Birth trauma resolution

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ORIGINAL

In 2015 the Royal College of Midwives (RCM) announced its recommendation that every Trust should have a specialist maternal mental health midwife (RCM 2015). This signalled the growing need for specialist care for mothers suffering from mental health problems. This paper is designed to examine a new and exciting treatment being offered to women and their partners who have been traumatised by birth, including those suffering from the hugely debilitating symptoms of post-traumatic stress disorder (PTSD).

To do this, it is necessary to examine what is meant by the term 'emotional and psychological trauma'.

The original meaning of the Greek word 'trauma' is 'wound' and was often used to describe physical damage. However, the word 'trauma' can also be used to describe psychological trauma. This is a condition in which a person has lived through an extraordinarily stressful event, shattering their sense of security, wounding their psyche and leaving them to feel like a helpless being living in a dangerous world. When reading this description, you might, in an attempt to understand its meaning, allow your mind to gloss over the true horrors suffered by women who have had a traumatic birth. In truth, many women who are already going through one of the most stressful life transitions by becoming a new mother, are doing so accompanied by the horrific symptoms of panic attacks, nightmares, flashbacks and intrusive thoughts about the birth, so typical of those suffering from birth trauma/PTSD.

It is, therefore, my belief that the following quote offered by the Human Givens Institute, moves some way towards helping us to understand the true horrors of birth trauma.

***'A traumatised creature lives in a private hell, terrorised by an invisible mental wound, helplessly in thrall to a powerful emotional memory of a life-threatening event'* (Griffin & Tyrrell 2013:319).**

Birth trauma resolution therapy comes at a time when the world is crying out for a unique system of diagnosis and treatment that is able to quickly and effectively dissolve the hugely debilitating symptoms of birth trauma/PTSD. The Birth Trauma Association estimates that 10,000 women in Britain each year are treated for PTSD as a result of a traumatic birth (McLaren 2017). That is the largest cohort of PTSD sufferers in the country. However, this is only the tip of the iceberg as it is believed that a further 200,000 women are left with undiagnosed symptoms of PTSD (McLaren 2017). I believe that this is largely due to the country's postnatal screening system only being set up to identify women suffering with postnatal depression.

Mothers are not the only ones to experience trauma symptoms following a traumatic birth. I believe that birth partners, having witnessed their partners' traumatic birth, will further add to this alarmingly high statistic, with a significant number of men reporting with symptoms of trauma.

Furthermore, a study conducted at the University of Liverpool's psychological services (Sheen *et al* 2015), with a sample of over 400 midwives, revealed that 5% of midwives having witnessed traumatic births experience symptoms of trauma. This statistic may be conservative and one could estimate that as many as 30% of midwives will suffer from trauma at some point in their career.

Treatment for birth trauma/PTSD

At present, birth trauma treatment offered by counsellors and psychotherapists within the NHS includes cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) (Carlson *et al* 1998). Studies reveal that it usually takes 6–10 treatments of CBT and 8–12 treatments of EMDR to offer relief from the symptoms of trauma in around 77% of cases (National Institute for Health and Care Excellence 2005).

The treatment that is to be examined here has been designed to offer birth professionals a way of dissolving the symptoms of trauma quickly and effectively, and in the case of a single trauma, often in as little as one or two treatments. It is based on a sound understanding of how trauma affects the brain and how nature attempts to correct that imbalance. Techniques used by a birth trauma resolution practitioner support nature's own natural trauma processing system. This enables traumatic memories to be filed away in the neocortex, where they can be remembered as a normal memory without triggering the strong emotionally aroused trauma template that often leads to panic attacks, intrusive thoughts, flashbacks, nightmares and other symptoms associated with PTSD.

So how does it work?

