

1 ABSTRACT: **Objective:** To review the efficacy of debriefing interventions for reducing posttraumatic
2 stress (PTS) and/ or depressive symptoms in postnatal women. **Background:** Techniques referred to as
3 debriefing have been adapted for use within maternity care settings to prevent the development of PTS
4 symptoms or depression. There is a requirement to disaggregate methods and approaches used by
5 existing studies, rather than review the research as a whole, to identify elements that may contribute to
6 an efficacious intervention and to clarify what is currently a confused position. **Methods:** Papers
7 assessing the utility of providing a brief psychological intervention involving discussion of a birth with
8 the mother and a professional, to reduce symptoms of PTS or depression, were reviewed. Discussions
9 could be structured or unstructured, and involve any aspect of discussing the birth, responses and coping
10 strategies. **Results:** Nine papers (eight studies) were reviewed. Whilst the majority of studies reported
11 findings indicating that debriefing was ineffective for reducing post traumatic stress or depressive
12 symptoms, there was evidence indicating that targeted interventions (for women who experienced a
13 traumatic birth) were efficacious. **Conclusion:** There may be potential utility in providing a debriefing
14 intervention for women who perceive their childbirth experience to have been traumatic. A diversity of
15 approaches termed ‘debriefing’ highlight a requirement to consider alternative terminology; the term
16 ‘childbirth review’ is suggested as a useful alternative. Further research evaluating the efficacy of
17 debriefing using a targeted approach for trauma perception is recommended.

18

19 KEY WORDS: Depression, childbirth, debriefing, intervention, posttraumatic stress

20

21

1 MAIN TEXT

2

3 INTRODUCTION

4

5 In the developed world childbirth is generally considered to be a normal, positive event for women.
6 However up to 45% of women perceive childbirth as traumatic, believing themselves or their child to
7 be at risk during birth (Alcorn et al., 2010; APA, 2013). Following childbirth up to 6% of women
8 develop symptoms of posttraumatic stress disorder (PTSD) (APA, 2013; Czarnocka & Slade, 2000;
9 Ayers & Pickering, 2001) and up to 13% of women experience symptoms of depression (O’Hara &
10 Swain, 1996). Both PTSD and depression can hold adverse implications for the mother’s wellbeing,
11 family relationships and bonding with the baby (Ayers, Eagle & Waring, 2006; Nicholls and Ayers,
12 2007), and therefore attempts to prevent or reduce the development of symptomatology are important.

13

14 Psychological debriefing was originally developed for use with emergency personnel, aimed at
15 facilitating processing of traumatic event information to reduce psychological distress (Parkinson,
16 1997; Rose et al., 2002; Selkirk et al., 2006). Postnatal ‘debriefing’ was introduced in the 1990’s; in
17 this context the debriefing typically provided the mother with an opportunity to discuss her birthing
18 experience with a midwife or obstetrician (Ayers, Claypool & Eagle, 2006). Studies indicate that
19 postpartum debriefing is still offered on an informal basis routinely across the UK (Ayers et al., 2006;
20 Collins, 2006).

21

22 A systematic review reported that single-session debriefing interventions following general trauma did
23 not reduce symptoms of PTSD, depression or anxiety (Rose et al., 2002). Review papers specifically
24 considering evidence for postnatal debriefing indicate that interventions are ineffective at reducing
25 posttraumatic stress (PTS) or depressive symptomatology (Gamble et al., 2002; Lapp et al., 2010; Peeler
26 et al., 2013). However, within the negative findings certain elements of debriefing interventions were
27 highlighted for their utility. Peeler et al., (2013) identified aspects such as the relationship between the
28 mother and midwife may positively influence the outcome of interventions.

