Safety Action Series

Improving Care and Support for Patients Experiencing Birth Trauma

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Speakers

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Disclosures

➢ Heidi Koss, MA, LMHC has no real or perceived conflicts of interest.

➢ Dawn Thompson has no real or perceived conflicts of interest.
Objectives

➢ Discuss the impact of traumatic birth experiences from a patient’s perspective
➢ Identify clinical and communication skills to more sensitively support parents experiencing birth trauma
➢ Share methods to mitigate and prevent birth trauma in the future
➢ Discuss how to better support patients for subsequent births following a traumatic birth experience
Birth Trauma: In the Eye of the Beholder

Traumatic Birth is defined as “An event occurring during the labor and delivery process that involves actual or threatened (perceived) serious injury or death to the mother and her infant. The birthing woman (and/or her partner) experiences intense fear, helplessness, loss of control, and horror.”

- Cheryl Beck, 2004
Incidence Rates

• 33-45% of women experience their births as traumatic, and

• 2 – 17% meet the full PTSD criteria

• Partners suffer, too!

(Creedy, et al., 2001; Soet, et al., 2003; Adewuya et al. 2006; Cigoli et al. 2006; Alcorn, et. al., 2010; Andersen et al., 2012; Stramrood et al. 2011; Schwab et. al.; 2012; Shaban 2013)
Some Impacts of Birth Trauma

- Avoids postpartum care
- Impaired bonding with baby; long-term child impact
- Vicarious trauma – partners, doulas, staff
- Sexual Dysfunction
- Avoidance of future pregnancies
- Heightened Anxiety & relapse of Sx in future pregnancies
- May choose elective c-sects in future pregnancies
- Relationship difficulties, marital distress
Subsequent Birth Choices after Traumatic Childbirth Experience

Interestingly,

• 23% of moms opted for homebirth following prior traumatic birth

(Cheryl Beck, Nursing Research Journal, 2010)
Know your patient’s trauma Risk Factors

- Prior medical traumas
- Prior traumatic birth, stillbirth, or pregnancy loss
- History of Anxiety, OCD, Depression *especially during pregnancy*
- History of betrayals of TRUST
- History of sexual abuse
- History of physical or emotional abuse
- Impact of Cultural Inequities as cumulative trauma Hx:
  - Racial
  - Immigration status
  - Gender, Sexual Orientation
  - ETC
Be Sensitive to Sexual Abuse Survivors

- Pelvic exams might trigger abuse memories, especially if perceived as ‘done to you’ (no body control) vs. ‘done for or with me’ (respect for body).
- Miscarriage or pregnancy loss may resurrect prior trauma from previous forced abortions from sexual abuse.
Disclaimer

Our intention in today’s presentation and in sharing these case examples of real mother’s stories is not to lecture or shame, but rather an opportunity to learn and elevate our patient care practices.

We acknowledge we all entered these caring professions with the goal to help, not hurt. But, there’s room for improvement, so we hope this information helps you be the best practitioner you can be.
Pelvic Exams

• A sleeping patient still requires consent
• A numbed patient still requires consent
• When No Means No
Factors contributing to Birth Trauma

• Prior factors
  – Life experiences and their influence on how they now process information and emotions

• Subjective factors during birth
  – Patient’s emotional and cognitive experiences

• Objective factors during birth
  – Number and type of interventions
Objective Factors: Arenas of Distressing *Experiences* linked to Traumatic Birth

**Number and type of Obstetric Interventions**

As listed in order of psychological severity of impact on the mother:

1. Forceps delivery
2. Vacuum assisted delivery
3. Episiotomy
4. C-section
   - especially unexpected, emergency

Objective Factors: Arenas of Distressing *Experiences* linked to Traumatic Birth

**Maternal Complications**

- HELLP syndrome
- Preeclampsia
- Maternal hemorrhage
- Retained/manual removal of placenta
- Infection during labor
- Extensive lacerations (3\textsuperscript{rd} or 4\textsuperscript{th} degree)
- Active phase of labor greater than 12 hours
What to do to mitigate trauma in this scenario

• As much as is humanly possible, have someone **EXPLAIN** to patient and her loved ones what is happening; if possible, designate a staff ‘Narrator’ explaining in a calm, simple, direct way.

