spoke to each other as if the woman were not present. Procedures were not explained to the women, such as, the use of a vacuum extractor.

After a traumatic delivery, mothers have an intense need to talk about their labor and delivery, to ask questions, to try and determine what went wrong. Being able to communicate with clinicians about their birthing process is vital to a new mother's mental health. Mothers perceived that their traumatic deliveries were glossed over and pushed into the background as the infants took center stage. No one wanted to listen to the women who had a tremendous need to discuss their traumatic deliveries. Women need to be able to talk about their unmet expectations regarding the birth of their baby.

Women who perceived they had experienced birth trauma viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away one at a time, leaving the women exposed to the onslaught of birth trauma. Mothers were stripped of their individuality, dignity, control, communication, caring, trust, and support. Obstetric care providers need to remain vigilant during the early postpartum period of each mother's reaction to the delivery. Does she display any signs of having experienced a traumatic birth such as, being withdrawn, or dazed?

Additional interventions that clinicians can do to help prevent traumatic births include taking a careful history from each woman as she is admitted into labor and delivery. Clinicians need to ask if a woman has any particular fears regarding giving birth, such as, needle phobia. If a woman has had previous deliveries, this admission history should address whether any of these previous deliveries were perceived as traumatic by the mother. Identification of any possible contributing factors to birth trauma can alert labor and delivery staff so that special care can be taken regarding these factors.

Labor and delivery staff need to be aware that birth trauma lies in the eye of the beholder. What is important is how the mother perceives her delivery, not how the clinicians would view it.

Professor Cheryl Beck,
University of Connecticut
School of Nursing
March 2005

Women traumatised through childbirth and caesarean sections

I have been a consultant obstetrician/gynaecologist for the last four years at Rochdale Infirmary, Lancashire. For a long time I have recognised there is a small group of woman who want to have children, but have a tremendous fear of giving birth. Some get through this by going ahead with a pregnancy, stay terrified through the pregnancy and dare not confide their fear to anyone, and give birth in terror. The latter months of their pregnancy are marred with dread and worry. Some women are so terrified about delivery they become unable to have sex just in case they might become pregnant.

Why is it that these women are so scared about giving birth? Is it something soft about them, or are they being histrionic and attention seeking? After all, most women seem to get through birth without much of a song and a dance about it. Well of course, there is nothing daft or soft about these women, but that is very much how they can be made to feel.

For some women, the fear of giving birth stems from having had a previous traumatic delivery. For example, I had a patient who had a 18 hour labour with their first baby, had an attempted forceps delivery that failed, so then went to theatre for a caesarean under general anaesthetic - the baby was marked from the forceps and affected by the anaesthetic and traumatic delivery and so went to special Care Baby Unit for a couple of days. The mother had an unusual reaction to the anaesthetic and because of that and the fact she had bled a lot, she had to spend two days on intensive care. I don't think all the counselling in the world as suggested by the recent NICE guidelines is going to persuade her to go for a vaginal delivery again! As it was, I saw her six months after, and assured her in her next pregnancy she would have a planned elective caesarean section under spinal anaesthetic. Nothing more needed to be said and when she did again become pregnant, that's what happened. For other women, it was this or else something similar that happened to their friend, or sister, and this has put the fear of labour into their mind.

Sexual abuse is something we all have a higher level of awareness now than before, and I get the impression that some women who are wary about having a vaginal delivery , have been abused in the past and are naturally wary of people going anywhere near their genital region. Although some of these women may well benefit with APPROPRIATE SPECIALISED counselling, I doubt this exists in anything like the amount required. Also many of these women will view their history of being abused as a shameful secret to be told to no one, so they are not likely to come forward and talk of what happened, not at least to an obstetrician or midwife they have never met before. So they are not going to get the appropriate counselling that the NICE guidelines speak so highly of.