29

30 There is often ambiguity and variation in the content of postnatal debriefing interventions (Gamble et
31 al., 2002; Gamble & Creedy, 2004); and both structured and unstructured approaches have been used.
32 An example of a structured approach to debriefing is Critical Incident Stress Debriefing (CISD)
33 (Mitchell, 1997; Parkinson, 1997). CISD is typically provided 1-10 days after a traumatic event and
34 involves a sequential discussion about affective and cognitive responses to an adverse event, structured
35 into 7 stages (Mitchell, 1997). Unstructured approaches provide an individual with the opportunity to
36 discuss their experience, but the individual in receipt of support determines the content.

37

1 Heterogeneity of what is meant by postnatal 'debriefing' prevents general conclusions regarding the
2 efficacy of debriefing without further qualification and there is a need to disaggregate findings based
3 on the specific approaches taken. One way to do this is to consider whether the intervention was
4 universal (i.e., provided to all experiencing a particular event) or targeted (e.g., provided to a specific
5 population considered at risk of psychological distress), whether the intervention is structured or
6 unstructured, and when the intervention is provided after a specific event.

7
8 Psychological debriefing as indicated is provided universally following an adverse event (Parkinson,
9 1997). However, providing a debriefing intervention to all women postnatally will include high
10 proportions that have not experienced an objectively adverse event. Perception of trauma is subjective,
11 and in any cohort experiencing an objectively severe event, only a proportion will perceive the event as
12 traumatic. A smaller percentage would be expected to require (or request) additional input. Women
13 who experience an instrumental birth or emergency caesarean section may be at greater risk of
14 developing PTS symptoms in the postpartum (Astbury et al., 1994; Boorman et al., 2014; Ryding,
15 Wijma & Wijma, 1998). Therefore, for postnatal populations, it may be more useful to target
16 interventions for women who are considered at greater risk of developing symptoms of PTS or
17 depression, due to specific intrapartum events or negative appraisal of the birth.

18
19 The requirement for interventions to be structured is uncertain. A valued element of debriefing
20 interventions as reported by women is the opportunity to discuss their birthing experience, as this
21 contributes to a perception of 'validation' (Baxter et al., 2014; Lee, Slade & Lygo, 1996). If a key
22 element in postnatal debriefing is the opportunity to discuss the birthing event, then the requirement for
23 this process to be standardised (as with the original approach of psychological debriefing), needs further
24 consideration.

25 26 AIM

27
28 This review synthesises findings from studies that have provided a psychological debriefing
29 intervention for postnatal women with an aim to assess utility in reducing PTSD or depression
30 symptoms. Findings will be critically analysed in terms of their approach (universal or targeted
31 application), method of delivery (structured or unstructured) and efficacy for reducing psychological
32 distress (PTS symptoms or depression) in comparison to usual care alone.

33 34 METHOD

35
36 A search was conducted using PsychArticles, WOK and Scopus to identify empirical investigations
37 published between 1980 and 2014. The terms 'childbirth', 'preg*', 'postpartum' were searched
38 alongside 'debrief*', 'counselling', 'counseling' and 'trauma'. Papers were hand-searched for
39 additional references.

1
2 Included papers assessed the impact of psychological debriefing on symptoms of PTS or depression in
3 women following childbirth, and involved a brief (1-2 sessions) psychological intervention provided
4 by a midwife or psychologist in either a group or individualised situation. The primary outcome measure
5 was the assessment (self-report or clinician evaluation) of PTS or depressive symptomatology. Papers
6 were excluded if the population did not give birth to a live infant at or near (>37 weeks gestation) term,
7 as this is likely to involve different psychological sequelae. Due to an unavailability of translation,
8 papers were excluded if they were not published in English. Interpretation of study findings was driven
9 through the appraisal of the design and methodology used, however no study was excluded on the basis
10 of this quality appraisal. Figure 1 displays the selection process used.

11

12 RESULTS

13

14 Nine papers, reporting findings from eight studies, were included in the review (Table 1). Two studies
15 conducted universal interventions (Priest et al., 2003; Selkirk et al., 2006), and six reported findings
16 from studies (including one longitudinal follow up), which targeted interventions either according to a
17 perception of trauma (Gamble et al., 2005; Meades et al., 2011) or mode of birth (Kershaw et al., 2005;
18 Ryding et al., 2004; Small et al., 2000; Small, Lumley & Toomey, 2006). One study (Lavender &
19 Walkinshaw, 1998) did not provide a universal intervention, but did not target interventions for
20 individuals potentially at higher risk for PTS or depression after childbirth (e.g., due to perception of
21 trauma or instrumental delivery).