• If at all possible, **allow support people to remain present** in the room while care is given (this offers comfort to the patient and allows her loved ones to see that all that can be done is being done, as well as helps her create a coherent narrative later)

• Offer **physical support and direct eye contact** to patient and her support people
Objective Factors: Arenas of Distressing *Experiences* linked to Traumatic Birth

**Infant Complications**
- Fetal demise/infant loss
- Placental abruption
- Shoulder dystocia
- Infant Resuscitation
- Cord complications (prolapse, tight nuchal, short)
- Intrapartum asphyxia
- Low apgar scores (specifically at 5 minutes)
- Premature delivery
- NICU stay
PTSD in NICU Parents

Risk Factors

• Neonatal complications
• Pre-term delivery
• Greater length of NICU stay
• Infant Loss

Prominent Symptoms

• Intrusive memories of infant’s hospitalization
• Impaired Bonding
• Avoids reminders of child’s birth (Anniversary dates such as birthdays are very hard)

Patient’s internal experience is KEY

• **SUBJECTIVE** experience is likely a **larger contributor** to the perception of trauma and the consequent development of PTSD than objective experiences, although objective experiences remain very important.

• Most Subjective distress is due to **disruptions in the relationships** between the birthing woman and her care providers.
6 Interpersonal disruptions during labor and delivery contributing to Birth Trauma

1. Staff *not explaining* procedures nor asking permission before carrying them out; *consent issues*
2. Not included in decision making;
3. Tension and *arguments between caregivers*;
4. Lack of *information* regarding normality of and progression of labor.
5. Lack of *individualized* attention or care – feeling like “a cog in the machine,” “just a number”
6. Being treated with *harsh words, impatience, threats, coercion, abrupt or painful touch*.

Elmir, et al, 2010; Women’s perceptions and experiences of a traumatic birth: J of Adv Nursing; Reed et al., 2017; Women’s descriptions of childbirth trauma relating to care provider actions and interactions, BMC Pregnancy and Childbirth
What does coercion look like

- "If you don't let me check your dilation, I can't continue to care for you."

- "The placenta stops working at 40 weeks and your baby won't be getting ANY nutrients. We MUST induce before your due date."

- "Your cervix is posterior and closed so we need to schedule a cesarean. You won't be able to have a vaginal birth"

- "If you attempt to come in for a TOLAC, I will call child protective services."
"We doctors do many things that are otherwise unacceptable. We are trained not only in how to do such things but in how to do them almost without noticing, almost without caring, at least in the ways we might care in different circumstances or settings."

What to do...

DO YOUR BEST TO REPAIR THE SITUATION IMMEDIATELY

• “It’s not what you do, it’s what you do NEXT”

• Initiate conversation about what you have noticed

• **Validate** patient’s concerns or feelings; support her expression of emotion

• **Apologize** that this caused her distress (don’t be disingenuous)

• Make certain patient knows she can request a new nurse or physician
Staff behavior can Set the Stage for Trauma & Perception: How “the eye beholds”
Themes of Care Provider Actions leading to Women’s Birth Trauma – Reed 2017

1. Prioritizing the care provider’s agenda
   - Women felt that care providers prioritized their own agendas over the needs of the woman. This could result in unnecessary intervention as care providers attempted to alter the birth process to meet their own preferences. In some cases, women became learning resources for hospital staff to observe or practice on.

2. Disregarding embodied knowledge
   - Women’s own awareness and wisdom about her body and her baby was disregarded in favor of care provider’s clinical assessments.

3. Lies and threats
   - Care providers used lies and threats to coerce women into complying with procedures. In particular, these lies and threats related to the wellbeing of the baby.

4. Violation
   - Women also described actions that were abusive and violent. For some women these actions triggered memories of sexual assault.

