the birth trauma association

helping women traumatised by childbirth

ANOTHER BABY?

Practical advice on coping with a subsequent pregnancy after a traumatic birth

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1. Introduction

The thought of a subsequent pregnancy and birth after a traumatic experience can be very daunting, and in some cases it can prevent women from even trying for another baby. Sometimes, the symptoms of Post Natal Post Traumatic Stress Disorder do not even surface until a woman starts to plan a further pregnancy. The distress caused when parents find themselves in similar surroundings to those that caused the traumatic experience is genuine and complicated.

In the following pages we hope to provide information, support and advice from the differing perspectives of three health care professionals – a midwife, a psychologist and an obstetrician. There are also two stories from women who themselves experienced traumatic labours and births and went on to have very positive experiences the second time around.

We are aware that we cannot offer a ‘quick fix’ solution to this problem but we hope that this publication will give you some food for thought and the opportunity to receive advice from experts in their fields. We also hope that this information will help women and their families make informed decisions which are right for them and their own individual circumstances.

If this publication raises any unanswered questions, please do contact the Birth Trauma Association, and we will endeavour to provide the answers and support to help you and your individual circumstances.

2. 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.

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

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3. Coping with a subsequent birth after a traumatic birth

Fear of pregnancy

After a traumatic birth many women are frightened of getting pregnant again and the prospect of going through another birth. If you have had a traumatic birth experience it is quite normal to be scared and frightened of experiencing birth again. Some women take steps to avoid getting pregnant such as avoiding sex, using multiple forms of contraception, or getting sterilised. A lot of women say that before the traumatic birth they wanted to have more children but their traumatic experience stops them from planning another pregnancy. Extreme fear of pregnancy and birth is called tokophobia.

Planning a pregnancy

After a traumatic birth it is quite normal to be scared that the same thing will happen again. The important thing is to examine these fears, look at how likely it is that the same thing will happen again, and look at ways you can reduce the likelihood that it will be the same. Psychotherapy can help you do this and, if possible, it is better to have psychotherapy *before* you get pregnant again so you can work through what happened to you in your traumatic birth experience, resolve it, and plan another pregnancy more calmly. If you have a chronic illness, disability, or genetic risk that mean similar problems might arise in a subsequent pregnancy or birth you should try to discuss this with relevant medical personnel before getting pregnant again.

If you are already pregnant

If you are already pregnant it is likely that you already feel anxious about the prospect of the impending birth. This is not the best time to try to work through what happened to you during your traumatic birth experience because you are facing having to go through it again. However, seeing a psychotherapist can still be helpful because they can help you look more realistically at the impending birth, plan your pregnancy and birth in a way that minimises chances of it being traumatic again, and explore different ways of coping.

If you cannot see a psychotherapist then look at ways you can plan your pregnancy and birth to increase the chances of it going well. You can do this in a number of ways, for example, make sure the doctors and midwives know about your previous experience. Talk to your consultant and midwives about how to plan your birth so the risk of it being traumatic for you is minimised. Some women find that opting for an elective caesarean helps them feel they have more control over the birth. Some women find that using a private midwife, planning a home birth, or deciding to use a birth centre helps them (birth centres are small private maternity units, usually staffed by midwives). Plan to have someone with you at the birth (your partner, a friend, or Doula) who knows your history and who you trust to be your advocate during birth. Doulas are trained to help women during and after birth. They are used to dealing with medical personnel during birth and can be hired to help with the birth and the postnatal period (see www.doula.org.uk).

After the birth

It is unusual for women to have multiple birth experiences that are traumatic. For many women having a subsequent birth experience that is more positive helps them deal with their previous traumatic experience. However, if you find that your subsequent birth is also traumatic, or has not helped you resolve your previous birth experience, you should try to

see a psychotherapist, either through referral by your GP or privately (see www.bps.org.uk or www.babcp.org.uk for lists of chartered psychologists).

by Susan Ayers PhD CPsychol, Psychologist at University of Sussex

4. Birth trauma – what happens next?

For many women who have been traumatised either emotionally, physically or both, in the process of giving birth, the prospect of doing so again is a dreadful prospect. This is a potential source of much tension, both within the individual and the family.

Most, although not all, women wish to have more than one child, for themselves, their partners and also the child they already have. Birth trauma can leave a woman feeling torn between the desire to have another much wanted child, and the desire to avoid ever putting herself in a position where she has to give birth again.

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.

The plan for each woman will be different but what ever it contains, it must be reliable. If a woman has, for example, been promised an elective section for her next delivery then processes must be set in place to ensure that this promise will be delivered. It is very important indeed that promises should not be made unless they can be delivered and that the woman understands and agrees with any caveats that might apply.

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.

It is very helpful if the obstetrician or midwife who has been involved in counselling the woman when she presents with birth trauma can be a part of her continued care throughout the next pregnancy. Being able to see someone that she knows and trusts regularly allows women to feel more safe and supported as the birth approaches. If possible it is desirable for a woman to meet in advance some of the staff who may be caring for her throughout the birth. For example, if a home delivery is planned, it would be appropriate for a woman to meet as many of the team of community midwives who may be called to attend her in labour as possible so that she is not attended by total strangers when the time comes.