22

23 *Universal application*

24 Priest et al. (2003) assessed the efficacy of a structured (CISD) debriefing intervention provided 72
25 hours after birth ($n= 1745$). A control group received usual postnatal care. There were no differences in
26 PTS or depressive symptomatology between the intervention or control group at two, six or 12 months
27 postpartum. Random allocation to treatment or control group was stratified by parity and mode of birth,
28 thus controlling for these potentially confounding factors. Furthermore, the large sample size recruited
29 from two sites increases the generalizability of findings. Selkirk et al., (2006) also tested a structured
30 (CISD) intervention, 48- 72 hours after birth, with a smaller sample of women ($n= 149$). At 28 weeks
31 postpartum, there was no significant difference in PTS symptomatology between groups. The authors
32 note that the small sample size limited statistical power, and the one-site recruitment also limits
33 generalizability of findings. Findings from both studies indicate that structured debriefing interventions
34 universally provided shortly after birth, were ineffective preventative methods for PTSD or depressive
35 symptomatology.

36

37 *Targeted: perception of trauma*

1 Gamble et al. (2005) provided a structured (CISD) intervention with women ($n=103$) initially within 72
2 hours of birth, and again by telephone at 4-6 weeks postpartum. There was no significant difference in
3 PTSD 'caseness' between the intervention and control group at 4-6 weeks or 3 months postpartum.
4 However the intervention group reported significantly lower PTS symptomatology than the control
5 group at 3 months postpartum. Strengths of this study include blind allocation to control or intervention
6 groups, and assessment of trauma perception using Criterion A of the DSM (APA, 2000).

7
8 Meades et al. (2011) evaluated the efficacy of an existing postnatal debriefing service in a study with
9 women ($n= 80$) where allocation to treatment group was based on perception of childbirth as traumatic
10 and a request to receive debriefing. Interventions took place between 12 weeks and 6 years postnatally
11 (median 16 weeks). The debriefing intervention was unstructured but included elements included in
12 structured approaches. Women receiving the intervention reported significantly lower PTS
13 symptomatology one month later in comparison to controls, but there was no difference in depressive
14 symptomatology. Therefore postnatal debriefing effectively reduced PTS symptomatology when
15 targeted for women who perceived their experience of birth to be traumatic, and who were receptive
16 receiving an intervention.

17
18 *Targeted: mode of birth*

19 Three studies (and one follow up) reported findings from targeted interventions for women based on
20 mode of birth; emergency caesarean section (EmCS) (Ryding et al., 2004) and instrumental delivery
21 (Kershaw et al., 2005; Small et al., 2000; Small, Lumley & Toomey, 2006).

22
23 Small et al. (2000) reported findings indicating that the provision of an unstructured debriefing session
24 with women shortly after an operative birth was not effective in reducing symptoms of depression at 6
25 months postpartum in comparison to usual care alone. There was a (non-significant) trend for women
26 in the debrief group to report higher symptoms of depression than women in the control group. A
27 follow-up study, 4-6 years later, reported no difference in depression between groups (Small, Lumley
28 & Toomey, 2006). Timing of the debriefing session was not provided, limiting comparison to other
29 studies. Selection for operative delivery also included elective caesarean sections, unlike other studies
30 that selected only EmCS (e.g., Ryding et al., 2004) or operative vaginal delivery (e.g., Kershaw et al.,
31 2005), which may include women with different experiences.

32
33 Ryding et al. (2004) investigated the utility of unstructured group (4-5) counselling for mothers ($n=$
34 157), one to two months following EmCS. There was no significant difference in PTS severity between
35 intervention and control groups at six months postpartum. However there was a (non-significant) trend
36 for lower PTS symptoms reported by the intervention group.