Reed et al., 2017; Women’s descriptions of childbirth trauma relating to care provider actions and interactions, BMC Pregnancy and Childbirth
Care Dynamics Contributing to PTSD – Beck 2004

1. Perception of lack of respect by providers
   - Feeling abandoned
   - Stripped of dignity
   - Lack of support and assurance
   - Lack of continuity of care providers

2. Feeling powerless or out of control -- Feels actions done TO her, not WITH her -- perceived lack of choice or consent
   - Betrayal of trust
   - Didn’t feel protected, safe
   - Threatened “you don’t want your baby to die, do you?”

3. Poor Communication
   - Perceived lack of communication by medical staff
   - Mom feels invisible

4. Do the ends justify the means?
   Mom is Minimized: “all that matters is your baby is healthy”
Undermining

- "You have a birth plan? Birth plan equals cesarean. You should sign the consent forms for the cesarean now- maybe that will lift the curse of the birth plan."

- "You realize that you're just here for a trial of labor, right? You're likely going to have another cesarean."

- “You know people don’t actually have VBAC’s around here.”

- “Why are you doing this to yourself? You know you aren’t going to get a gold star or anything right?”

- "I had the bed right outside your door ready to wheel you to the OR- that must have been what lifted the curse of the birth plan!“
Red Flags for Providers

• There never should be a risk to the patient to say “this is what I want”

• If a patient’s trauma feels threatening to YOU, then YOU have a problem – seek help!
Implicit Bias and Cultural Barriers Influencing Traumatic Birth

Why are black mothers and babies in the United States dying at more than double the rate of white mothers and babies? The answer has everything to do with the lived experience of being a black woman in America. — by Linda Villeneuve
Other Barriers to Quality Care

• Take care of YOU
  – This is a hard line of work!
  – Your own traumas and vicarious trauma
  – Exhaustion, Fatigue, Stress
Symptoms associated with PTSD

- **Intrusion** - a term which refers to repeated vivid though unwelcome memories of the traumatic experience, including flashbacks, dreams, and troubled associations with the memories.

- **Avoidance ornumbing** - this refers to the patient’s conscious avoidance of all situations or triggers which recall the trauma, or developing a shell to avoid reacting to such triggers.

- **Hyperarousal or overreacting** - the patient with PTSD develops strong symptoms of mental and emotional arousal, such as irritability or inability to sleep well.
Fear, Pain, PTSD & Childbirth

- Fear of pain in labor is associated with suffering, shame, loss of control and helplessness (Fenwick et al, 2009)

- Fear or feelings of helplessness during labor and delivery are predictive of PTSD (Olde et. al., 2005)

- The most common reasons for childbirth fear were a lack of trust in obstetric staff and feeling excluded from decisions. (Sjögren, 2000)

- Negative emotions associated with poor pain management are predictive of PTSD following birth (Lyons, 1998)
Fear & Childbirth

- Women with fear in childbirth endure a longer labor and higher incidence of caesarean section. (Otley, 2011, Fear of Childbirth: Understanding the Causes, Impact and Treatment, The British Journal of Midwifery)

- Risk Factors for increased prevalence include:
  - Young maternal age
  - First-time mother
  - Pre-existing psychological problems
  - Lack of social support
  - History of abuse
  - Adverse obstetric events
    (British Journal of Obstetrics & Gynecology, 2012)
Fear contributing to “Failure to Progress”

- Fear, anxiety and not feeling safe increases catecholamine levels and can inhibit the progression of labor

- Pain as state dependent (Emotional and cognitive state)
  - Those who are distracted tend to experience less pain.
  - Those who are anxious tend to experience more pain.

- Thus, Soothing her fear is PREVENTIVE CARE: it can mitigate unnecessary complications and interventions leading to birth trauma
Things that are scary

- Recognizing from staff’s behavior that something “very serious” or “catastrophic” was taking place
- Worrying that partner or baby could die/were dying
- Chaotic nature of the delivery room – numerous people in and out, noises, sights, smells, room changes, etc.
- Overhearing dramatic language: “get the baby out NOW” “We’re losing her” “She’s circling the drain”
- Noting tension/argument between caregivers
- Being or witnessing partner being treated harshly, with abrupt touch, impatience
- Waiting for surgical outcomes (without updates or information)
What to do...

