

Description

How Can Midwives Prevent Birth Trauma?

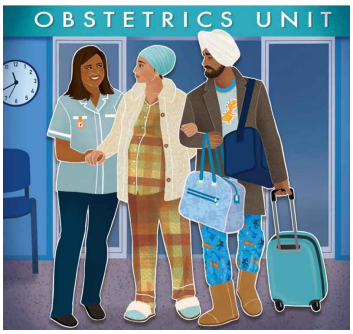
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Summary

Recently qualifying as a midwife and having various conversations with colleagues and families has reiterated the common misconception that birth trauma is something we can diagnose from simply reading a delivery summary. The notion that birth trauma exclusively happens when an emergency buzzer is pulled, or when the total blood loss ticks over 500mls disregards the impact that our care has on women's experience, be it positive or negative. With this in mind, the objective of this article is to unpack what we can do as midwives to prevent women being traumatised by their birth experiences.



What is birth trauma?

Birth is an experience that should be, and is for many women, positive and life-affirming. However, between nine per cent to 45.5% of women experience their birth as traumatic and will exhibit symptoms of post-traumatic stress following their birth.[1] This can include flashbacks of the birth, feelings of shame, guilt, fear, irritability, avoidance of hospitals and avoidance of future pregnancies.[2] Around 2.9% to 3.1% of women meet full diagnostic criteria for PTSD following childbirth.[3]

Why does it matter?

Crucially, the psychological impact of birth trauma may account for some of the poor rates of maternal mental health issues.[4] With maternal deaths by suicide in 2018 to 2020 increasing threefold since the previous report, and deaths from mental-health causes accounting for nearly 40% of deaths within a year after birth, there is an urgency for healthcare practitioners to recognise the potential that a traumatic birth experience has to negatively affect a woman's mental health in the long term.[5] Birth trauma can impact the relationship between a woman and her partner, and damage bonding between a mother and her new baby.[6] Evidence shows that birth trauma also impacts women's decision making about future pregnancies, with some women avoiding them entirely, and other women opting for birth by elective caesarean section rather than risk reliving a previous traumatic vaginal delivery or emergency caesarean.[7] This is especially poignant given the growing discourse in the UK surrounding the rate of caesarean sections.[8]

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Literature search

My literature search was for (trauma* OR ptsd OR "post-traumatic stress disorder" OR psycholog*) AND (birth OR childbirth OR labour OR labor) NOT (covid OR coronavirus OR covid-19) NOT (perineal OR bladder), with these terms within the title to limit the number of hits. I searched CINAHL Plus, Maternity and Infant Care, MEDLINE, Psychology and Behavioural Sciences, APA PsycINFO and Science Direct.

Mode of delivery and obstetric interventions

Mode of delivery is a complex topic within discourse surrounding birth trauma. Between 2021 and 2022, 20% of pregnant women in the UK underwent a lower segment caesarean section (LSCS).9 On the surface, LSCS has been found to be a risk factor for birth trauma.[2] With this in mind, it may seem tempting to suggest that midwives should simply advocate for vaginal births over operative ones in order to prevent psychological trauma. However, the evidence shows more nuance within this discussion.[2,3]

A systematic review of literature on mode of delivery and birth trauma by Carter found that Emergency Caesarean Section (EmCS) was tangibly the most traumatic mode of delivery, with six out of the 14 studies analysed showing a direct relationship between EmCS and an increase of postnatal post-traumatic stress disorder (PTSD) symptoms.[10] However, when an elective caesarean section was factored in, women who had a LSCS of any kind were only marginally more at risk of a traumatic birth experience than women who had a vaginal birth (spontaneous and instrumental). Instrumental deliveries were found to carry greater risk of birth trauma than spontaneous vaginal births, and emergency LSCS carrying greater risk than elective LSCS.[10] Given that instrumental deliveries and emergency LSCS are only indicated when there are urgent clinical concerns, it could be that the clinical indication for operative or instrumental delivery is the risk factor for birth trauma, rather than the mode of delivery itself: notably, concerning fetal heart traces can be associated with PTSD even in normal vaginal births.[11] Without being able to isolate the mode of delivery from the clinical context, the results of this study do not conclusively show that mode of delivery is a cause of birth trauma.

> The researchers also found that women who preferred a vaginal delivery but had an elective LSCS had no greater risk for birth trauma symptoms.[12]

Garthus-Niegel aimed to determine whether it is a mismatch between a woman's preferred and actual mode of delivery that contributes to birth trauma, rather than the mode of delivery itself.[12] The study compared outcomes for four groups: two whose preferences matched their outcomes (preference for LSCS, received an LSCS; and preference against an LSCS, no LSCS), and two mismatch groups – one group who wanted an LSCS but did not get one, and the other group who did not want an LSCS but got one. One key finding from this study was that women who preferred a delivery by LSCS, but who delivered vaginally, actually had the highest level of PTSD symptoms.[12] The researchers also found that women who preferred a vaginal delivery but had an elective LSCS had no greater risk for birth trauma symptoms.[12] This credibly suggests that it is not the mode of delivery itself that causes trauma, but instead the mismatch of expectations

and reality. For midwives, this is crucial information: preventing birth trauma is not about promoting vaginal birth, but instead supporting the mode of birth that the woman wants. In terms of practice, this indicates the importance of properly considering and accepting women's requests for elective LSCS.