Women should be given clear written plans for the next birth outlining the various options for care and with contingency plans for what will happen if the clinical situation changes. A copy of the plan should also remain in a prominent place in the woman’s medical records. It is also helpful for the woman and the records to have a brief summary of the previous birth experience, outlining the main problems that arose. These two documents may be combined as one. In our department such a summary is printed on bright orange paper so that it stands out and is easy to find in the medical records. Staff can quickly read through the summary and gain some understanding of the woman’s needs and concerns without her having to tell the whole story over and over again.

In essence, there is almost always a way that can be found to help a woman give birth again with appropriate support in order to avoid any semblance to the previous birth experience that was so traumatising. Staff must appreciate how very brave these women are being in trying to overcome their fears and have another child and realise that the solution needs to be tailored to the needs of each individual woman.

by Dr Helen Allot, Consultant Obstetrician, Royal Berkshire Hospital

5. Birth Stories

These stories have been written by two women who suffered trauma during their first pregnancy and birth. The stories are in their own words.

Story 1

My story starts with my first pregnancy, in 2002 (George born 28th Sept). The pregnancy was unplanned, although welcome, but due to a lot of work stress and also to excessive morning sickness (all day for 9 months) it was not a good pregnancy. I ended up with antenatal depression and had counselling. I realised that a lot of this was down to the feeling of "loss" of control and so I planned, with the aid of a great Midwife and Husband, a home birth using a pool for pain relief.

I went into labour on the Friday, niggles all day and then active labour started around 6.30pm. My waters broke at 10.30pm, I gave birth at 12.38pm had no pain relief and a really easy birth. Pretty perfect and exactly what I hoped for after the pregnancy. I chose a natural 3rd stage, spent a blissful 45 mins with George before my cord was cut and then waited for the contractions to deliver the placenta. Nothing happened.

After a while I was given the injection to try to encourage the placenta (needles are a big deal for me). Nothing. Then the midwife decided to give me a catheter. I was lying on my bathroom floor, screaming with the pain at this. It didn't help. The midwife then decided to pull the cord. So I was hanging on to the sink, she was pulling. It broke, spraying blood everywhere. I was just in tears at this point, but taking little notice of what was being done to me. My husband describes it as barbaric. I don't want to criticise my midwife here, she was fantastic throughout and was only doing what she thought was best. *I have since discussed this all with her personally, see below. The midwives then tried to manipulate the top of my uterus through my stomach. Nothing happened. All this time my new baby boy was in a different room with my sister. Finally, 3 1/2 hrs after George was born an ambulance was called. George went in the car with my husband and I went in the ambulance. I was by this time bleeding heavily.

On arrival at the hospital I was put on a syntocinon (? I think) drip and left. For 3 hrs. Every now and then my husband got more towels to mop up the blood. Still no contractions.

Finally I went into theatre where I was given a spinal block, had my legs put into stirrups and had the placenta TORN out of me whilst another person pushed hard on my stomach (hard enough for hand mark bruising). I had to stay in hospital overnight and stay on a drip to replace fluid. Just avoided blood transfusion (all after drug free Home birth). On my return home I was unable to walk unaided very far, took a week to get up stairs alone and that was on hand and knees and nearly another 2 weeks to be able to carry George. A year later I was still being treated for SPD that was (in my opinion) caused by the stirrups. Hospital won't say.

I saw a counsellor from the hospital 15 months later and saw my notes.

Two years later I was pregnant again. I decided I wanted another Home birth. I was actually high risk so policy would have said no, but I had the same midwife as before who agreed it as the blood loss was all some hours after birth. I am glad she agreed so I didn't have to fight. I talked through with the midwife my feelings about the placenta and that I felt she had been misguided in trying so hard to keep me out of hospital. She understood my point of view completely and we made a placenta birth plan. I chose a natural 3rd stage again,

figuring that if it all went to pot at least I would have a lovely 45 mins bonding session first. I then put that I wanted to be transferred into hospital within the hour of the cord being cut if I was having no contractions.

At 37 weeks I had a blip. This is the point at which my Home birth became "permitted" and I freaked out. I guess because I was not going to automatically go to hospital for early labour now. I changed my mind 100 times about Home birth vs hospital but worked it through with a lot of people, Baby Centre board, friends, husband and midwife. We went back over the birth plan and I decided to stay with my original plan! 10 days later I went into labour.

Well, Peggy Elizabeth was born on 9th September at home. I had a long back labour with 3 stops and very little progress for 12 hours, but with the support of my midwives I avoided a hospital transfer. The midwives thought that my anxiety over the placenta were causing the stops and after a counselling session with me sitting on the loo mid-labour, I got some positive vibes back, the ambulance was cancelled and we did it. I say we, because I had my husband, mum, sister and two mid-wives willing my success.

Peggy was born in the bath, I had a natural 3rd stage of labour and then after 45 minutes delivered the placenta. I achieved a drug free, intervention free natural labour and my husband and I sobbed together for an hour with relief at the way be both felt healed of previous trauma.

