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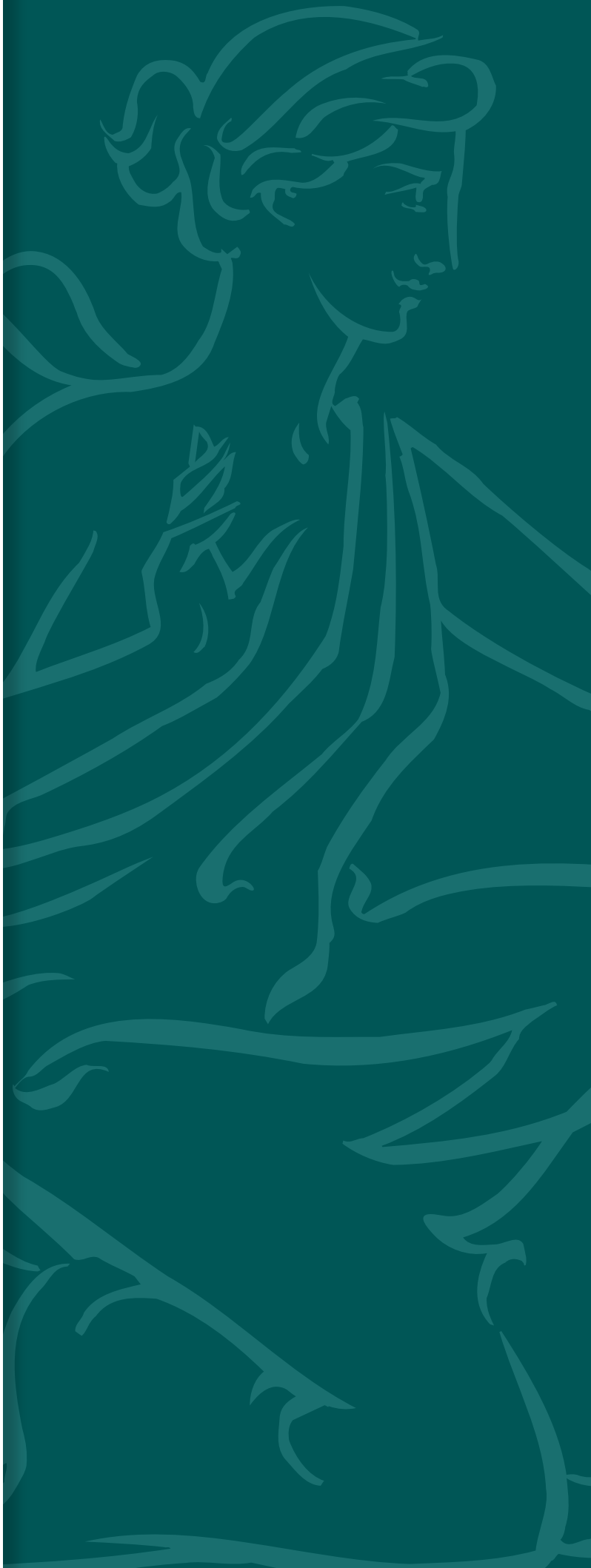
Providing psychological therapies for perinatal trauma and loss in maternity services: A position statement



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AUTHORS

DR RACHEL MYCROFT,
Consultant Clinical Psychologist; Past Chair, Faculty of Perinatal Psychology, BPS.

DR CAMILLA ROSAN,
Consultant Clinical Psychologist; Chair, Faculty of Perinatal Psychology, BPS.

PROFESSOR PAULINE SLADE,
Professor of Clinical Psychology/Consultant Clinical Psychologist; Past Chair, Faculty of Perinatal Psychology, BPS.

DR KYLA VAILLANCOURT,
Principal Clinical Psychologist; Committee Member of the Faculty of Perinatal Psychology, BPS.