Based on the premise that traumatic birth is not exclusive to LSCS births, Martinez-Vázquez conducted research into what obstetric practices or clinical factors are traumatising women with lower risk deliveries.[11] Risk factors included severe perineal tears, multiple repeated vaginal examinations and manual removal of placenta without analgesia, which were in line with findings in other research.[13] Original findings from this study included concerning fetal heart traces, administration of an enema and being made to lie down during labour.[11] These factors reiterate the notion that a traumatic birth is not exclusive to an instrumental or operative delivery, and that vaginal birth is not a protective factor from trauma.[2] The issue of consent was also highlighted as a major risk factor for trauma, with findings showing that in some cases, it is lack of consent for an intervention that is the cause of trauma, rather than the intervention itself, highlighting the importance of communication in relation to birth trauma.[11]

Intrapartum care and communication

Crucially, a woman's perception of her birth experience is more greatly influenced by the support from midwives than the actual events of birth itself;[14] a caring and nurturing environment can act as a protective barrier against potentially traumatising obstetric interventions.[15] Indeed, Baptie found that over half of the women in their study who experienced complications or interventions did not identify their birth as traumatic, because of the other contributing factors in communication and care.[15] This offers midwives a unique opportunity to prevent birth trauma, if it is possible to coherently identify what effective support looks like.

One study that unpacks what types of communication and behaviours from midwives help or hinder during labour is Baptie's research from 2021.[1] This study interviewed seven women who had interpreted their births as traumatic and seven who didn't and compared the data within two opposing themes of 'empowered' and 'powerless'. Women within the 'powerless' category relayed specifically that they felt their care was impersonal (for example, one woman had three different midwives swapped in during the first hour). Some felt they were not listened to or asked for input on their care, and that they were also given insufficient information to understand what was happening, which led to a feeling of fear.[1] Conversely, women in the 'empowered' category of the study felt aware of all their options before and during birth, and that they had control in making their own choices. When challenging situations occurred that were in opposition to their birth plan, they felt that the 'ends justified the means' because they were confident in their understanding of the situation and felt empowered by their choices.[1]

Control is a major factor in preventing or causing birth trauma. De Schepper argues, albeit 'tentatively', that healthcare professionals should be cautious with interventions so that women are able to maintain the locus of control, on the basis that interventions can be a risk factor for birth trauma.[16] However, the Ockenden report has highlighted the risks when midwives do not offer timely intervention and refer appropriately.[8] Moreover, lack of control does not necessarily come from interventions themselves, but from a lack of information and a woman's feeling of not knowing what is happening to her.[16] Some women in Hollander's study felt their trauma could have been reduced if they had asked for more interventions, but reiterated that the interaction around intervention was more important that the intervention itself, negating De Schepper's suggestion to be cautious with intervention to maintain the woman's control.[3]

Thinking in practical terms, Patterson, Hollins Martin and Karatzias used interviews with six women who experienced birth trauma to identify what aspects of care they felt impacted them most.[17] The women again reported the desire to feel informed and have things explained, but also the need for midwives to use positive tones of voice, make eye contact, be physically beside them, actively listen and speak with them rather than at them.[17] With some women feeling that the primary cause of their birth trauma was the communication from staff, it is imperative that midwives think about all aspects of the care they give, including both their non-verbal and verbal communication.[3] Interestingly, one small gesture identified as a means of showing compassion and support to women is the act of making tea, which can give a sense of connection, safety, normality and calm.[18] Small gestures in care evidently go a long way in women's perception of their birth and can also build a rapport that facilitates trust between the woman and the midwife, which is something identified as a core component in preventing birth trauma.[1]

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Recommendations

Lack of control and lack of information are two of the largest contributors to birth trauma so it is imperative midwives allow women to play a role in their own care.[16] Antenatally, midwives should take the opportunity to ensure women are informed about their choices and feel empowered to make their own decisions,[6] as the more informed women are, the lower the risk of feeling traumatised, as woman are more likely to understand the justification for any intervention.[1] During the intrapartum period, any emergencies should be explained to the woman to ensure that she feels informed and in control of the situation,6 and is able to give full consent for all intervention.[11]

It is important for midwives to remember that their care of the woman can have a greater impact in preventing birth trauma than obstetric factors, and that kind, compassionate care can be a protective factor in an otherwise traumatising experience.[14] Building a rapport with the woman from the start of her care will help to establish trust and a sense of safety, which will aid the woman if her plans for the birth are not fulfilled.[1] Attention should be paid to nonverbal communication, the use of eye contact and a positive tone of voice, and speaking to women on their level, both physically and tonally.[17] Naturally, midwifery care will always be limited by external factors, such as organisational pressures and staffing issues.[18] For midwives to prevent birth trauma, a multifaceted approach that includes a midwife-centred system of work is required, alongside a system of woman-centred care.[17]

Limitations

The main limitation of this project was the brevity, which meant excluding discussions about antenatal education which plays a major role in the prevention of birth trauma, as well as the secondary prevention of birth trauma through debriefing counselling style interventions.