Although being pregnant can be a time of great joy with something very special to look forward to, it is also a time when women never before in their life have felt so vulnerable - any minor deviation from the norm can cast such a chill of fear into their hearts. Things that wouldn't cause a midwife or obstetrician any worry if it affected their patient - such as a trace of protein in the urine, or a slightly raised blood pressure, can cause women (and I can assure you their Obstetrician husbands too) to worry way beyond what it should. Whilst people pass comment and make value judgements about many things, matters relating to pregnancy are

the things that people seem to feel most free to pass comment. And most of the comments are pretty negative. "Oh you're having a baby eh? Well your life won't be the same again , sleepless nights, no money, no nights out etc" Yet when other life changing events come along, such as learning to drive, earning a wage, first enjoying the pleasures of drink and sexual relationships, no one says "Oh well your life will never be the same"

Lurid stories of births are told "My sister had a baby, they had to cut her to get the forceps on" , or "When I had my baby, I ripped terrible" or "I was in agony for hours and hours and the epidural didn't work" You rarely hear tales of what labour is really like (Unless you are friends with a number of good midwifes) Yet, despite having been regaled all these stories, if the woman says right that's it I'm going to ask for a caesarean, the narrators of the stories will then turn round and chastise the woman for being soft or whatever "Your not a proper woman till you have ripped/tore/had 35 stitches" But do realise how you have your baby is your business and not anyone else's.

So, what can be done for women who have had a previous traumatic delivery? Well, the attitudes of some Obstetricians could change. However that is more easily said than done - in this fast moving world everyone is meant to have policies and protocols for absolutely everything , there are only approximately 1500 consultants in England and Wales for approximately 600,000 deliveries per annum, and with the best will in the world, no one can be all things to all women.

The best thing is to ask around. There are Obstetricians out there who are deeply sympathetic to you - Ask your midwife as she is going to know the low down of most of the obstetricians in the area, and if she doesn't know, she can always ask someone who does know.

Malcolm Dickson
Consultant Obstetrician
Rochdale Infirmary
Rochdale, Lancashire, OL12 0NB

The Post-Delivery Counselling Clinic

Working in the antenatal clinic as a registrar back in 1993, I found that some of the women I was seeing would become distressed and even tearful when we started talking about their previous experiences. I wanted to try and do something to help these women but a busy antenatal clinic with waiting time targets to be met was not the place to do it, so I approached the management team and asked if I could set up a special clinic where there would be time to talk without pressure. I was given permission and the counselling clinic started 12 years ago.

I sent round flyers to local GPs, midwives, health visitors and NCT groups informing them about the proposed service, wondering quite what would happen. It didn't take long for the patients to start coming and I have been seeing three or four women a week ever since.

I think the most important thing I do is listen to the women. They are invited to tell their story, with an emphasis on the bits that have left them confused, distressed, frightened or angry, and I just listen. If at all possible, it is very helpful to have the hospital notes to hand so that I can fill in any gaps and try to answer questions about why certain things happened. I find that women have an excellent recall about what was said to them, although they are sometimes confused about the exact timings of events which is hardly surprising in the circumstances.

Certain recurring themes have emerged. Sadly, one of the avoidable problems relates to poor communication skills or even simple rudeness on the part of staff in some cases. Women are frequently distressed at being left on their own without a member of staff present, particularly when they are in pain. Not knowing what is going to happen or when things will happen is very disempowering, for example, not knowing when the anaesthetist will come and put the epidural in. A combination of pain and delay is a potent recipe for distress, leading to women feeling trapped and sometimes quite desperate.

Sometimes there is a perception on the part of the woman that things are much worse than they really are. For example, women having an emergency caesarean section may fear that their baby will die or be born with brain damage, when in reality this very rarely happens. If the staff caring for a woman have not picked up on her fears and alleviated them, then it is not surprising that she will remain very frightened. Some obstetric emergencies, such as shoulder dystocia or major haemorrhage, are genuinely very stressful events for staff and mothers alike.

Some of the women I see have symptoms of post-traumatic stress disorder and are in need of further help. These women are offered an appointment with a clinical psychologist with a special interest in PTSD. If appropriate, a plan of management for any future births is made, and a summary of our discussion is placed in the hospital records, with a copy sent to both the woman and her GP.

Helen Allott, Consultant Obstetrician, March 2005

Journey of a subsequent pregnancy following a previous traumatic experience of childbearing

No matter what the outcome, every pregnancy is an experience of parenting for both the mother and father of the baby. At the time of any subsequent pregnancy many families re-

experience feelings and emotions associated with pregnancy, delivery and parenting previous babies.

What follows are some thoughts concerning a subsequent pregnancy journey following a traumatic experience for one or both partners in a previous childbearing experience. For the purposes of this work trauma only will be considered – as opposed to loss/death of a baby or partner - though it is recognised that similar experiences may ensue, this is perceived by the author to merit separate consideration.

