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What is current practice in offering debriefing services to postpartum women and what are the perceptions of women in accessing these services: a critical review of the literature.

Abstract

Objective: The main research question is to describe current practice in offering debriefing services to postpartum women and learn about the perceptions of women accessing these services
Design: Critical review of the literature using a meta ethnography approach.
Findings: Twenty papers were identified. These included four surveys, three qualitative studies, one mixed methods study and three literature reviews. Nine randomised controlled trials (RCTs) provided additional information from alongside surveys and description of interventions. Two types of debriefing were identified: structured and unstructured. The more formal psychoanalytic forms took place within the RCTs whilst the unstructured discussion sessions commonly with midwives were identified in other research papers. In addition there is confusion amongst service providers about the nature of debriefing and what is delivered. Various aspects of providing a postnatal debriefing service were identified including the optimal timing, specific groups offered debriefing and the number of sessions offered.
Postnatal debriefing enabled women to have their birth experiences validated by talking and being listened to and being provided with information. Finally from the limited literature identified relating to midwives' perceptions of postnatal debriefing there was an overall feeling from midwives that they considered it to be beneficial to women.
Key conclusions: The findings of this literature review imply that women's responses to receiving postnatal debriefing are generally positive. This review has found that women appear to value talking and being listened to by a midwife following birth. They seem to have a strong need to have their story heard. This discussion also allows the women to have questions answered and information given where necessary. The whole process places a seal on a woman's birth experience which is validated.
Implications for practice: Although there is no evidence to suggest that postnatal debriefing reduces morbidity, women find the service of value. Maternity providers should consider offering a postnatal debriefing service to meet those needs in advance of further research in this area.

Keywords
Postnatal debriefing
Postnatal counselling
Posttraumatic stress
Midwives

1. Introduction

In the late 1990s postnatal debriefing services were introduced in the United Kingdom (UK). Postnatal debriefing allows a woman the opportunity of meeting with a midwife, to discuss her birth experience. Since that time a series of randomised controlled trials (RCT) has been conducted to evaluate whether the services have an effect on psychological outcome. The RCTs were not always comparable with

regards to the backgrounds of participants and interventions used. It was therefore difficult to compare outcomes from these studies.

The introduction of postnatal debriefing was influenced by a Cochrane systematic review undertaken in 2002 to assess the effectiveness of brief psychological debriefing for the management of psychological distress after trauma, and the prevention of post traumatic stress disorder (Rose et al 2004). Six randomised controlled trials, including two in the maternity context, were included in the analysis. One of the two randomised controlled trials (RCT) set in the maternity context found postnatal debriefing to be beneficial whilst the other found no evidence of benefit. The review found no evidence that debriefing carried out on an individual basis and delivered in a single session was of value in preventing post traumatic stress disorder after a traumatic incident (Rose et al 2004).

Based on the findings from the Cochrane review the National Institute of Health and Clinical Excellence (NICE 2007) recommended that postnatal debriefing should not be offered routinely and does not advocate the routine use of formal debriefing to women who have had a traumatic birth. Some units though decided to continue to offer postnatal debriefing. It appears unclear why the services continue to function and what benefits they offer to the women.

According to Parkinson (1997), critical incident stress debriefing (CISD) is a treatment for those involved in traumatic incidents, including both the victims involved and the professionals called to the scene. CISD is based on the psychoanalytical assumption that talking helps and usually takes place within a group setting. A less structured approach has been used by the maternity services (Niven1992) where a range of approaches to postnatal debriefing have been recognised.

The aim of postnatal debriefing is to reduce psychological morbidity. Women following birth by caesarean section or instrumental vaginal delivery have been found to be at increased risk of developing postnatal depression (Astbury et al 1994). Post traumatic stress disorder (PTSD) is also associated with vaginal operative and emergency caesarean sections but can also occur among women following a spontaneous vaginal birth (Gamble and Creedy 2005). PTSD is a condition developed by an individual in response to experiencing a highly traumatic event (Furuta et al 2012). Examples of criteria for PTSD such as intense fear, helplessness or horror are listed in the Diagnostic and Statistical Manual of Mental Disorder – Fourth Edition (DSM-IV-TR) (American Psychiatric Association 2000).