• **Ask** patient to describe *specifically* what they are afraid of;

• **Repeat** this back to them for clarification;

• Offer only specifically *relevant* information;

• Ask patient what they *need* for immediate self care and *comfort*;

• Have a support person *write* down the *plan* so all can see it (especially helpful with continuity over shift changes)

  **DO NOT OFFER PLATITUDES OR ‘GENERAL’ REASSURANCE** – this minimizes her experience and makes it worse.
DISSOCIATION

This is the strongest predictor of perception of one’s birth as traumatic, and the development of PTSD (Olde et. al., 2005; Zambaldi et. al., 2011)

Things to look for:

- A sudden disappearance of facial emotion or verbal expression;
- The patient appears to become disoriented, confused unable to remember things
- There is a sense that the patient is “not really here” “Floated away”
- Patient’s gaze becomes unfocused and far away, unseeing
- Patient unable to move or speak
- Patient not ‘oriented x3”
Personal Experience

• You realize that you're just here for a trial of labor, right? You're likely going to have another cesarean. “

• “You know people don’t actually have VBAC’s around here.”

• “Why are you doing this to yourself? You know you aren’t going to get a gold star or anything right?”
What to do....

• Verbally tell patient you are aware she has disconnected from her current experience. **Do not raise your voice. Low, slow and soft.**

• Help her feel **SAFE**

• Engage her with **eye to eye** contact allowed (holding the **LEFT hand**)

• Help her to return to the present situation by speaking out loud about what she can **see, hear, touch, and smell** right now. She can describe the room, your face, the presence of her partner, etc.

• Offer words of **encouragement**

• **Gently** remind patient that she is half of the mother-baby team, and needs to **stay here to help her baby**
How can Care Providers Reduce Risk of a Traumatic Birth Experience?

The “3 E’s”

• EXPLAIN
• ENCOURAGE
• EMPATHIZE

https://awhonnconnections.org/2017/03/16/lessening-the-risk-of-birth-trauma/ by Karin Beschen, LMHC
Explain

- When explaining a process, options or a procedure, always include the woman in the discussion of her own care.
- There is a distinct difference in hearing a discussion and being a part of one.
- If plans change, explain what is happening and what is needed to correct the situation.
Encourage

• The connection a mother has with those caring for her during childbirth is deep — you are present during one of the most emotional, unpredictable times in her life.

• Encouragement is empowering and can offer the mother a sense of control.

• Encourage questions.
Empathize

• Women in labor yearn for companionship, support and empathy.

• Phrases such as “I know,” “I’m here,” “I’m with you” and “Yes” are phrases that connect staff with a woman’s experience when she feels pain, fear, disappointment.

• **How the mother is cared for, is what she remembers.** The tone of your voice. The gentleness. The validation of feelings. Even in the midst of an emergency, someone saw her need. Someone saw her.
Provider Communication Tips

• Respectful, compassionate
• Collaborative Model
  – Don’t pull rank of power over the patient with a ‘we know best’ approach
• Listen – open mindset, intent to help
• Get CURIOUS – offers opportunities to understand and improve care
• Validate
  – Their pain, their experience, their fear, their reality
• ALWAYS Debrief the birth experience with your patient (and their partner, if possible)
• Don’t be an island – bridge the gap
  – add the power of touch to communicating with our patients. Hold their hand, put a hand on their shoulder
Some Do’s and Don’ts

- **DO:** Have anesthesiologists speaking supportively with mom during c-sect since they are right at her head.
- **DO:** Maintain Sustained Eye contact - very important in her feeling ‘seen’.
- **DO:** Use lots of validation statements about their experience (helps them feel seen, heard, that they matter).
- **DO:** Give a running narrative of what is going on - helps their experience get wired in the brain and memory in a more cohesive, integrated, organized narrative. Gaps or misunderstanding of the experiences creates fear and anxiety.
- **DON’T** “cross talk” with other staff when you are with the patient – makes them feel like they don’t exist or matter.
- **DON’T** try to lighten the mood with humor – TOO SOON!
Importance of Debriefing: Help them shift from “Old Story” to “Whole” story