Even with modern obstetric and neonatal care, childbirth can sometimes be an excruciating and terrifying experience which acts as a stressor for a traumatic response and may result in an increasing and unreasoned dread of future childbirth – tokophobia. It is acknowledged that tokophobia may also result from previous psychosexual trauma or violence both of which may complicate what is perceived as a normal pregnancy and childbirth. Here it feels appropriate to suggest that the concept of normality is extremely subjective and in this context it is the prerogative of the woman and her partner to define what for them is perceived as normal or abnormal.

Examples of experiences from childbirth which may compromise parental well being include:

- A long hard labour
- Instrumental delivery – ventouse or forceps delivery
- Emergency Caesarean section
- Inadequate pain relief
- Maternal loss of control in pregnancy, labour or postnatally
- Fear of death or permanent damage
- Fear for well being of the baby
- Birth of a damaged baby – if a child's disability resulted from birth trauma both parents may be distrustful of healthcare professionals in the future

It is well documented that there can be continuing effects of previous unpleasant events leading to:

- Avoidance of further childbearing
- Feelings of inadequacy
- Fear that previous events will recur with similar, if not worse, outcomes
- Postponement of further childbearing
- Requests for permanent contraception
- Requests for termination of pregnancy
- Often in the third trimester, the re-emergence of symptoms which may lead to a number of unpleasant events including repeated flashbacks and/or nightmares which contribute to a less than optimum lifestyle or a fear of sleeping. Women have been known to have these feelings re-emerge for the first time since the previous delivery; i.e the time between the previous delivery and subsequent delivery may have been symptom free.
- Fear of becoming pregnant again, leading to psycho sexual disorders
- Loneliness and social isolation
- Confusion – many feel they must do everything they can to avoid stimuli associated with the birth while, at the same time, they long for a return to their pre trauma state. This may

only be achieved with integration of the traumatic experience into the woman's personal theory of reality where it makes sense.

NB - time for this to occur may vary and could depend on degree of trauma, genetic make up, previous emotional health, immediate care following the trauma and the nature of social support networks. There is some evidence to suggest that very occasionally parents never fully recover.

However it must emphasised here that for some parents the emotion of the previous traumatic birth experience is superseded and far outweighed by the joy of another pregnancy and new baby. Thus if the parents can now have a positive experience this can have a marked therapeutic effect which has been described as a "redemptive birth".

So what considerations need to be made following traumatic birth experiences for one or both parents before embarking on a future childbearing experience?

- Discussion of the previous birth experience in a professional arena. Some Trusts offer a formal listening service and occasionally a debriefing service is also offered. This will validate experiences and feelings and not allow for them to be minimised or ignored; it will also enable the parents to identify if they need further help and support.
  - Further help may be gained from midwives, counsellors, health visitors, help groups

- Early identification of and appropriate treatment/intervention for psychological symptoms emanating from the traumatic experience e.g anger, guilt, flashbacks, depression, increased anxiety, avoidance,

- Counselling or therapy with an appropriately trained therapist and with whom a relationship may be formed which fosters trust and in which one can explore development of resources needed to go through childbearing again e.g courage, hope, power, control.

- Recognition of the fact that integration of the traumatic event (as mentioned above) often takes months or even longer and usually occurs after repeatedly revisiting and analysing intrusive thoughts.

- Is a future pregnancy desirable or dreaded? A decision needs to be made regarding whether or not to become pregnant and if so when, timing is important. Once an initial decision is made it is often helpful to make a time to re-evaluate the decision especially if it has been negative.

- Recognition that subsequent pregnancy and delivery experience may be a healing experience which allows integration.

- Finding appropriate healthcare personnel. Developing a trusting relationship with healthcare professionals who will offer sensitive communication skills, respect for decisions made, knowledge regarding place of birth, mode of delivery – possibly an elective caesarean section, birth companion and pain relief and choice in care planning all of which encourages a sense of control for the parents. It is documented that for parents, childbirth is a momentous occasion whatever the outcome, sadly for staff this

may not always be the case and this conflict of attitude can contribute to parents being disempowered and disillusioned.

- Appropriate, acceptable and safe contraception.