37

1 Only one study conducted a structured intervention targeted for mode of birth. Kershaw et al. (2005)
2 provided two sessions of CISD interventions with primiparous women ($n= 319$), 10 days and 10 weeks
3 postpartum. There was no difference in the proportion of women indicating symptoms of PTSD
4 between either group at 10 or 20 weeks postpartum. PTSD incidence was inferred using a cut off
5 typically used to infer ‘high PTSD’ symptoms (≥ 19 on the Impact of Event Scale). The control group
6 received standard postpartum care, consisting of a discussion with the doctor following the birth and
7 the opportunity to discuss and ask the community midwife questions at the first postnatal visit.
8 Therefore, it is possible that the control group received an element of ‘debriefing’, albeit less formally,
9 and findings may instead indicate a lack of efficacy for an additional (structured) debrief to existing
10 (unstructured) procedures.

11

12 *Not universal, not targeted*

13 One study included in this review provided a debriefing intervention for women who had specifically
14 experienced a normal vaginal delivery; and was therefore neither universal nor targeted for increased
15 risk. Lavender and Walkinshaw (1998) conducted unstructured ‘interactive interview’ sessions with
16 women ($n= 114$) 2 days after a normal vaginal delivery. Three weeks later, women receiving the
17 intervention reported significantly lower levels of depression and anxiety in comparison to those within
18 the control group. This study indicates the utility of providing an informal discussion with women soon
19 after birth for ameliorating symptoms of distress. However symptoms were assessed relatively shortly
20 after birth (3 weeks); one of the shortest follow-ups of all studies reviewed.

21

22 DISCUSSION

23

24 Of the eight intervention studies included in the review, three reported positive findings following a
25 debriefing intervention. Of these, two targeted interventions for women who perceived childbirth as
26 traumatic (Gamble et al., 2005; Meades et al., 2011) and one provided an intervention for women
27 following normal vaginal birth (Lavender & Walkinshaw, 1998). Two of these studies provided the
28 intervention shortly after birth (first point of contact within 72 hours; Gamble et al., 2005; Lavender &
29 Walkinshaw, 1998) and one provided the intervention at the mother’s request (median 16 weeks after
30 birth; Meades et al., 2011). Of the three studies reporting efficacious results, one used a structured CISD
31 approach (Gamble et al., 2005), and two used an unstructured approach (Lavender & Walkinshaw,
32 1998; Meades et al., 2011). Therefore findings from this review indicate some utility in targeting
33 interventions based on a perception of childbirth trauma, with an initial contact shortly after birth (or
34 when requested). There was no discernable pattern in the requirement for interventions to be structured
35 or unstructured.

36

1 Studies targeting interventions for women based on mode of delivery did not report a reduction in the
2 severity of PTS or depressive symptomatology (Kershaw et al., 2005; Ryding et al., 2004; Small et al.,
3 2000). However, targeting interventions for women who had perceived childbirth as traumatic did
4 significantly reduce symptoms of PTS; two of the three studies reporting efficacious effects of
5 debriefing took this approach (Gamble et al., 2005; Meades et al., 2011). Both studies defined
6 perception of trauma using Criterion A of the DSM-IV (APA, 2000), which assesses the perception of
7 threat to life during childbirth in addition to an appraisal of fear, helplessness or horror. Criterion A for
8 trauma exposure was recently amended for the DSM-V (APA, 2013), to include only a perceived threat
9 to life without requirement for appraisal. Findings from these studies indicate that debriefing
10 interventions may hold utility when targeted for women who have perceived childbirth to be traumatic,
11 and that assessment of trauma may need to reflect both a perceived threat to life and appraisal in line
12 with the DSM-IV criterion (APA, 2000).