Certified birth trauma/PTSD practitioners use an effective screening tool to identify women/partners

who meet the full criteria for PTSD. They also screen for those who do not meet the full criteria but have some of the symptoms of trauma and that would still benefit from treatment. Such patients include sufferers of subthreshold trauma, a term given to patients experiencing excessive emotional arousal to a given stimulus that they are not consciously aware of. Thus, in the case of birth trauma, they might experience seemingly illogical anxiety and panic every time they meet a red-headed woman (similar to the red-headed midwife at their traumatic birth). This is because the brain will unconsciously match the red-headed woman to a previous emotionally charged pattern of a red-headed midwife present at the traumatic birth.

The current postnatal screening system for women in the UK uses the Edinburgh Postnatal Depression scale. Due to the co-morbid relationship that exists between birth trauma/PTSD and PND, with one often leading to the other, mothers can be incorrectly diagnosed with PND, leaving symptoms of birth trauma/PTSD undetected and misdiagnosed.

As part of the comprehensive assessment system offered by birth trauma resolution practitioners, patients are asked to complete an emotional needs audit. This method of assessment suggests human beings have nine emotional needs that must be met to feel mentally well and healthy (Griffin & Tyrrell 2013:97-153). When a patient has been traumatised, these needs are often not met and further add to the debilitating symptoms of birth trauma/PTSD. Birth trauma resolution practitioners will assess what needs are not being met and take steps to correct the imbalance.

Following the birth trauma resolution double assessment system, patients are offered treatment to dissolve symptoms of birth trauma/PTSD. The main tool used is the Human Givens Institute's 'rewind' technique; designed to lower arousal enough to turn the trauma memory into a normal memory (Griffin & Tyrrell 2013). The technique allows the practitioner to dissolve the emotional tag from the trauma memory/pattern and in doing so prevents the amygdala from triggering the horrific symptoms associated with birth trauma/PTSD. Once the emotional charge has been removed the memory may be stored in the neocortex, allowing the mother to remember the birth without experiencing feelings of anxiety and panic (Griffin & Tyrrell 2013).

As with many birth trauma/PSTD patients, their confidence in their ability to give birth, be a mother and take part in the normal activities associated with motherhood, has been damaged. Practitioners will then employ further release and confidence building techniques to enable the mother to reintegrate into the normal activities of motherhood and family life. Further information is gathered from the emotional need audit, giving practitioners and mothers a clear understanding of what needs are not being met due to the trauma and taking on the life-changing role of motherhood. They will work out a plan allowing these needs to be met and helping the mother to feel emotionally balanced and well.

Often when women or their partners have endured or witnessed a traumatic birth they will become afraid of the associated symptoms of the anxiety and panic. Practitioners will teach specialised breathing techniques to combat anxiety and teach patients how to bring arousal under their control and shut off a panic attack. This can help the patient's confidence grow further.

When birth trauma resolution practitioners follow the above format, a single trauma can often be dissolved in one or two sessions with the trauma template itself being collapsed in just one session. However, it is common for those women predisposed to suffering from birth trauma to present with previous trauma templates, ie: multiple miscarriages, failed IVF, child abuse, domestic violence. Birth trauma resolution therapy offers practitioners the opportunity to dissolve additional trauma templates and thus provide mothers further help with their perinatal mental health. In addition, certified practitioners can help health care workers including midwives, obstetricians, gynaecologists, anaesthetists etc, who suffer vicarious trauma (caused by repeatedly witnessing traumatic births) to dissolve their trauma templates enabling them to offer a higher level of service to women and their partners.

Case histories

The birth trauma resolution practitioner training programme is a three-month course undertaken by birth professionals including midwives, doctors, doula's, hypnobirthing practitioners and counsellors.

The following case histories have been given by graduates of the certified programme. Patients names have been withheld to maintain confidentiality and all clients have given permission for their story to be told.