- Securing a social support network – formally through a self help group / agency and informally through friends/relatives as appropriate

- Developing self awareness, making realistic goals and appreciating that parents matter and have a right to be heard and make choices.

Parents also have a right to feel however they do feel, as well as a right to take up or refuse sensitive, appropriate care as and when they are ready.

Should a new birth be considered then this could be planned for with both parents being encouraged to consider their options and recording them for the benefit of both themselves and their carers. Professional help from a counsellor/therapist or midwife may be helpful here.

A care plan could look like this:

Example

Our pregnancy history

- We have a 4 year old daughter who was born at 38 weeks after 29 hours in the delivery suite.
- I felt the pain even after an epidural and gas and air; no one believed me.
- Holly was born by high forceps and I had a big episiotomy. I bled a lot and had a transfusion and a drip for 2 days.
- Holly was ok after 24 hours in SCBU.

Our fears

- I don't want to lose control.
- I want to be told everything that's going on; I am afraid you won't tell me everything.
- I have issues with breathing and don't want anything rubber or an oxygen mask on my face.
- I am terrified of the pain and have had 3 panic attacks since Holly was born.
- Tony speaking now – I am afraid we will be judged as "awkward" just because we have made our wishes clear and asked to be understood.

Labour preferences

- **Drugs** – I do not want an epidural under any circumstances. I would like injections for the pain after the operation.
- **Interventions –** I do not want artificial rupture of membranes. I would like to go into labour normally and then as soon as it starts for real I would like a caesarean section under General Anaesthetic.
    - If I need a catheter or a drip up please wait until I have had the anaesthetic.

- **Environment** – I would like to avoid lying looking up at fluorescent lights. I would like Tony to stay with me throughout the whole procedure – up beside my head.
- **Positions** – I want to walk around as much as I can up until we go to the theatre.
- **Baby care** – I would like Tony to hold our baby as soon as possible and to stay with the baby until I am awake.
    - I would like all examinations of the baby to be done in my presence and the baby to stay with me for the entire stay in hospital.
    - Holly wants to see her brother or sister as soon as possible please.
- **Extra** – please do not do anything no matter how small without first asking us.
    - As soon as possible (if possible) we would like Jan - our community midwife to be with us in theatre and to visit us each day after the operation. We also have a private counsellor and would like her to come as we ask her and if we need her.

Mary Hopper Msc, DipCPC PgDipEd RGN RM RSCN RCNT - October 2004

What is the best form of treatment for PTSD?

PN PTSD is best treated by psychotherapy. There are a number of different types of psychotherapy available which range from counselling to cognitive behavioural therapy. Counselling usually provides a supportive environment for you to talk through your problems. Cognitive behavioural therapy (CBT) is more structured therapy where you go over the events of your birth experience, look at your perceptions and thought processes, and use relaxation techniques to try and create a safe environment in which you can go over particularly difficult or traumatic aspects of your birth. CBT has been shown to be effective for PTSD and is therefore the treatment of choice. It usually involves 6 to 10 sessions of up to an hour over the course of two or three months. Medication can also help in some cases, in the form of selective serotonin reuptake inhibitors (SSRI's). These are also used as anti-depressants so if you are on anti-depressant medication it is worth checking whether it is an SSRI.

As yet there are very few services set up for PN PTSD specifically. Some hospitals offer midwife-led services, which usually involve an appointment to go over the events of your birth with a midwife or doctor who has your notes available. This can be useful in terms of understanding why particular decisions were made or particular interventions occurred. However, it is unlikely to resolve established symptoms of PN PTSD.

A few hospitals in the UK do offer psychotherapy as a part of their Obstetric service so it is worth checking whether your hospital has this and whether you would be eligible. However, more commonly you would have to go to your GP and ask for a referral to a clinical psychologist for PN PTSD.

It is also possible to arrange cognitive behavioural therapy privately. The British Association for Behavioural and Cognitive Psychotherapies (http://www.babcp.org.uk/) has a list of all UK accredited CBT therapists. However, most chartered psychologists will be able to offer CBT and a list of chartered psychologists in the UK can be obtained from the British Psychological Society (http://www.bps.org.uk).

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July 2004

DEBRIEFING

The Debate:

Critical Incident Stress Debriefing (CISD) or Psychological Debriefing as it is also called emerged in the 1980's. CISD is defined as a meeting of those involved in a traumatic event, which aims to diminish the impact of the event by promoting support and encouraging processing of traumatic experiences in a group setting (Richards, 2001).