13

14 An additional aim of this review was to consider current evidence for conducting a structured or
15 unstructured debriefing intervention. Five studies adapted a structured approach based on CISD
16 (Gamble et al., 2005; Kershaw et al., 2005; Priest et al., 2003; Selkirk et al., 2006). Two studies referred
17 to using an unstructured approach, yet the content of these interventions were similar in principal to
18 CISD; aimed at eliciting discussion of the event and evoked responses (e.g., Lavender & Walkinshaw,
19 1998; Ryding et al., 2004). Of the three studies reporting efficacious results, one involved structured
20 debriefing (Gamble et al., 2005), and the remaining two involved an unstructured approach but with
21 some similar elements to CISD content (Lavender & Walkinshaw, 1998; Meades et al., 2011).

22

23 The timing of interventions following birth is an important, in order to prevent inadvertently disrupting
24 normal psychological adaptation (Peeler et al., 2013). Timing of interventions following birth ranged
25 from a mean of 2-3 days (Gamble et al., 2005; Lavender & Walkinshaw, 1998; Priest et al., 2003,
26 Selkirk et al., 2006), 10 days (Kershaw et al., 2005), 4-8 weeks (Ryding et al., 2004) and finally a
27 median of 16 weeks (Meades et al., 2011) after birth. Findings from this review indicate that the
28 provision of debriefing interventions may hold greater utility when provided shortly after birth, or when
29 requested by the mother at a later time point.

30

31 *Implications*

32 Further research systematically investigating the efficacy of conducting a targeted intervention based
33 on trauma appraisal is required. Overlap in terminology used to refer to interventions across studies
34 highlights a requirement for standardised terminology. Studies cited 'counselling interventions',
35 'interactive interviews', a 'discussion of labour,' and 'debriefs.' There appeared to be no discernable
36 pattern within this review to the efficacy of interventions when implemented as a structured, process-
37 driven approach (e.g., Gamble et al., 2005; Kershaw et al., 2005; Priest et al., 2003; Selkirk et al., 2006)

1 or as an informal, patient-driven discussion (e.g., Lavender & Walkinshaw, 1998; Ryding et al., 2004;
2 Small et al., 2000). However, discussion of the childbirth event and associated responses was associated
3 with an effective reduction in psychological distress (Gamble et al., 2005; Lavender & Walkinshaw,
4 1998; Meades et al., 2011). For this reason it is suggested that the term ‘childbirth review’ holds utility
5 describing interventions that facilitate the discussion of labour, feelings and responses without
6 associated connotations held with the term ‘psychological debrief.’

7
8 Study findings indicated that interventions are welcomed by women (Priest et al., 2003; Small et al.,
9 2000). Priest et al. (2003) reported that two in three women in their study reported the intervention as
10 moderately to greatly helpful. Therefore, despite the limited evidence for their efficacy, the women who
11 receive debriefing interventions perceive them as acceptable and helpful.

12 13 *Limitations*

14 Findings are limited by a small number of studies fulfilling the inclusion criteria. Whilst some studies
15 selected only primiparous women (e.g., Kershaw et al., 2005; Lavender & Walkinshaw 1998),
16 controlling for the potential confounding factor of parity, or stratified allocation of women to treatment
17 groups according to parity (e.g., Priest et al., 2003), several studies did not. Several studies did not
18 provide details about the care received by control groups (e.g., Lavender & Walkinshaw, 1998; Selkirk
19 et al., 2006). If a control group received usual care in the form of a discussion with their doctor or
20 midwife about the birthing event (e.g., Kershaw et al., 2005), then it is unclear as to whether providing
21 an (unstructured) debriefing ‘intervention’ will be advantageous, or indeed different. All studies used
22 self-report assessments of symptom severity; studies using clinical interview methods are required to
23 infer clinical utility in providing debriefing interventions.

24 25 CONCLUSION

26 The efficacy of providing a debrief or ‘childbirth review’ for postpartum women to prevent the
27 development of psychological distress is uncertain. Of the small number of studies implementing
28 controlled evaluations, the majority reported null effects in reducing psychological distress. There
29 appears to be some promise in providing an early childbirth review meeting with women who have
30 perceived their experience of birth to be traumatic. Two of the three studies reporting a beneficial effect
31 of debriefing women had used this strategy. Conclusions over the utility of childbirth reviews need to
32 be drawn from their applicability to the populations sampled, and further research targeting debriefing
33 for women following traumatic childbirth is required.