This literature review aimed to gain a fuller understanding of postnatal debriefing and address some of the questions emerging from the evidence on this topic. There were three objectives. The first was to learn the views of both women who use the service and midwives who undertake the session. The second was to describe the provision of postnatal debriefing and the third to identify approaches taken.

2. Methodology

i)Scope, research question and objectives

The research question was:

What is current practice in offering debriefing services to postpartum women and what are the perceptions of the women who access these services?

The objectives are as below:

- To assess the perceptions of women and maternity care staff of postnatal debriefing
- To provide a typology of the approaches and terms being used in debriefing in postnatal care
- To undertake an analysis of the application of postnatal debriefing in practice, including content, style and underpinning theory
- In relation to the previously stated objectives to identify the gaps in the body of knowledge on debriefing in maternity services

ii) *Search strategy used to identify the studies*

In this study the PICo mnemonic used by the Joanna Briggs Institute was utilised to frame the question of this literature review.

Using this model a comprehensive set of search terms was constructed that are listed on Table 1 below.

The PICo Model			
Population	***Phenomena of Interest***	***Context***	***(Outcome)***
Childbirth	Debrief*	Psycholog*	
Postnatal	Counsel*	Anxiet*	
Pregnan*		Trauma	
Postpartum		Depression	
Antenatal		Posttraumatic	
Pregnanc*		Ptsd	
Birth			

Table 1 Identification of search terms using PICo mnemonic applied to research question

iii) Inclusion/exclusion criteria

Both primary and secondary studies as well as non-research based papers were included in the search. Only those articles written in English were included in the literature review. No restriction was made for setting or country and no limits on publication date of research articles were set. As `postnatal debriefing has been in existence for less than two decades it was important to ensure all possible papers were retrieved. A search was conducted of the major electronic databases:

MEDLINE, CINAHL, Cochrane Library, DARE, Embase, PubMed, Ovid Medline, Social Science Index, Maternity and Infant Care, PsychoINFO and Social Policy and Practice using the pre-specified search terms. In addition key papers were hand searched to identify any further relevant references. Initially the abstracts were read and reviewed and relevant papers kept for the full review.

iv) Methods

The steps taken to identify the included studies are listed below. The number of studies retrieved are listed at Table 2 below:

1. All terms for population combined with Boolean term “or”
2. All terms for phenomena of interest combined with Boolean term “or”
3. Steps 1 and 2 combined with Boolean term “and”
4. All terms for context combined with Boolean term “or”
5. Steps 3 and 4 combined with Boolean term “and”

Search engine	***Database***	***Number of publications***
OVID	Maternal and infant care	382
OVID	Embase	382
OVID	EBM reviews	71
OVID	AMED	4
OVID	Global Health	114
OVID	HMIC	6
OVID	OVID Nursing Full Text	128
OVID	Social Policy and Practice	20
EBSCO Host	CINAHL	184
EBSCO Host	Psychinfo	368
EBSCO Host	MEDLINE	608
EBSCO Host	Psychology and Behavioural Sciences Collection	75
EBSCO Host	PsycARTICLES	337

Table 2 Results of searches of the electronic databases

As described above hand searching of key papers identified further papers which were added to the search. Finally all relevant papers were chosen and included in the literature review following a review of the titles and abstracts of all retrieved papers as listed on Table 2. In total 32 papers were identified, including 20 research papers and 12 commentary/opinion papers.