Mitchell & Everly (1997) coined the term 'critical incident stress management' (CISM) to differentiate the single-session, stand-alone debriefing meeting from a broader, multicomponent programme including pre-trauma training, CISD, follow-up and case management.

Debriefing has been widely applied both in the public and private sectors. Since the mid 1990's there has been much debate about the evidence base and efficacy of providing CISD. Some studies indicated negative outcomes (Wessley et al, 1998; Bisson et al, 1997; Hobbs et al, 1996), whilst other studies suggested positive and beneficial outcomes (Chemtob et al, 1997; Deahl et al, 2000; Flannery & Penk, 1996). Nevertheless, the debate continued, despite only two published RCT's which indicated negative outcomes, both utilising CISD with injured individuals e.g. burn trauma (Bisson et al, 1997) RTA victims (Hobbs et al, 1996).

The British Psychological Society's report on 'Psychological Debriefing' introduced balance into the debate, concluding that some of the most widely publicised studies were found to be methodologically flawed and that if debriefing were to be successful, it has to be undertaken by competent practitioners, within an appropriate setting, with support and supervision (2002). In addition, there is evidence that many organisations such as the Police, The Royal Marines and major aid organisations such as the United Nations High Commissioner for Refugees (UNHCR) and Médecins Sans Frontìeres (MSF), are providing early interventions such as debriefing for personnel following critical or traumatic incidents.

Other reviews, however, came to the conclusion that CISD is a useful technique as part of an overall CISM programme (Everly *et al,* 2000; Everly & Mitchell, 1999) and that the studies included in the negative reviews had many methodological flaws, so it is questionable how much validity can be placed in them.

Unfortunately the recently published NICE (National Institute for Clinical Excellence) guidelines 'Post-traumatic Stress Disorder (PTSD): the management of PTSD in adults and children in primary and secondary care', (March 2005) state that: 'For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services'

These recommendations are supposedly based on the best available evidence, however NICE looked for evidence of debriefing <u>preventing</u> the development of PTSD. Most people who offer a debriefing service however believe that what it actually does is offer support, and encourages earlier help seeking by those individuals who go on to develop PTSD. CISM has received no criticism in the NICE guidelines.

What is Critical Incident Stress Debriefing?

The aim of CISD is primarily to mitigate against the development of adverse stress reactions following exposure to extremely stressful or traumatic events. Most importantly, it is aimed at helping individuals to recognise and understand normal reactions to traumatic or extremely stressful events and seek appropriate further help and support if necessary. So it aims to aid emotional processing, cognitive processing, reduce unnecessary after effects, prevent psychological complications and enhance future coping. It does not involve 'reliving' the event or intense imaginal exposure, it is not intended as counselling or therapy

A debriefing is a meeting that generally includes only individuals involved in an event. A debriefing focuses primarily on the traumatic event and it's effects on the individuals, and to educate people about possible reactions they may experience and the possible course of the same.

By allowing people to talk about/discuss the traumatic event they were involved in, debriefing allows for:

- Understanding the cause and reasons for events
- Ordering the sequence of events
- Understanding the reactions of self and others
- Allows for the understanding and construction of meaning of events
- Constructing a narrative of the event/experience

To achieve this a debriefing session is usually a:

- Structured Group Discussion of a Crisis Event
- 1 to 3 Hours in Length
- Requires Specialised Training of Team Members
- Consists of 7 Phases

The 7 stages are:

- *Introduction*
- Fact Phase
- Thoughts (and Sensory Impressions)
- Emotional Reactions
- Normalisation Phase
- Future Planning and Coping
- Disengagement

Dave Hannigan,
Professional Lead Nurse in Behavioural & Cognitive Psychotherapy

Childbirth and Human Rights

"Treat humanity, whether in your own person or in that of another, always as an end, and never as a means only"

Emmanuel Kant

Why human rights matter in the context of childbirth

Research undertaken by the Birth Trauma Association illustrates how frequently women feel violated by present childbirth practices. Their privacy is unnecessarily invaded. They feel that they are not listened to, or properly supported. Their dignity is not respected. Medical procedures are often carried out without consent, and choices which they wish to make about pain relief are ignored, without medical contraindication. The unnecessary use of stirrups, operations without anaesthetic, unnecessary invasions of privacy and the failure to respect basic dignity are all factors which appear again and again in the stories women tell – see http://www.birthtraumaassociation.org.uk/what_womensay.html. Where such bad practice occurs, women can feel de-humanised and degraded. This can have serious and long-term adverse effects upon the women and their children.