• In traumatic birth, both birthing women partners may miss significant pieces of information (women lose consciousness, men taken out of the room)

• Due to placement in the room, fathers can see what is happening with the baby, but not with the woman, or vice versa

• Sometimes they witness what is occurring, but have no idea what is really going on (may misunderstand)

• The storyline/content – WHAT happened

• The reasons – WHY and WHEN things happened

• The Impact – address HOW things felt from patient’s point of view
Communication Heirarchy Bucket Model:
Flows OUT only, never IN. Process one’s trauma with people only either in the SAME circle as you, or outer circles, NEVER with inner hierarchy of circles

Yet, Don’t overshare!
DO Share your empathy, compassion, DON’T unwittingly process your trauma with patients

Example: Don’t say “You Scared me when...” When debriefing with a patient. Process this with your peers, supervisor, a therapist
Trauma Treatment Options

- Therapy
- Psychopharmacology can be helpful (including sleep aids)
- Social Support
  - Caring OB’s & Midwives taking the time to understand mother’s history and trauma experience, reviewing her records
  - Doula support – birth and postpartum
  - Support Groups
Components for Recovery

- **Address Biology:** Biochemical imbalances, sleep, medication
- **Address Psychology:** Thoughts & Beliefs
- **Address Improving Social Supports**
Some Trauma Psychological Treatment Options

- Mindfulness & Mind/Body Somatic Approaches
- EMDR (Eye Movement and Desensitization Reprocessing)
- Life Span Integration & Parts Psychology/Internal Family Systems
- Narrative Therapy
- Exposure/Desensitization Therapy
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Psychodrama
- Journaling
- Art Therapy
Facilitate Connections, don’t abandon. Appropriate Support Includes Providing

- Local support group information
  - Miscarriage/Infant Loss groups
  - Birth Trauma groups
  - Perinatal Mood Disorder support groups
  - Parent support groups
- Identify APPROPRIATE Referral Providers
  - Trauma therapists
  - Psychiatrists/ARNPs
  - Perinatal Mental Health Therapists
Preparing Patients and Partners for Subsequent Birth

• Review the past to prepare for the future
• Create a Birth and Communication Preferences Plan – that is distributed to EVERY person that will have contact with the birthing parent
• Empower patients with knowledge – CBE, Evidence-Based Birth Practices, their Rights
Preparing Patients and Partners for Subsequent Birth

• **“TLC” Flag**: Create a flagging system in your practice/facility that flags this patient has trauma Hx

• **Encourage** the parents (and you) to work collaboratively with practitioners: childbirth educator, **doula (yes, get one!),** therapist, midwife or doctor who will:
  
  – work with and acknowledge the traumatic experience of your earlier birth instead of minimizing it
  – encourage you to make decisions
  – respectfully offer their own evidence-based expertise
  – And if they haven’t received trauma-based therapy yet for the previous birth, Refer out, STAT!
What’s “shareable becomes bearable” – Dan Siegel, MD
Appendix
Traumatic Birth Resources
Screening Measurement tool: PERINATAL POSTTRAUMATIC STRESS DISORDER QUESTIONNAIRE (PPQ)

• Developed by Michael Hynan and modified by Jennifer Callahan (originally “yes or no” format; now a Likert scale (0-4))
• Scores range from 0 – 56.
• Women with scores of 19 or higher are nearly twice as likely to require referral to mental health services
• A 14 item measure assessing intrusive and re-experiencing symptoms, avoidance behaviors, hyperarousal, and numbing of emotion. One item pertaining to guilt.
Helpful Intake Interview Tool

“Self-Assessment of Maternal Distress After a Difficult Birth”