I am not angry at my first labour, I just found it very hard to get over. I think that I have been extremely lucky with the best Midwife I have ever heard of, and may even go for baby no 3 now!

Article written by in the own words of a BTA Member

Story 2

After the depression I suffered as a result of my awful birth experience, I was referred to a consultant psychiatrist who I am still seeing on a monthly basis now 2 1/2 years after my daughter's birth and whose help has been invaluable in helping me to regain my mental balance.

This consultant works closely with the maternity unit in one of our 3 local hospitals so when I found out I was pregnant again it seemed logical to ask to go to that hospital.

My first daughter had been born premature and low birth weight so this pregnancy is classed as "high risk" and is therefore under the direct care of a consultant. At the first appointment with the consultant I handed her a brief written explanation of what had happened when my daughter was born (drugs given without informed consent, complete failure of communication and support from midwife) as I still find it too traumatic to talk about the events, she was horrified and arranged for me to see a clinical psychologist linked to the maternity unit.

The psychologist arranged for and supported me and my husband in visiting the SCBU (in case this baby is premature) and Delivery Suite. Before these visits she talked about the things we wanted out of the visit and during them she ensured that all our questioned were fully answered. With her help I wrote a detailed birth plan that has been discussed and agreed with Delivery Suite staff.

A note was written with my involvement which went into my hospital notes informing staff that I had a traumatic experience last time and reminding them that extra care needed to be taken this time. I also had the opportunity to meet several delivery midwives and discuss issues of communication with them. We also agreed that I would go to hospital early in the labour to allow time for a detailed discussion of the birth plan before labour becomes too established.

In general the major difference this time was that I felt like I was being taken seriously and treated as an equal member of the "team" responsible for looking after this baby. This is a massive cultural difference from my first experience where ante-natal and delivery care was done "to" me. The close links between the maternity unit and mental health department were important as was the fact that the maternity unit is lead by a female consultant and had a very open structure where all staff and patients are valued equally.

A practical example of the difference is the way internal examinations are dealt with antenatally. Last time I was expected to undress in front of the doctor and discussions would usually take place with his head between my knees which is not an empowering situation for a woman. This time staff closed the curtain and allowed me to cover myself with a sheet before beginning the examination. You are then allowed to get dressed and sit on a chair before discussing the results - it takes a few minutes longer for each appointment but is much better for a woman's self esteem.

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As for the birth itself, after discussions with my very sympathetic consultant we agreed that the labour would be induced at 39 weeks partly on medical grounds (baby was getting so big that vaginal delivery might not have been possible in another few weeks) and partly to allow for midwives who were briefed on the problems in my previous delivery to attend.

The staffing was also arranged so that the 2 midwives were both working 12 hours shifts which meant that nearly 24 hours could be covered by just 2 staff thereby creating continuity of care.

The midwives were both fantastic, they were supportive good communicators and very proactive in the care they offered. An example is that despite needing a drip and continuous foetal monitoring I was still able to be mobile with the midwife following me around the room with the equipment. They completely respected my decisions on pain relief and only offered options that I had already said I was willing to consider.

As with my first baby the last stages of the labour were very fast but this time because the midwife was in room the whole time she was aware when the tempo of the contractions and my reaction to them changed and kept a close eye on progress (after taking 7 hours to reach 5 cms I then dilated to 7cms in just 10 minutes) The birth itself was again very fast, just 9 minutes to deliver an 8lb 2oz baby but the midwife was full of encouragement and support throughout this (she even found time to give my shell shocked husband some guidance).

The main points that made this birth experience so positive for me were:

- One to one care from a midwife throughout the labour with a 30 minutes handover period allowed when shifts changed so that the new midwife was fully briefed.
- Midwives who read and respected the wishes in my birth plan.
- Open communication between the midwives and myself and my husband.
- A relaxed and co-operative environment created in the delivery room with plenty of silly moments and humour in the early stages of the labour and after the birth.

Nothing really that outstanding but it all made such a difference to the experience and I only wish I had met this team when I had my first baby.

I'm not planning another baby but at least now I would no longer dread the birth as I did after my first experience. I've yet to see if the Post natal depression returns but I'm hopeful that a positive start will lessen the severity of it if does.

Article written by in the own words of a BTA Member

6. Conclusion

We hope this publication provides some guidance and support to women as they struggle to make a decision about future pregnancies following a traumatic experience.

We hope we have illustrated with this document that there are several simple processes and steps which can be taken to greatly improve a subsequent pregnancy, labour and birth for women and their families. We also hope that we have helped to emphasise how important it is for every woman to get the opportunity to enjoy the pregnancy, labour and birth they want, within every possible limit. The two birth stories we have included also go to show that a subsequent experience does not have to be as traumatic and daunting as the previous one.

Today, there is no need for women and their families to feel isolated and alone after suffering a traumatic childbirth experience, because the Birth Trauma Association can offer valuable support and advice for women thinking of a subsequent birth, all based on the extensive knowledge and experience of our members.

If you have any questions arising after reading this document, please do not hesitate to contact the Birth Trauma Association at enquiries@birthtraumaassociation.org.uk

We would like to thank all those responsible for the articles within this publication for their support and guidance.

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