But what happens to women in childbirth goes beyond questions of good or bad practice. Serious violations of a woman's dignity, or the infliction of unnecessary pain, can breach her human rights. After all, women in childbirth remain human, and remain competent to make their own choices in this, most intimate of human experiences. How women are treated during childbirth engages some of the most fundamental human rights values – rights to respect for private life and dignity, and the right not to be subjected to inhuman and degrading treatment.

The stories reported to the Birth Trauma Association suggest that serious cultural and institutional changes are needed to give effect to the human rights of women who happen to be giving birth. Not just because violations of human rights are unlawful, and could lead to litigation (though they are, and they could), but because they are wrong.

The idea of universal human rights

Human rights are those rights which every human being has, all the time. Not because they have been earned, or given, or bargained for, but simply by virtue of being a person. We have human rights as a reflection of our common humanity.

This idea that rights are universal permeates all international human rights documents. For example, the United Nations' Universal Declaration of Human Rights starts by recognising

> "the inherent dignity and the equal and inalienable rights of all members of the human family",

and continues (in Article 1)

"all human beings are born free and equal in dignity and rights".

The underlying values of equality, dignity, autonomy and social solidarity

The first value underlying this is the *equality* of human beings in dignity and rights: each individual has intrinsic value. *Dignity* is not an earned characteristic. To treat an individual as less worthwhile than others undermines their essential humanity.

Yet many women in childbirth are treated as mere vessels – their intrinsic rights to dignity are not respected, and their essential humanity is ignored.

The second underlying value is *autonomy* – the idea that a human being is born free, and has the right to make her own choices. Autonomy is a vital part of dignity, because to value a human being requires respect for their own self-concept, beliefs and desire for self-determination.

But there are many situations – and child-birth is one – where it is unhelpful to think of the right to autonomy as just a negative right to be "left alone". Indeed, a woman in childbirth need positive help to realise her own desires and choices.

This leads onto the third pillar of fundamental and universal human rights - the principal of social solidarity. This means that society must take positive steps to protect the human rights of the people within it. It must create and operate institutions which ensure that the intrinsic dignity of individuals is respected by the state and preserved from intrusion by others.

The effect of the Human Rights Act

The UK has been a signatory to the European Convention on Human Rights (ECHR) for more than 50 years - but it could only be enforced by going to the European Court of Human Rights, and few people knew about it, or how to do this.

Since October 2000, when the Human Rights Act 1998 (HRA) came into force, however, there has been a legal as well as a moral obligation on public bodies to give effect to human rights principles. Section 6 of the HRA requires "public authorities", including NHS hospitals and their staff, to act compatibly with the European Convention on Human Rights (ECHR) unless another piece of legislation positively prevents them from doing so.

There is now a far greater awareness that the Convention gives people individual rights. If NHS bodies breach these individual rights, they can now be sued in the ordinary British courts.

The most relevant articles of the Convention are articles 3 (freedom from torture, inhuman and degrading treatment) and 8 (right to respect for private life).

What these articles mean has been explored and explained in decisions of the European Court of Human Rights in a number of successful cases against the UK – though not yet in the context of childbirth.

Article 3 is the absolute right not to be subjected to torture, or treatment which is "inhuman" or "degrading". The European Court of Human Rights says that this means that vulnerable people, especially those in the care of the state, must be given protection against inhuman or degrading treatment (*Keenan v UK*).

Article 3 does not only prohibit deliberate torture. Neglectful failure to provide the care which is necessary to avoid preventable suffering can amount to inhuman or degrading treatment (*Price v UK)*. Article 3 can, therefore, be violated by those who fail to ensure that adequate provision is available to ensure that such unnecessary suffering is avoided.

Article 8 is the right to be afforded respect for your "private life". The right to respect for private life does not mean only that the state must keep confidential information secret. The European Court of Human Rights says that the right to respect for private life is a right to respect for

> "that which constitutes a reasonable expectation of control of that which is personal"

(*Peck v UK)*. The state must protect and respect to a person's "private life" in this sense, unless there are very weighty public policy reasons to the contrary.