Originally Developed By
Penny Simkin and Phyllis Klaus

PDF Available Here:
Websites

- Prevention and Treatment of Traumatic Birth – PATTCh [www.pattch.org](http://www.pattch.org)
- Improving Birth [www.improvingbirth.org](http://www.improvingbirth.org)
- Solace for Mothers [www.solaceformothers.org](http://www.solaceformothers.org)
- Birth Trauma Association [www.birthtraumaassociation.org.uk](http://www.birthtraumaassociation.org.uk)
- Post Traumatic Stress Disorder After Childbirth [www.ptsdafterchildbirth.org](http://www.ptsdafterchildbirth.org)
- Trauma and Birth Stress [www.tabs.org.nz](http://www.tabs.org.nz)
- Postpartum Support International (PSI) [www.postpartum.net](http://www.postpartum.net)
WHO “Intrapartum Care for a Positive Childbirth Experience”

• New Guidelines Establish The Rights Of Women When Giving Birth
• set of 56 recommendations such as:
  – a long, slow labor is not a good reason in itself to give drugs to speed labor, perform a C-section or otherwise medically step in
  – allowing a woman to be accompanied by a companion of her choice during childbirth,
  – honoring her decisions about pain management and delivery position, and
  – providing her with confidentiality and privacy
– guidelines emphasize respect and dignity

Available as free PDF download: http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf?sequence=1
Recommended Books

• Traumatic Childbirth by Cheryl Beck, Jeanne Watson Driscoll & Sue Watson (2013)
• Transformed by Postpartum Depression by Walker Karraa (2014)
• In Shock: From Doctor to Patient – What I learned About Medicine’s Inhumanity by Dr. Rana Awdish (2017)
• When Survivors Give Birth by Penny Simkin and Phyllis Klaus (2004)
Recommended downloads/links for patients

At Improving Birth [https://improvingbirth.org/resources/#](https://improvingbirth.org/resources/#)
- “Pathways to Healing: A guide to healing after a difficult childbirth”
- “Accountability Toolkit: A guide to filing a formal grievance after a difficult childbirth”
- Information on Evidence Based Maternity Care, Induction, C-Section, & VBAC Facts, and Patient Legal Rights

At National Center on Trauma-Informed Care
Recommended downloads/links for patients

At PATTCh  http://pattch.org/resource-guide

- **Traumatic Births and PTSD: Definition and Statistics** Penny Simkin, PT, PATTCh
- **Pre-Existing Risk Factors for PTSD and Childbirth** Heidi Koss, MA, LMHC
- **What to do during a traumatic labor and birth to reduce the likelihood of later Post-Traumatic Stress Disorder** Penny Simkin, PT, PATTCh
- **Ten Questions for a Partner of PTSD Survivor** Walker Karraa, MFA, MA, CD(DONA)
- **Fathers and PTSD** Walker Karraa, MFA, MA, CD(DONA)
- **Breastfeeding After a Traumatic Birth** Teri Shilling, MS, LCCE, CD(DONA), IBCLC
- **Treatments Options for Trauma Survivors with PTSD** Kathleen Kendall-Tackett, Ph.D., IBCLC, FAPA
- **Living Through Traumatic Birth: Loss, Grief, and Recovery** Katie Rohs, Doula
- **Having a Baby after Traumatic Birth** Suzanne Swanson, PhD, LP
- **No “Typical” Birth: NICU Experiences and Post-traumatic Stress Disorder (PTSD)** Leslie Butterfield, PhD
- **Risk for Traumatic Birth for Women with Pre-Existing PTSD** Julia Seng, PhD, CNM, FAAN
- **Trauma-Informed Care during the Childbearing Year** Mickey Sperlich, PhD, MSW, MA, CPM
Resources for Perinatal Loss

- Babyloss  www.babyloss.com
- Center for Loss in Multiple Birth  www.climbsupport.org  First Candle/SIDS Alliance  www.firstcandle.org
- Healing Hearts Baby Loss Comfort  www.babylosscomfort.com
- The M.I.S.S. Foundation  www.missfoundation.org
- Silent Grief  www.silentgrief.com
- The Tears Foundation  www.thetearsfoundation.org
Provider-Patient Communication Tips

• Wonderful appendix in Dr. Rana Awdish’s book with very user-friendly communication improvement tips
• Designed specifically by a physician, for her peers
• From Book, “In Shock: From Doctor to Patient – What I learned About Medicine’s Inhumanity” by Dr. Rana Awdish (2017)
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Q&A Session

Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org