On behalf of the Executive Committee of the British Psychological Society Faculty of Perinatal Psychology

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SUMMARY

On behalf of the British Psychological Society, this position statement is making four essential recommendations to support the safe and effective provision of psychological therapies for perinatal trauma and loss in maternity services. These include that:

1. All maternity staff have a crucial role to play in preventing and reducing psychological trauma in maternity services by providing compassionate and person-centred care in a trauma-informed way.
2. Women and birthing people should have access to NICE-recommended, evidence-based psychological assessment and therapy for Post-Traumatic Stress Disorder (PTSD) following perinatal trauma and loss, which includes trauma-focused Cognitive Behaviour Therapy (TF-CBT) and Eye Movement Desensitisation Reprocessing (EMDR).
3. Non-evidence based and non-NICE recommended therapies or techniques (including but not limited to: Rewind Technique; Birth Trauma Resolution; Conscious Perinatal Resilience Method) should not be provided.
4. Trauma-focused psychological therapies should only be provided by psychological practitioners who have the core professional background and appropriate training to provide them.

This Position Statement describes the rationale for these recommendations and how they might be implemented.

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Introduction

A key part of maternity care includes consideration of the mental health of women and birthing people through pregnancy, childbirth and the postnatal period. Maternity professionals aim to safeguard the mental health of those who use their services by providing compassionate, personalised, and high-quality maternity care. Maternity services also play a crucial role in effectively identifying and responding to mental health problems ranging from severe mental illness (e.g. postpartum psychosis) to common mental health problems (e.g. anxiety and depression), ensuring that service users can access appropriate mental health and psychological care suitable to their needs.

Other mental health presentations that are especially pertinent to maternity settings are Fear of Childbirth (or Tokophobia), Post-Traumatic Stress Disorder (PTSD) following childbirth and PTSD following pregnancy loss or baby loss, due to their direct relevance to the maternity experience.

The following is a statement to guide best practice specifically related to the role of maternity professionals in reducing and preventing trauma responses, and the delivery of psychological therapies for the consequences of traumatic childbirth or loss in maternity settings. The aim is to ensure that care and working environments are safe and effective for both service users and staff, are informed by current evidence for the delivery of psychological therapies and are aligned with the NHS England Good Practice Guidance for Supporting Mental Healthcare in a Maternity and Neonatal Setting [1].

This document will be relevant for all staff in maternity services and the mental health professionals and psychological practitioners working with them. It will also be relevant for women and birthing people, and their families, who may be seeking care for the psychological consequences of a traumatic childbirth or loss.

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KEY DEFINITIONS

TRAUMATIC CHILDBIRTH

For purposes of this document, we define traumatic childbirth based on the definition developed by the COST Action CA118211 Research Network. 'A [...] woman's experience of interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/ or long-term negative impacts on a woman's health and wellbeing.' [2]. In this document, we consider the birth of a live baby, the loss of a pregnancy or death of a baby (anytime between conception and 28 days after birth) as maternity events which may be experienced as traumatic.

POST-TRAUMATIC STRESS RESPONSE

A psychological reaction or response that can follow exposure to an event or multiple events (either short or long-lasting) of an extremely threatening or horrific nature. This includes directly experiencing such events, witnessing them occurring to others, or learning of an event having occurred to someone else [3]. A post-traumatic stress response may or may not later develop into a clinical diagnosis of PTSD.

POST-TRAUMATIC STRESS DISORDER/PTSD

A clinical diagnosis which is defined by the DSM-V or ICD-11 diagnostic criteria. PTSD describes the presence of a series of symptoms for at least one month following a traumatic event, including: re-experiencing (flashbacks, nightmares, intrusive memories), avoidance (of people or places that remind the person of the event), and hyperarousal (e.g. hypervigilance, irritability) that is causing significant impairment [3, 4].

PURPOSE OF THE STATEMENT

- To promote the delivery of trauma-informed care in maternity with the aim of preventing trauma responses in the context of childbirth or perinatal loss for staff, service users, and families.
- To ensure access to evidence-based, NICE recommended psychological assessment and therapies for those who experience distress, PTSD or other mental health problems in relation to their maternity experience.
- To ensure that any professional delivering psychological therapy for post-traumatic stress symptoms related to traumatic childbirth or perinatal loss have the appropriate professional background and training and access to appropriate supervision and governance structures.