"A reasonable expectation of control" in the context of childbirth is that a woman be given options and entitled to exercise informed consent as to the treatment which she will undertake. Even before the Human Rights Act was in force, it has been very clear that a mentally competent woman retains her rights of autonomy and the right of self-determination in relation to her treatment in childbirth – *St George's Healthcare NHS Trust v S* (1998).

Violations of human rights during childbirth

There is no doubt that many of the practices described to the Birth Trauma Association may violate article 8 or – in extreme cases – article 3 of the ECHR. For example:

- The failure to provide pain relief, including for serious operations such as repairs to a torn cervix, without medical contra-indication, may violate article 3;
- Un-necessary invasions of privacy or violations of dignity – such as unnecessary use of stirrups – may violate article 8;
- The failure to give effect to a woman's choices (and changes of choice) about childbirth, particularly the withholding of treatment, or the administration of drugs such as oxytocin, may violate article 8 as well as the long-established common law principle of consent.

Unless urgent steps are taken to avoiding these practices, there is no doubt that in time, they will lead to litigation against NHS bodies and their staff.

A major cultural and organisational shift needs to take place to avoid this. Resources need to be devoted to ensuring that choices can be respected and pain relief is available when required. But it is not rocket science. A woman is a person with human rights. These do not disappear merely because she is giving birth to another person. The values involved are fairly fundamental and obvious: human autonomy, human dignity, respect.

What is needed is for hard-pressed childbirth practitioners to remember, and to be given the resources and cultural support, to act, on the basis that a woman in child-birth remain a human. Her humanity should remain “an end in itself”. She is not just a means to producing a baby.

Helen Mountfield
Barrister,
Matrix Chambers
March 2005

ANNEXES

1. **Mother and Baby Magazine Study**
2. **DSM-IV Criteria for PTSD**
3. **Summary of leading research**

The Birth and Motherhood Survey 2005,

Extract from summary results of The Birth and Motherhood Survey 2005, commissioned by the website motherandbaby.com:

Birth in Britain today is a terrifying, high-tech experience which leaves women in a state of shock according to a survey commissioned by this website, motherandbabymagazine.com.

Pain relief and intervention

Of those giving birth normally, 78% have 'gas and air', 24% are 'induced', 38% have an 'epidural' and 41% have 'pethidine'.

And 21% have an 'episiotomy', 16% 'ventouse suction', 10% 'forceps' and almost half - 46% - need 'stitches'.

No wonder 84% of mums say they were 'in pain after the birth' for an average of 21 days.

3,000 mothers and pregnant women were questioned over 11 TV regions including Wales, Scotland and Northern Ireland, making it the biggest National Survey ever of women's feelings about pregnancy, birth, maternity care and motherhood.

75% say their labour was 'more painful than they ever imagined'. A THIRD say their antenatal classes hadn't properly prepared them for the childbirth experience in Britain today and 43% had been encouraged by the classes to 'avoid pain relief'. In fact, 53% of mums say they found the whole experience of giving birth 'far more shocking than they thought'.

Six out of 10 women say they were 'mainly confined to bed during labour' (62%) and 42% were 'not allowed to move around at all during labour'. Almost TWO-THIRDS were 'strapped to a monitor' either 'continuously' (43%) or for 'most of the time' (19%) and a QUARTER say they were 'NOT told what was happening during their labour and birth' (25%).

Staggeringly, mums-to-be are left on their own completely unattended by medical staff for an average of 'one hour and 21 minutes' during labour - and almost two hours in some parts of the country.

No wonder, six out of 10 women say they 'relied more on their partner than their midwife' (58%). Only 43% had the same midwife throughout and only 4% had the same midwife they saw during their antenatal visits.

Although 61% say they 'were encouraged to have pain relief' by medical staff, those requesting an epidural had to wait an average of 60 minutes to receive one.

Three-quarters of mums say over-stretched maternity staff 'tried to listen to their wishes'

(75%) and 'reassure them' (73%) - but a QUARTER didn't. Those that ended up having an emergency caesarean had already been in labour an average of 19 hours.

