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**What happens after a difficult birth? Postnatal debriefing services.**

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### **ABSTRACT**

There is increasing pressure to improve maternity services and provide postnatal services for women who have a difficult birth experience. However, there is little information about services currently offered. This survey aimed to establish the type and availability of postnatal services in the UK for women who have a difficult or traumatic birth. A telephone survey was carried out of a quarter of UK hospitals randomly chosen from the Department of Health listing. Seventy-one hospitals took part (76% of eligible hospitals). Results showed that 94% (CI 86% to 98%) of hospitals provide postnatal services for women who have difficult births. Most of these are debriefing services (78%: CI 67% to 86%) that were implemented in response to need; only 5% (CI 2% to 13%) were reportedly started on the basis of research evidence. Results are discussed in relation to the relative lack of awareness that such services exist and the controversy over the use of debriefing after trauma.

## INTRODUCTION

Maternity services are under increasing pressure to improve their services. In the UK, a recent report from the Healthcare Commission (Commission for Healthcare Audit and Inspection, 2005) was highly critical of maternity services and, in response, the Government has set up an advisory group which will set new standards for maternity services. Pressure groups such as the Association for Improvement of Maternity Services (AIMS) and Birth Trauma Association (BTA) are pushing for better maternity services, and national newspapers intermittently join this campaign (e.g. *The Observer's* 'Better Birth Campaign'). The increasing culture of litigation also adds to the pressure for improvement of maternity services. In the UK, problems with maternity services account for more than seventy percent of litigation in the National Health Service (NHS), which increases pressure on hospitals to both improve care and provide some form of postnatal psychological support to try to reduce litigation.

Difficult birth experiences can affect women's psychological health but, for the majority of women, this does not lead to clinically significant psychological problems. Research suggests that approximately one third of women in the Western world evaluate their experience of childbirth as traumatic (Ayers, 2004). Ten percent of women have severe symptoms of traumatic stress in the weeks following birth but the majority of these women recover without intervention. Between one and two percent of women go on to develop clinical post-traumatic stress disorder (PTSD) as a result of birth and require treatment (see Ayers, 2004, for a review). Although this is a relatively small percentage, the numbers of women giving birth means up to 13,000 new cases of postnatal PTSD occur every year in the United Kingdom alone.

Prevention or intervention for postnatal PTSD can take a number of forms. Prevention can involve identifying vulnerable women in pregnancy (e.g. those who have a history of psychological problems or trauma) and offering them psychological support or alternative birth procedures. Similarly, specialised training for midwives and obstetricians might reduce the incidence of postnatal PTSD. For women who have symptoms of traumatic stress after birth, intervention can take various forms.

Current recommended treatment for PTSD is psychotherapy, such as cognitive behaviour therapy, with the addition of pharmacological treatment (SSRI's) in severe cases, or where there are comorbid disorders such as depression (Foa et al., 1999; National Institute for Health and Clinical Excellence (NICE), 2005).

The main issue surrounding intervention for postnatal PTSD is whether to offer early, short-term intervention to women with symptoms of traumatic stress in the initial weeks after birth or whether to provide later long-term intervention for women with clinical PTSD. There are advantages and disadvantages to each of these approaches. Early intervention might prevent the development of clinical PTSD but might not be cost-effective because the majority of postnatal women recover spontaneously from symptoms of traumatic stress without intervention (Ayers, 2004). Later intervention can be targeted at women with clinical PTSD but these interventions need to be more intensive, longer, and might not be as effective. Although there is no published research looking at treatment efficacy for postnatal PTSD, research into PTSD in other groups suggests variable success rates of cognitive behaviour therapy with between 40% and 90% of people recovering (Harvey et al., 2003).

In secondary care it is often easier to offer short-term follow-up services rather than long-term follow-up, so this appears to be the favoured approach. Five years ago, Small et al. (2000) reported that 36% of UK healthcare trusts have formal arrangements for postnatal debriefing and an additional 26% planned to implement similar procedures. However, these figures come from unpublished data so it is difficult to know how reliable they are. In addition, debriefing interventions are currently controversial. Debriefing is a broad term covering a range of approaches which usually consist of one session within four weeks of a traumatic event where individuals are encouraged to talk about the event to promote emotional processing and prevent the development of PTSD. Debriefing originated from critical incident debriefing which was a highly structured group session that included going over the facts, thoughts and impressions, emotional reactions, normalizing, planning for the future, and disengagement (Mitchell, 1983). The attraction of debriefing is the potential to prevent the

development of PTSD with one session very soon after the event. However, research examining the efficacy of debriefing in non-obstetric samples has found little evidence it is effective and some evidence that it increases the risk of developing PTSD (Rose et al., 2002). Recent guidelines in the UK and USA therefore recommend against the use of debriefing interventions for PTSD (Foa et al., 1999; NICE guidelines, 2005) and its use is therefore controversial.