CURRENT CONTEXT

Maternity services often deliver care for women and birthing people who have had negative or traumatic experiences within the maternity setting which is either affecting their attitudes, feelings, and preferences about birth in a subsequent pregnancy, or is causing significant distress in the postnatal period. For many years there has been a gap in the provision of psychological therapy for women and birthing people within maternity. It is understandable that this has left maternity staff seeking ways they can help women and birthing people to alleviate distress following traumatic maternity experiences.

In some areas, this gap in provision has led to examples of care in maternity settings which are not evidence-based and/or with staff delivering psychological therapies and counselling approaches without appropriate training, supervision, or governance structures to treat the psychological consequences arising from traumatic experiences in maternity. There are a number of memory-focused techniques that are not evidence based and currently are not recommended for use to treat PTSD or other forms of psychological distress (these include but are not limited to: Rewind Technique; Birth Trauma Resolution; Conscious Perinatal Resilience Method). Some of the training providers that deliver training in these methods do not require a core mental health training or practitioner psychologist training in order to train in or to practice these techniques. It is also the case that there are commonly no formal requirements with regards to supervision or governance for those who go on to use such techniques in practice. Although some trainings offer 'accreditation', this is not part of a legitimate professional body that is bound within a regulatory framework, and thus this term may be misleading to those who are seeking psychological treatments.

Recommended practice for the treatment of traumatic stress reactions and PTSD

The National Institute for Clinical Excellence (NICE) recommended psychological therapies for PTSD after childbirth, miscarriage or stillbirth are trauma-focused Cognitive Behaviour Therapy (TF-CBT) and Eye Movement Desensitisation Reprocessing (EMDR) [10, 11] delivered by an appropriately trained, accredited, and supervised mental health professional.

Where women or birthing people do not meet diagnostic criteria for PTSD but there is significant distress or impairment, it is still recommended that a psychological assessment is offered by a trained psychological practitioner to inform appropriate psychological treatment.

PROFESSIONAL TRAINING REQUIREMENTS FOR THE DELIVERY OF TRAUMA-FOCUSED INTERVENTIONS

- The completion of a Clinical or Counselling Psychology Doctorate and registration with the Health Care Professions Council (HCPC)

  OR

- A core professional mental health training followed by specialist training leading to CBT accreditation with the BABCP or accreditation in EMDR with EMDR Europe

These professional trainings and regulatory bodies require ongoing supervision and Continued Professional Development (CPD) in order to maintain registration.

Competency frameworks for CBT and EMDR are available here:

- **EMDR:** https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks/competence
- **CBT:** https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks-0

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Concerns about the use of non-NICE recommended therapies or techniques for trauma within maternity settings

RISKS FOR SERVICE USERS

The offer of therapies or techniques for perinatal trauma and loss which are non-evidence based and non-NICE-recommended and which are delivered by staff without appropriate training, professional background or supervision means there is a risk of poor mental health outcomes and/or adverse events (e.g. re-traumatisation) for service users, particularly where these involve recalling or reliving traumatic events. The offer of this technique within maternity may also mean that service users receive this treatment instead of first-line recommended treatment that corresponds to their needs as outlined in NICE.

RISKS FOR STAFF

Staff who attend trainings like the ones listed above and who do not have the appropriate professional background and training to deliver psychological therapy are placing themselves at professional risk of working outside of their competence. They might be subject to complaints, internal or external investigations including from the Care Quality Commission and/or litigation. If allowed to continue, there is a risk that systems will develop in an unregulated and unsafe way with widespread practice that does not meet recommendations for evidence-based, best practice care or the quality standards for NHS care provision.

ESSENTIAL RECOMMENDATIONS

In response to these concerns, the BPS is making four essential recommendations for the safe and effective provision of psychological therapies for trauma and loss in maternity services.

RECOMMENDATION 1: ALL MATERNITY STAFF HAVE A CRUCIAL ROLE TO PLAY IN PREVENTING AND REDUCING PSYCHOLOGICAL TRAUMA IN MATERNITY SERVICES BY PROVIDING COMPASSIONATE AND PERSON-CENTRED CARE IN A TRAUMA-INFORMED WAY.