Pain, shock and poor nursing care

Most women are shocked at the amount of pain they continue to suffer after the birth. An overwhelming 84% of mums say they were 'in pain after the birth' for an average of 21 days.

Only 51% think their 'nursing care was efficient' and only 49% found the nurses 'kind and compassionate' - 51% didn't. And four out of 10 mums say the ward they were on was 'dirty' (41%). Overall, only four out of 10 mums think they received 'very good' care on the ward after giving birth (43%), 45% say it was 'patchy' and 12% say it was 'poor/hopeless'. Four out of 10 mums felt 'shocked by their postnatal experience' (44%) and 16% suffered 'post natal depression' (16%). Only 20% received any professional help.

Six out of 10 mums say they DIDN'T receive any help with 'breastfeeding' from nursing staff (59%) and

only 65% left hospital 'breastfeeding' - 32% found it 'too problematic'. The average first-time mum
spends 3 days in hospital and 51% say they 'DON'T feel confident when they arrive home with their baby'.

Elena says: "New mums are completely overwhelmed and unprepared for life with a newborn baby and the support they receive from health professionals can make all the difference to how they cope with their new life. Most modern parents have never even changed a nappy before. Mums particularly need help with breastfeeding to help them overcome early difficulties and when this support isn't available, it's no wonder many mums feel discouraged and give up."

The arrival of baby also puts the brakes on a couple's sex-life. Couples don't have sex for an average of EIGHT weeks after the birth of their baby and even after this time, 75% say their sex life has deteriorated since baby arrived - 76% of mums are 'too tired for sex' and 39% have 'lost interest'.

Pregnancy is dominated by anxiety rather than joy

If birth in Britain today is a terrifying experience, the preceding pregnancy is also a time of angst rather than joy.

More than three-quarters of mums say they felt 'anxious' during their pregnancy (77%) and six out of 10 mums say the antenatal tests 'worried them' (57%). In fact, 37% of women say they were 'unnecessarily alarmed by medical staff during their pregnancy' - for example, being told the baby was 'too small for dates' or 'too big for dates', that the 'placenta was in the wrong place' or the 'baby was breech' when there was still plenty of

time for the baby to turn.

Elena says: "From the moment they become pregnant, most mums-to-be don't know who to turn to with their natural questions and worries and end up spending most of their pregnancy worrying needlessly. This is mainly due to the fact that pregnant women in the UK are no longer able to build up a relationship of trust with one midwife, who will then be present at the birth. Instead, they rarely see the same midwife twice during their antenatal care and only meet the one who will deliver their baby when they enter the delivery suite."

British women are dominated by pregnancy

Almost three-quarters of new parents say they made 'no effort to become healthy before conceiving their baby' (72%). Two-thirds drank 'alcohol' in the weeks and days before conception (65%) and 42% drank 'the night they conceived'. More than HALF of all mums-to-be continue to drink occasionally 'throughout pregnancy' (51%).

Almost a THIRD of women (29%) and four out of 10 men (39%) 'smoked while trying to conceive a baby' - and two out of 10 mums-to-be continue to 'smoke throughout pregnancy'.

Meanwhile, 99% of pregnant women say they suffer from 'tiredness', 81% from 'backache', 57% from 'swollen ankles/legs', 45% from 'excess weight gain', 23% from 'high blood pressure', 16% from 'varicose veins' and 8% from 'pre-eclampsia'. Six out of 10 say they feel 'tired and dumpy' (57%).

With the workplace more demanding than ever, six out of 10 mums say they 'find it difficult working during pregnancy' (58%) and 57% wish they could have 'give up work, relax and enjoy their pregnancy' - 69% of mums over 35 years-old feel this way. And almost HALF of all pregnant women say their boss is 'not sympathetic' (46%).

Elena says: "Parents owe it to their unborn child to try and become as healthy as possible before conception. As well as improving your chances of conceiving, your prospect of having a healthy baby is significantly improved just by following a healthy diet, stopping smoking and reducing the amount of alcohol. Remember, the care you take of yourself before and during pregnancy will affect the whole of your child's life."

http://www.motherandbabymagazine.com/nav?page=motherandbaby.pregnancy.list.detail&resource=1710688

The DSM-IV Criteria for Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Post Natal Post Traumatic Stress Disorder (PN PTSD).

Summary of Leading Research

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This summary was prepared by the Birth Trauma Association. 2005
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