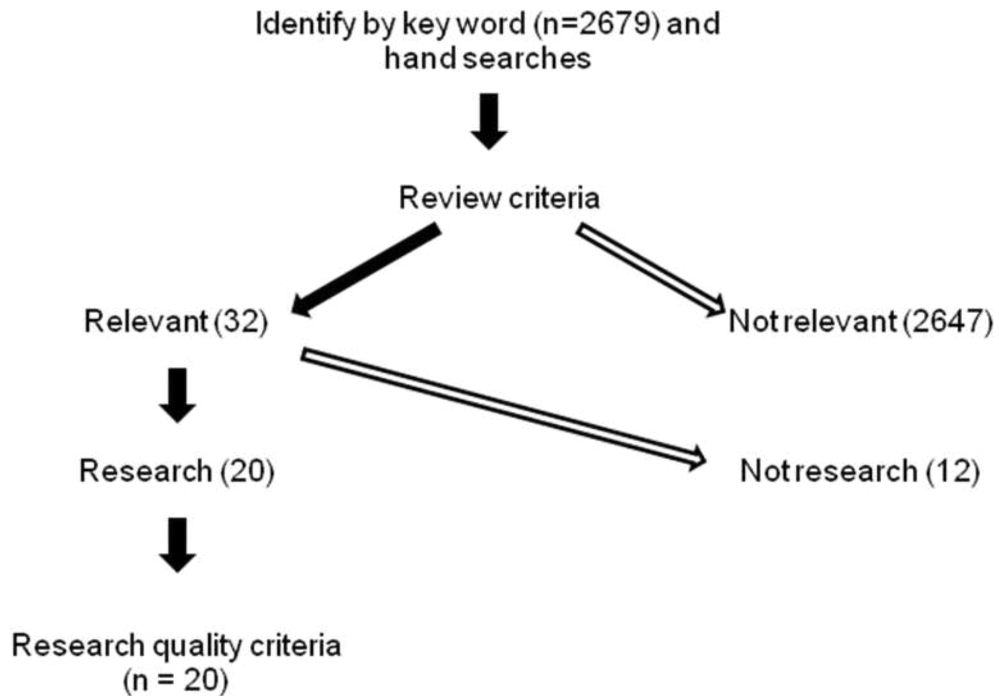

Figure1:Illustration of process of selecting the studies to include in the review

Figure 1 above illustrates the process in the form of a flow diagram. It was anticipated that both qualitative and quantitative studies would be included. Whilst taking a forthcoming Cochrane review on debriefing in maternity into consideration, (Bastos et al 2008) (the results are due at the time of writing) this current work was confined to all empirical work, including quantitative and qualitative research approaches. Whilst this literature review did not set out to measure the effectiveness of the debriefing intervention, RCTs were included for their description of services and where additional surveys have been undertaken within the RCT.

There was a need to ensure that papers included in the review met an accepted level of methodological and theoretical quality. Quality criteria of the individual studies were assessed using critical appraisal guidelines appropriate to the type of research approach used. The framework used was the Critical Appraisal Skills Programme (CASP) 1993. The authors utilised four different checklists according to the type of research approach: systematic review, RCT, qualitative and survey. This process facilitated a consistent approach and helped to ensure the appraisal was systematic and uniform (Aveyard 2010).

The success of all research is dependent on a full review of the literature being undertaken (Hart 1998). There was also the need to ensure that the questions and the data fitted with each other (Punch 2005). In view of this a clear protocol was created in advance to guide this study. This supported a focused and transparent literature search, critical appraisal and data synthesis process was in place.

Integrating studies with different methodological backgrounds when undertaking systematic literature reviews is problematic and difficult (Lucas et al 2007, Thomas et al 2004). There is the need to consider different epistemological and theoretical

perspectives (Mays et al 2005) and the development of robust ways of incorporating qualitative evidence into systematic reviews (Dixon-Woods et al 2005).

Meta ethnography was used as the approach for synthesising the data in this review. This method of synthesis was primarily chosen due to its potential ability to deal with quantitative data. As well as having the capacity of utilising quantitative data by treating it as themes another advantage of this approach to synthesis is its ability to preserve the interpretative properties of primary data (Dixon-Woods et al 2004). In this way it was anticipated that this interpretative method of synthesis would be in line with the type of research data being synthesised i.e. both qualitative and quantitative. In addition undertaking synthesis can involve a re-interpretation of the included studies and in this way goes beyond traditional integrative methods for a literature review (Britten et al 2002). Another recognised advantage of using meta ethnography is its systematic approach (Britten et al 2002).

However there are also disadvantages to the use of meta ethnography and as Ring et al (2011) write, this approach is still evolving. In contrast to the discussion above in relation to interpretation other authors show concern about the possibility of "context-stripping" rather than enhancing interpretation when conducting meta ethnography (Estabrooks et al 1994 cited in Dixon-Woods et al 2004). In addition some authors have highlighted the need for caution in relation to transparency due to the approach's inability to clearly describe the process itself and how the appraisal of the included studies should be conducted (Britten et al 2002, Dixon-Wood et al 2005).