Conclusion

While certain obstetric interventions can increase the likelihood of a woman experiencing birth trauma, midwives are able to mitigate for this with strong communication skills and compassionate care. Midwives should ensure that care is woman-centred, that women feel informed and able to have input on their own care, as this can be a protective factor against a traumatic birth experience. **TPM**

References

1. Baptie G, Januário EM, Norman A. Empowered or powerless? Contributing factors to women’s appraisal of traumatic childbirth. Br J Midwifery. 2021;29(12):674.
2. Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of posttraumatic stress following childbirth: A meta-analysis and theoretical framework. Psychol Med. 2016;46(6):1121-1134. doi.org/10.1017/ s0033291715002706.
3. Hollander MH, van Hastenberg E, van Dillen J, van Pampus MG, de Miranda E, Stramrood CAI. Preventing traumatic childbirth experiences: 2192 women’s perceptions and views. Arch Womens Ment Health. 2017;20(4):515-523. doi.org/10.1007/s00737-017-0729-6.
4. Gökçe Isbir G, Inci F, Önal H, Y?ld?z PD. The effects of antenatal education on fear of childbirth, maternal self-efficacy and posttraumatic stress disorder (PTSD) symptoms following childbirth: An experimental study. Appl Nurs Res. 2016;32:227-232. doi.org/10.1016/j. apnr.2016.07.013.
5. Knight M, Bunch K, Patel R, et al, eds. MBRRACE-UK: Saving Lives, Improving Mothers’ Care 2022 – Core Report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. https://www. npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternalreport-2022/MBRRACE-UK_Maternal_CORE_Report_2022_v10.pdf. Published November, 2022. Accessed April, 2023.
6. Koster D, Romijn C, Sakko E, et al. Traumatic childbirth experiences: Practice-based implications for maternity care professionals from the woman’s perspective. Scand J Caring Sci. 2020;34(3):792-799. doi.org/10.1111/scs.12786.
7. Anderson CA. The trauma of birth. Health Care Women Int. 2017;38(10):999-1010.

doi.org/10.1080/07399332.2017.1363208.
8. Ockenden D. Ockenden review: Summary of findings, conclusions and essential actions. Gov.UK. https://www.gov.uk/government/ publications/final-report-of-the-ockenden-review/ockenden-reviewsummary-of-findings-conclusions-and-essential-actions. Published March 30, 2022. Accessed April, 2023.
9. NHS maternity statistics, England – 2021-22. NHS Digital. https://digital. nhs.uk/data-and-information/publications/statistical/nhs-maternitystatistics/2021-22. Published November 29, 2022. Accessed April, 2023.
10. Carter J, Bick D, Gallacher D, Chang Y. Mode of birth and development of maternal postnatal post-traumatic stress disorder: A mixed-methods systematic review and meta-analysis. Birth. 2022;49(4):616-627. doi.org/10.1111/birt.12649.
11. Martinez-Vázquez S, Rodríguez-Almagro J, Hernández-Martínez A, Delgado-Rodríguez M, Martínez-Galiano JM. Obstetric factors associated with postpartum post-traumatic stress disorder after spontaneous vaginal birth. Birth. 2021;48(3):406-415. doi.org/10.1111/ birt.12550.
12. Garthus-Niegel S, von Soest T, Knoph C, Simonsen TB, Torgersen L, Eberhard-Gran M. The influence of women's preferences and actual mode of delivery on post-traumatic stress symptoms following childbirth: A population-based, longitudinal study. BMC Pregnancy Childbirth. 2014;14:191. doi.org/10.1186/1471-2393-14-191.
13. Viirman F, Hesselman S, Wikström A, et al. Negative childbirth experience – what matters most? a register-based study of risk factors in three time periods during pregnancy. Sex Reprod Healthc. 2022;34:100779. doi.org/10.1016/j.srhc.2022.100779.
14. Ford E, Ayers S. Stressful events and support during birth: The effect on anxiety, mood, and perceived control. J Anxiety Disord. 2009;23(2):260-268.
15. Baptie G, Andrade J, Bacon AM, Norman A. Birth trauma: The mediating effects of perceived support. Br J Midwifery. 2020;28(10):724.
16. De Schepper S, Vercauteren T, Tersago J, Jacquemyn Y, Raes F, Franck E. Post-traumatic stress disorder after childbirth and the influence of maternity team care during labour and birth: A cohort study. Midwifery. 2016;32:87-92. doi.org/10.1016/j.midw.2015.08.010.
17. Patterson J, Hollins Martin CJ, Karatzias T. Disempowered midwives and traumatised women: Exploring the parallel processes of care provider interaction that contribute to women developing post traumatic stress disorder (PTSD) post childbirth. Midwifery. 2019;76:21-35. doi.org/10.1016/j.midw.2019.05.010.
18. Patterson J, Ménage D. Compassion as a powerful intervention: How the interactions between women, midwives, and maternity services influence women's childbirth experiences and subsequent trauma. TPM. 2020;23(8):41. doi.org/10.55975/IAOD9019.

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