Case 1

'The lasting PTSD symptoms that this poor mum has now are the worst I've seen. She has so many physical symptoms (apart from the injuries she had). Every time her baby cries she gets a tingling sensation where the epidural went in. She feels dizzy and her mouth goes dry. Sometimes she can't let anyone else touch him, other times she tries to give him to her mum saying that she must be killing him and shouldn't be trusted with him. She is hypervigilant, she can't go to sleep easily because she has nightmares, she wakes all through the night to check on her boy. The only person she can bear to pick him up is her mum and the baby's father (who she left because he punched her while she was pregnant and is still verbally abusing her). She has only left the baby a couple of times for medical appointments and to come to me. She texts to see how the baby is every 10–15 minutes and her mother can't just answer the text, she must

send her a photo of him. She asked how long the relaxation and rewind would take and asked for it to be quicker as she didn't feel comfortable to not check on him for so long. She has terrible flashbacks, and one time, when she had blood loss, (she couldn't breastfeed him so her periods came back) she was screaming thinking she was back in labour, which she knew she couldn't be, as she hadn't had sex since the baby was born.'

Practitioner action plan

The practitioner taught the client abdominal breathing to lower arousal and used the 'rewind' and confidence building techniques: the subjective units of distress (SUDS) dropped from a ten down to a one with the trauma memory no longer triggering any strong emotions with the associated symptoms.

Treatment results and client feedback

Following the session, the client commented that she felt strangely calm, and felt better than she had done any day since the birth. She left with a hug and a smile. Later that evening she said that she still felt calm and was sitting in bed reading a book and actually considering going to sleep. She had been unable to do this until now and usually had to wait until she was exhausted because she was too afraid of falling asleep and having nightmares. She didn't have a great sleep because Kai had an unsettled night and she was up and down from 1am until 4.30am. However, she didn't remember having any bad dreams or feeling the usual dizzy sensation when she woke up. It wasn't the best night's sleep but it was a huge improvement.

After a second session, the client commented that she had been helped more in two sessions than the eight sessions she had had with the Improving Access to Psychological Therapies (IAPT) and her sessions with the mental health charity MIND put together.

Case 2

'I filled out the Trauma questionnaire and identified that my patient had PTSD.

She had recently returned to work as a medical registrar in a busy teaching hospital and was finding it difficult to cope. Four months previously she had been victimised by two senior colleagues, in which she had endured being publicly humiliated, leaving her feeling professionally incompetent. She was then taken into an office alone with the same two colleagues and blamed for the death of a patient in the team's care, which left her feeling "trapped and unable to escape from the situation". She sought supervision for assistance and a debrief session, inadvertently reliving the situation, further activating the trauma template by adding an extra layer of trauma.

Immediately after she was signed off sick by her occupational health department with stress and anxiety, which lasted for two months. She was referred for counselling and increased her personal interests of tai-chi and yoga sessions in an attempt to regain a balance in her life and aid her recovery. On her graduated return to work over a six-week period in another hospital, she felt she was coping quite well. However, she attended a seminar in which she was due to give a presentation and came face-to-face with these same colleagues. This strong trigger and pattern match to the original trauma immediately reactivated her trauma template and terror response – she had a full-blown panic attack, rendering her unable to give her presentation, further compounding her feelings of professional inadequacy. She describes suffering from increasing levels of anxiety ever since, especially at work where she feels jumpy and hyper vigilant on a daily basis throughout most of her 12-hour shift (SUDS 6–7). Although she is also experiencing an altered sleep pattern, sleep is the only time she feels any relief from her symptoms, with a resultant fear of a full recovery. She describes both her work and home life as very difficult. She feels her present colleagues and supervisor, although kind, are constantly watching her, waiting for her to 'slip-up'. This renders her unable to make sound professional judgements, yet she recognises that to take more time off would be detrimental to her medical career. She also describes not having a menstrual period and distancing herself from her husband, with a lack of intimacy since the initial episode six months ago. Whilst recounting both these incidents she was visibly distressed and gave a SUDS of 8–9. She asked if what she was experiencing was normal.'