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1 Table 1. Description of studies included in the review

| Author (date); location | Timing and approach of intervention | Details | Symptom assessment | Population | Results |
|----------------------------------|---|---|---|---|---|
| Gamble et al., (2005); AUS | Within 72 hours after birth and 4-6 weeks postpartum. Targeted: perception of trauma (Criterion A of DSM IV). | Face to face counselling intervention (lasting between 40-60 minutes) provided by one research midwife at 72 hours postpartum, telephone counselling at 4-6 weeks postpartum. Based on theoretical perspective incorporating CISM and issues related to childbearing. | 4-6 Weeks and 3 months postpartum: PTSD (MINI-PTSD) | N= 103 women giving birth to a live infant in any of three hospitals within one region, attending for antenatal appointment in the last trimester of pregnancy. Exclusion criteria: under 18 years of age, delivering prior to third trimester, not able to complete materials in English, women experiencing stillbirth or neonatal death. | No sig diff between intervention and control group in PTSD diagnosis at either 4-6 weeks or 3 months postpartum. No sig diff between PTS symptom severity treatment groups at 4-6 weeks, significantly lower PTS in intervention group at 3 months postpartum. At 3 months the intervention group had a sig. lower proportion of depression caseness. |
| Kershaw et al., (2005); UK | 10 days and 10 weeks after birth. Targeted: mode of birth (operative delivery) | Structured debrief carried out by midwives in the mothers’ homes twice: 10 days and 10 weeks postpartum A structured CISM approach was followed. | PTS symptoms (IES) assessed at 10 days, 10 weeks and 20 weeks postnatal | N= 319 primiparous women (n= 158 control, n= 161 debrief) who had experienced an operative birth (forceps, vacuum, EmCS). Exclusion criteria: not able to read/speak English, women experiencing stillbirth or NN death, requiring ICU treatment or infant requiring treatment in a special care baby unit. | No sig diff in PTS caseness between groups at any time point. Non-significant tendency for debrief group to have less clinically relevant cases of PTS |
| Lavender & Walkinshaw (1998); UK | 2 days postpartum Targeted: mode of birth (normal vaginal delivery) | ‘Interactive interview’; ask questions, explore feelings. Conducted by one midwife who received no formal training in counselling. Non-structured approach; psychological intervention to | 3 weeks postpartum: Anxiety and depression (HADS) | N= 114 women (n= 58 intervention, n= 56 control). Primiparous women, singleton pregnancy, normal vaginal delivery. Recruited at 20-week scan. Exclusion criteria: third degree perineal tear, manual removal of placenta, baby admitted to special | Intervention group had lower proportion of clinical levels of anxiety/depression in comparison to controls at 3 weeks postpartum |