Despite the controversy of debriefing it is increasingly used with postnatal women. Contributing to this controversy is a lack of clear distinction between what does, and what does not, comprise debriefing. As outlined above, psychological debriefing as originally proposed is a highly structured, one-off, group session within four weeks of the traumatic event that covers facts, thoughts, and feelings. This is different to midwife-led or obstetrician-led debriefing, which suffers from a lack of clear definition but generally seems to comprise of one session within the first few months after birth where midwives or obstetricians go over the obstetric events of birth with a woman. Finally, 'Birth Afterthoughts' programs are becoming increasingly popular in the UK, where women meet with a midwife or midwife-counsellor to go over the obstetric events of birth and express their feelings about the birth (Curtis, 1994).

Five studies have looked at midwife-led debriefing in postnatal samples with mixed results. Lavender & Walkinshaw (1998) randomised 114 primiparous women in the UK into either a debriefing intervention or normal care and found that women who received debriefing had lower anxiety and depression three to four weeks after birth. In contrast a similar UK trial of 319 primiparous women found no differences in fear of future childbirth between women who received debriefing and women who received normal care (Kershaw et al., 2005). Similarly, Small et al (2000) randomised 1041 women in Australia into debriefing or normal care and found no significant differences between groups in depression six months after birth.

Three studies have looked at postnatal PTSD following debriefing. In the first study 1745 Australian women were randomised into debriefing or normal care. This trial used midwife-led critical incident

debriefing within 72 hours of delivery and found no differences between women who received debriefing or normal care in depression or PTSD up to 12 months postpartum (Priest et al., 2003). In the UK study mentioned above, 319 primiparous women who had an operative delivery were randomised into debriefing or control groups. The intervention consisted of midwife-led critical incident stress debriefing to individual women 10 days and 10 weeks after birth. This study also found no differences between women in the intervention and control groups in PTSD symptoms up to 20 weeks postpartum (Kershaw et al., 2005). In contrast, Gamble et al (2005) randomised 103 Australian women with symptoms of PTSD immediately after birth into debriefing or control groups. The intervention comprised of midwife-led counselling within 72 hours of birth and telephone counselling four to six weeks after birth. Women in the debriefing group reported fewer symptoms of depression and PTSD three months after birth.

The evidence on postnatal debriefing is therefore conflicting and there are a number of issues that need to be clarified. First, as already mentioned, it is not clear what midwife-led debriefing entails. A recent review of postpartum counselling concluded that “descriptions of postpartum counselling and debriefing are generalised and nonspecific” (Gamble & Creedy, 2004). It may be that midwife-led debriefing, where the focus is on medical events and explanations, has a different effect to debriefing that uses more psychological approaches, such as critical incident debriefing. Secondly, it may be that the timing or targeting of debriefing is crucial. The scant available research on postnatal debriefing suggests that debriefing might only be effective if it is targeted at women who have severe symptoms of PTSD immediately after birth, as oppose to research that assumes obstetric factors, such as being primiparous and having an operative delivery, are inherently traumatic and therefore a risk factor. There is therefore conflicting information about the use and efficacy of debriefing with postnatal women.

Given the current lack of research into the treatment of postnatal PTSD and the controversy over the use of debriefing generally, it is worrying that midwife-led debriefing and Birth Afterthoughts programs might be used without any strong evidence base regarding their efficacy. Research is



urgently needed to examine what services are currently being offered to women after birth and the efficacy of different approaches to intervention. The study reported here addresses this first aim and reports a survey of UK hospitals to ascertain what postnatal services are currently offered, how they are run, funded, and evaluated.