Within maternity services, staff should be trained and supported to prevent and reduce experiences of birth trauma in ways that are within their professional areas of competence. Maternity has a wide-ranging role in the prevention and response to birth trauma, including: (i) preventing trauma responses through sensitive communication and support in pregnancy and the intrapartum including responding and supporting women appropriately who have fear of childbirth [12], (ii) offering an open, timely and supportive discussion of the birth experience post-natally [13], (iii) offering the opportunity for a detailed review of the birth at any time a person wishes that includes opportunities to clarify and answer queries [14]. The latter needs to be actively linked with expertise in the identification of additional psychological need, including PTSD, to allow for further assessment from a mental health professional who ideally is integrated in the maternity system and who can offer evidence-based trauma-focused therapies, consistent with NICE Guidance (i.e. TF-CBT and EMDR) [15]. The involvement of maternity staff in these areas of trauma-informed care are crucial and are supported by research relating to reducing and preventing birth trauma [1, 14].

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RECOMMENDATION 2: WOMEN AND BIRTHING PEOPLE SHOULD HAVE ACCESS TO NICE-RECOMMENDED, EVIDENCE-BASED PSYCHOLOGICAL ASSESSMENT AND THERAPY FOR PTSD FOLLOWING PERINATAL TRAUMA AND LOSS, WHICH INCLUDES TRAUMA-FOCUSED COGNITIVE BEHAVIOUR THERAPY (TF-CBT) AND EYE MOVEMENT DESENSITISATION REPROCESSING (EMDR).

Within Maternity, as in all service settings, it is essential that all psychological interventions adhere to evidence-based practice as described in the NICE Guideline for Antenatal and Postnatal Mental Health (this includes therapies for PTSD) [10].

RECOMMENDATION 3: NON-EVIDENCE BASED AND NON-NICE RECOMMENDED THERAPIES OR TECHNIQUES (INCLUDING BUT NOT LIMITED TO: REWIND TECHNIQUE; BIRTH TRAUMA RESOLUTION; CONSCIOUS PERINATAL RESILIENCE METHOD) SHOULD NOT BE PROVIDED.

Currently, NICE does not recommend these therapies or techniques due to a lack of evidence. The use of these approaches by non-psychological practitioners is at odds with ensuring the psychological skills necessary to manage the range of reactions that may emerge when undertaking these techniques. Furthermore, it is not in keeping with national recommendations that only those with the appropriate professional background and training and whom have the associated qualification, accreditation and registration with the relevant professional and/or regulatory body should undertake trauma focused therapies [5–9].

RECOMMENDATION 4: TRAUMA-FOCUSED PSYCHOLOGICAL THERAPIES SHOULD ONLY BE PROVIDED BY PSYCHOLOGICAL PRACTITIONERS WHO HAVE THE CORE PROFESSIONAL BACKGROUND AND APPROPRIATE TRAINING TO PROVIDE THEM.

Psychological therapies must be delivered by those with the appropriate professional background and training, and with regular supervision to meet standards of their regulatory bodies (See BABCP and EMDR Europe). Given the specialist nature of delivering psychological therapies in the perinatal period, psychological therapists also require perinatal mental health knowledge that will enable them to evaluate the likely risks and benefits of a given psychological therapy for a particular service user at any point in time, taking account of the stage of the perinatal period and personal and mental health history.

There will be variability in how available and responsive current psychological therapy services are, however, the provision of non-evidence based techniques by maternity professionals without the appropriate training is not an appropriate solution to this problem. Ongoing attention is required to support investment across all four of the devolved nations in the UK to improve access to evidence-based psychological therapies for mental health problems that arise in the context of the maternity experience. Recommendations about workforce and service structures for psychological therapies in maternity and perinatal mental health services are addressed in other publications [16–22].

In line with BPS Policy, this Position Statement will be revised and reviewed within a five year time frame, in order to reflect future developments in the evidence relating to interventions for PTSD in general, and PTSD following traumatic experiences in maternity in particular.

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St Andrews House
48 Princess Road East
Leicester LE1 7DR, UK

☎ 0116 254 9568 www.bps.org.uk info@bps.org.uk

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