Practitioner action plan

The practitioner taught the client diaphragmatic breathing to reduce anxiety and panic symptoms and how to shut down a panic attack.

The 'rewind' was employed to dissolve the trauma template and the client, using past positive resource states, rehearsed seeing herself in her professional life feeling very self-sufficient, in control, assertive, powerful in her own right, trusting her own abilities and feeling very happy with herself.

Client feedback

A second session was planned but the client telephoned and cancelled it as she felt well and comfortable in herself and felt that no further treatments were required.

Practitioner action plan

The patient was offered three one-hour treatments:

Session 1 – information gathering and abdominal breathing

Session 2 – the rewind and confidence building

Session 3 – 'new reality generator', confidence building and a visit to the labour room.

Case 3

'Emma and I spent time exploring her current symptoms and emotional needs. We completed the trauma questionnaire she scored five on section A, four on section B and three on section C, confirming that she was experiencing Post-Traumatic Stress Disorder. Emma was experiencing intrusive thoughts about feeling "really out of it" and being unable to move or get away from what was happening to her. She scored her symptoms as ten out of ten on a Subjective Units of Distress (SUDS) scale.

Emma had been attached to a syntocinon drip during her baby's birth and received heavy doses of morphine intravenously, feeling "out of it" again was a major fear. She was unable to go near the hospital where she gave birth without feeling panicky. This was a major issue as she was hoping to attend an opening ceremony of a special room there that she had raised funds to develop in memory of her son. Emma had purposefully chosen to plan her birth at another hospital to avoid giving birth there again.

On completing the emotional needs audit Emma gave low scores of three for feeling in control of her life and feeling connected to the wider part of the community. Emma also described feeling more and more dependent on John and how she was now becoming afraid to go anywhere without him.

Emma initially felt that she may need to plan a caesarean birth as she may be unable to cope with another labour. However, she was very open to exploring other options for treatment. She had received some counselling after her son's birth to help her manage her grief and had found this useful. She was also a huge advocate of yoga and mindfulness techniques and I felt this was a positive influence in her understanding what we might achieve through our sessions and in her agreeing to try the rewind technique.'

Treatment results and client feedback

The therapeutic relationship Emma and her practitioner developed, and the techniques employed have enabled Emma to reduce her SUDS score from a ten to a two after three sessions. Emma continues to work on increasing her confidence in her ability to birth her baby calmly by attending hypnobirthing classes. She has written a birth plan to communicate her needs and wishes to all members of staff in the maternity unit, which sits proudly in her hospital file. In December, the day before her last session, Emma attended the opening of the special room at the hospital where her son was born. She was delighted she had felt able to go back to do this and although the day had been very emotional she had not experienced a sense of panic. Her baby is due this month and she is no longer filled with dread and anxiety, instead her feelings appear to have been replaced by excitement, something she would not have believed when we first met.

Conclusion

This new treatment is highly successful for the following reasons:

- Patients feel that they have an opportunity to tell their story in a setting where their perception of their birth experience is acknowledged and validated. This helps them to feel heard and helps to lower their arousal (vital for dissolving the emotional tag of the trauma template/pattern).
- Patients are offered an understanding of how their traumatic birth experience has resulted in the horrific symptoms of PTSD. This understanding of neuroscience, offered in a no-psychobabble fashion, helps patients to feel that their symptoms are normal, in the circumstances. This helps to take away any sense that they have failed or are going out of their mind.
- A dual assessment system is used to identify trauma and help practitioners identify the emotional needs not being met.
- A variety of tools and techniques are used to dissolve the emotional tag of the trauma template and build confidence.
- Practitioners teach patients how to lower their own arousal and shut down a panic attack.
- Practitioners are taught to offer practical lifestyle and well-being advice to ensure a fast return to emotional health and well-being.

Jenny Mullan, Founder of the certified birth trauma/PTSD resolution practitioner training programme.

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