## METHODS

This was a cross-sectional telephone survey of postnatal services for women who have a difficult birth. Just over a quarter of UK hospitals (304/1162) were randomly chosen from the Department of Health list of hospitals using computer-generated randomisation. Ninety-three of these hospitals had an obstetrics department and were eligible for the survey. Of these, 71 completed the survey (76%); 7 were not contactable (8%); and 15 did not complete the survey (16%). The survey was mostly carried out by telephone (90%) although 10% requested the survey by mail. Surveys were completed by the head of midwifery, senior midwife, or consultant obstetrician. The survey asked about whether postnatal services were available for women who had 'a difficult or traumatic birth'. If so, further questions were asked about the type of service, how it was run, funded, evaluated, how long it had been in place, etc. Most questions were open i.e. did not have prescribed response categories. Respondents' answers were noted and results are reported according to naturally occurring categories. Ethical approval was obtained from the University of Sussex Ethics Committee for the Department of Life Sciences.

## RESULTS

Table 1 displays the results of the survey and it can be seen that 94% (CI 86% to 98%) of hospitals in the UK have formal or informal services in place for women who have a difficult birth experience. Most of these are debriefing services provided by midwives, midwife-counsellors, or doctors (65%; CI 53% to 76%). Thirteen percent were Birth Afterthought programs, which are similar to debriefing services. This means that 78% (CI 67% to 86%) of postnatal services offered in UK services are debriefing type services. Psychotherapists (counsellors or clinical psychologists) are involved with 23% of services (CI 14% to 34%). Most services are provided and funded by midwifery departments

(70% of services provided by midwifery and 87% funded by midwifery). In the majority of cases, services are open to all women who are informed about the service by a midwife after birth. Most services evolved in response to need, with only 5% started on the basis of research evidence. Those services started on the basis of research evidence consisted of two 'Birth Afterthought' programs and one a postnatal drop-in group. Just over half of services had been running for three years or more (51%; CI 39% to 63%). Finally, approximately one third of services were formally evaluated (34%) and the remainder had only informal feedback or no feedback.

- Insert Table 1 about here -

Comparison of debriefing services (excluding Birth Afterthought programs) with other services found that a larger proportion of debriefing services evolved in response to women's needs (74% compared to 26% of other services;  $\chi^2 = 8.51$ , df 3,  $p=0.04$ ), and women were more likely to be informed about debriefing by midwives (76% compared to 24% of other services;  $\chi^2 = 14.82$ , df 5,  $p=0.01$ ).

## DISCUSSION AND CONCLUSION

The survey establishes that nearly all the UK hospitals surveyed provide a service for women who have a difficult birth, and the majority of these services are debriefing services. This widespread provision of postnatal support is in direct contrast to criticisms of maternity services by the Healthcare Commission, pressure groups, and media that were outlined in the introduction. Criticisms of maternity services are rarely countered by recognition of services, such as these, which provide postnatal help and support for women who have difficult births. It is therefore possible that lay people and pressure groups are largely unaware of the widespread availability of these services. This suggests that we need to increase awareness of these services and that the current practice of midwives informing women about services is ineffective. Effectiveness could be improved by ensuring all women are informed of these services on discharge from hospital, in the community (e.g. midwives, health-visitors, primary care physicians) and are given the information in both verbal

and written form. In addition, primary care workers who come in contact with postnatal women could be informed about the services and relevant referral processes. Health visitors, for example, are well placed to identify women who might need help and to refer them back to hospital maternity services.

It is therefore commendable that most hospitals provide a postnatal service for women who have a difficult birth, and that fourteen percent of these are psychotherapy services as per guidelines for PTSD treatment. However, the widespread use of debriefing is worrying given the controversy over the efficacy of debriefing for PTSD and the current guidelines not to use debriefing for PTSD. As previously discussed, it is possible that postnatal debriefing is different to psychological debriefing and may well be more effective but the evidence to date is inconsistent (Kershaw et al., 2005; Lavender & Walkinshaw, 1998; Small et al., 2000). Given the problem of litigation in obstetrics, it is possible that many postnatal debriefing services have been implemented because of the need for some form of damage limitation. Thus hospitals have provided what is *possible*, in the absence of any sound empirical evidence of what is *effective*. The finding in this study that many hospitals reported services were instigated on the basis of need supports this. Thus research urgently needs to be carried out to inform clinical practice in this area. It may be possible to start with the third of maternity services that reported their postnatal services had been formally evaluated. A systematic review of these evaluations may provide a useful first step towards examining the efficacy of different services.