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|-------------------------------|---|---|---|--|--|
| | | reduce psychological morbidity after exposure to trauma. No in-depth questioning. | | care baby unit, woman requiring high dependency care. | |
| Meades et al., (2011); UK | Median 16 weeks postpartum. Targeted: Criterion A of DSM IV, wanting to receive debrief. | 1:1 sessions with one of two midwives, specially trained in either CBT and solution focused therapy, or counselling techniques. Debrief gave opportunity to discuss the pregnancy and birth, feelings and emotions, concerns about future birth (if appropriate). | Depression (EPDS), PTS symptoms (PSS-SR), posttraumatic cognitions (PTCI) assessed prior to debrief and 1 month after | <i>N</i> =80 women recruited (<i>n</i> = 46 debrief, <i>n</i> = 34 control). Exclusion: not perceiving childbirth as traumatic (defined using DSM-IV Criterion A for PTSD), under 18 years of age, not fluent in reading/writing English. | Debrief group sig. greater reduction in PTS and negative appraisals in comparison to control group. No significant difference in depression scores between groups over time. |
| Priest et al., (2003); AUS | Standardised CISD, within 72 hours postpartum. Universal provision. | Single, standardised debriefing session in hospital within 24 hours of recruitment. Based on CISD, adapted for postpartum allocation. Provided by a midwife (one of many) trained in CISD. Control group received standard PN care. | PTS symptoms (IES-R) & EPDS at 2, 6 and 12 months postpartum. | <i>N</i> =1745 recruited (<i>n</i> = 870 control, <i>n</i> = 875 intervention group). All women birthing >35WG at any of two hospitals. Exclusion criteria: currently receiving psych care, <18 years old, infant in NICU. | No group diff in PTS symptoms or depression at any point of follow up. No difference in depression caseness. |
| Ryding et al., (2004); SWEDEN | Group counselling sessions (4-5 women, 2 hours duration) at 1-2 months postpartum. Targeted: mode of birth (EmCS) | Unstructured. Provided an opportunity to discuss, to meet others who had experienced similar, share experiences, discuss physical and psychological/emotional responses, signpost to further help. | PTS symptoms (IES), depression (EPDS) assessed at 6 months postpartum | <i>N</i> =157 women (<i>n</i> =82 intervention, <i>n</i> = 75 control) delivering a live infant by EmCS. Exclusion criteria: Low BW and infants needing NN care. | No group difference in median PTS symptoms or depression at 6 months postpartum |
| Selkirk et al., (2006); AUS | 2-3 days postpartum. Universal provision. | Debrief session informed by hospital guidelines: 8 phases; Introduction, fact phase, thoughts phase, feelings | Symptom Checklist 90-R (SCL 90-R), anxiety (STAI), depression (EPDS), PTS symptoms (IES). Feedback | <i>N</i> =149 women in their 3 rd trimester recruited. Exclusion criteria: none stipulated. | No main effect for condition for PTS symptoms, regardless of the level of medical |

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| | | phase, symptoms phase, education phase, re-entry phase, final phase). Questions asked and answered, signposted to additional input if required. | after Debriefing Questionnaire (FAD) completed at 28WG, 1-2days postpartum, 1 month postpartum, 3 months postpartum | | intervention experienced during birth. |
| Small et al. (2000); UK | Took place before the woman was discharged from hospital (not state when). Targeted: mode of birth (operative delivery including elective CS). | Discussion of labour, birth and postnatal events and experienced. Conducted by a midwife. Content of debrief determined by the woman. | Depression (EPDS) assessed at 6 month postpartum | N= 917 women (n= 467 debriefing, n= 450 control). Exclusion criteria: women experiencing stillbirth or birthing an infant weighing <1500g, who were ill or whose infants were ill, not able to understand English or whose private obstetrician did not permit approach for the study. | No sig. diff in depression between debriefing and control group. |
| Small, Lumley & Toomey, (2006); UK | None- follow up to Small et al. (2000) | - | Depression (EPDS) 4-6 years after taking part in previous study (Small et al., 2000) | N= 534 women (264 from debriefing group, 270 from standard care). Inclusion based on previous participation in study (see Small et al., 2000). | No sig diff in severity of depression between either study group 4-6 years after intervention. |

NOTE. WG= weeks gestation. Depression Anxiety and Stress Scale (DASS); Edinburgh Postnatal Depression Scale (EPDS); Emergency Caesarean Section (EmCS); Hospital Anxiety and Depression Scale (HADS); Impact of Event Scale (IES); Impact of Event Scale-Revised (IES-R); Mini-International Neuropsychiatric Interview- Posttraumatic Stress Disorder (MINI-PTSD); Posttraumatic Cognitions Inventory (PTCI); PTSD Symptom Scale- Self-Report (PSS-SR); Schedule for Affective Disorders (SADS); State-trait Anxiety Inventory (STAI); Symptom Checklist 90-R (SCL 90-R)

Figure 1. Flowchart depicting selection process for papers in the review

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