There are a number of implications of this survey. First, this survey establishes that many UK hospitals are providing postnatal services that lay people and the media may be unaware of. Therefore we need to increase awareness in primary and secondary care of available services so this information is better disseminated to women. Second, there is no strong evidence base for the type of service currently provided so research urgently needs to address the efficacy of different services in this area. Third, there are funding implications because mental health problems are traditionally dealt with by mental health services yet this survey shows midwifery departments are funding the majority of postnatal services. Research is therefore also needed to examine which of these types of service is more effective both in terms of cost and outcome.

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**Table 1. Postnatal services in the UK for women who have a difficult or traumatic birth**

		<b>N (%)</b>	<b>95% CI</b>
Is a service provided?	Yes	59/71 (83%)	73% to 90%
	Yes but informally	8/71 (11%)	6% to 21%
	No	4/71 (6%)	2% to 14%
What type of service?	Birth Afterthought program	8/64 (13%)	7% to 23%
	Debriefing with midwife or O&G consultant	29/64 (45%)	34% to 57%
	Debriefing with midwife counselor	13/64 (20%)	12% to 32%
	Psychotherapy*	9/64 (14%)	8% to 25%
	Based on individual needs	5/64 (8%)	3% to 17%
Service provided as part of:	O&G or midwifery department	47/67 (70%)	58% to 80%
	Other hospital service (requiring referral)	17/67 (25%)	17% to 37%
	Service outside hospital (requiring referral)	3/67 (5%)	2% to 12%
Service delivered by:	Midwives only	36/66 (54%)	43% to 66%
	Doctors only	2/66 (3%)	0% to 10%
	Psychotherapist only*	4/66 (6%)	2% to 15%
	Midwives & Doctors	13/66 (20%)	12% to 31%
	Midwife & Psychotherapist*	4/66 (6%)	2% to 15%
	Midwives, Doctors, & Psychotherapist*	7/66 (11%)	5% to 20%
Are all women informed of the service?	Yes	35/65 (54%)	42% to 65%
	No	30/65 (46%)	35% to 58%
How are women informed of the service?	Leaflet	16/63 (25%)	16% to 37%
	Consultation with doctor	2/63 (3%)	0% to 11%
	By the midwife	40/63 (63%)	51% to 74%
	Leaflet & midwife	3/63 (5%)	2% to 13%
	Other health professional	2/63 (3%)	0% to 11%
When are women informed?	During pregnancy	4/62 (7%)	3% to 15%
	After birth	46/62 (74%)	62% to 83%
	During pregnancy & after birth	12/62 (19%)	11% to 31%
How are women referred?	Routine screening	12/63 (19%)	11% to 30%
	Referred on basis of certain obstetric procedures	12/63 (19%)	11% to 30%
	Women have to request it	14/63 (22%)	14% to 34%
	Through midwife	24/63 (38%)	27% to 50%
	Other	1/63 (2%)	0% to 8%
Is the service open to all women?	Yes	59/64 (92%)	83% to 97%
	No	5/64 (8%)	3% to 17%
How is the service funded?	Midwifery department	54/62 (87%)	77% to 93%
	Department + contributions	1/62 (2%)	0% to 9%
	Not sure or not funded	7/62 (11%)	6% to 22%
How did the hospital decide what service to provide?	Evolved in response to women's needs	20/62 (32%)	22% to 45%
	Trust decision	4/62 (7%)	3% to 15%
	Evidence based	3/62 (5%)	2% to 13%
	Don't know	35/62 (56%)	44% to 68%
How long has the service been in place?	Less than 1 year	2/61 (3%)	1% to 11%
	1 to 3 years	11/61 (18%)	10% to 30%
	3 to 5 years	17/61 (28%)	18% to 40%
	5 years or more	14/61 (23%)	14% to 35%
	Not sure	17/61 (28%)	18% to 40%

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Has this service been evaluated?	Yes – formal audit or research project	21/61 (34%)	24% to 47%
	Yes – informal feedback	13/61 (21%)	13% to 33%
	No	18/61 (30%)	20% to 42%
	Not sure	9/61 (15%)	8% to 26%

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NOTE: Missing data meant  $n$  ranged from 61 to 71.

\* Psychotherapists included counsellors and clinical psychologist