Analysis was conducted through a process described by Noblit and Hare (1988). Meta ethnography proceeds by translating the interpretations of one study in to the interpretation of another study and this was employed in this study followed by a general synthesis.

<u>iv) Critical evaluation</u>

A critical evaluation has been undertaken of each study. This is summarised in Appendix 1. The majority of the studies are practice based, of a reasonable quality and provide reliable evidence for this review.

3. Findings

Twenty papers were identified from the literature search as relevant to the topic under investigation. These are summarised at Appendix 1 and included four surveys, three qualitative studies, one mixed method study, three literature reviews and nine randomised controlled trials (RCTs). The RCT's were included for description of the intervention and results of surveys, relating to women's views of the postnatal debriefing intervention employed. Ten studies were conducted in the United Kingdom (UK), seven in Australia and three in Sweden.

From the process of translating the interpretation of the different studies into each other four key aspects were identified: "The provision of postnatal debriefing",

"Aspects of providing the services", "Women's perceptions of postnatal debriefing" and "Midwives' perceptions of postnatal debriefing"

1. The provision of postnatal debriefing

Three key themes were identified in relation to approaches to postnatal debriefing: "Structured interview", "Unstructured discussion" and "Confusion about what individual services provide".

i) Structured interview

Five of the nine RCTs used a structured format for the intervention of interest. Three utilised the psychological approach Critical Incident Stress Debriefing (CISD) (Kershaw et al 2005, Priest et al 2003, Selkirk et al 2006,). Authors of one paper explicitly stated that their intervention was modelled on CISD (Priest et al 2003). However the authors of the other two studies failed to comment on this but the exact same headings were used to guide the session (e.g. "Facts phase", "Findings phase", "Symptoms phase")

Gamble and colleagues created an original counselling model for their RCT (Gamble et al 2005). This did not utilise a formal psychological approach. In their paper these authors explicitly stated that the intervention did not require psychotherapeutic skills and was aimed at being implemented by midwives.

ii) Unstructured/discussion ("Listening services")

Four papers which presented findings from RCTs included the term "discussion" or "listening service" to describe the service provided to postpartum women (Lavender and Walkinshaw 1998, Meades et al 2011, Ryding et al 2004, Small et al 2000). Researchers in Australia referred to "listening services" which had been set up in the UK (Gamble et al 2004b). It may be that this theme is linked to such "listening services". As far as it can be seen from the current literature review these sessions included discussions surrounding the birth.

iii) Confusion about what individual services provide

Two surveys were undertaken in the UK to assess provision of debriefing services for women. One survey (of a quarter of UK hospitals randomly chosen from a Department of Health list) identified 88 per cent of units offered debriefing only to women who felt traumatised (Ayers et al 2006). The other survey (Steele and Beadle 2003) found 94 per cent of units offered a service to all women.

In the background discussion to their study Ayers et al (2006) described three different types of postnatal debriefing: (1) structured psychological debriefing as proposed for use following traumatic events, (2) midwife or obstetrician led debriefing where professionals review the events of a woman's pregnancy and birth experience with her and finally (3) "Birth Afterthoughts" services run by midwives to discuss the

events of birth with the woman. They found a variety of types of services being undertaken across the UK. Thirteen per cent of services cared for women who had a difficult or traumatic birth in a “Birth Afterthoughts” service, 45 per cent had a “debriefing with a midwife or obstetrician”, 20 per cent a “debriefing with a midwife counsellor” and 14 per cent were seen by a psychotherapist.

Steele and Beadle (2003) created a list of nine activities and events which might be undertaken within a postnatal debriefing service and asked heads of midwifery in two health regions in England to state which of these were undertaken within their units. Three groups were identified:

- “Group A” consisted of units where all nine activities were undertaken and this was defined as structured psychological debriefing. This comprised 14 per cent of participants.

- “Group B” consisted of 28 per cent of participants and included units that reported routine postnatal care type activity only was undertaken.

- “Group C”, the largest group, comprised 58 per cent of participants who selected combinations of descriptor statements from the list. The names provided for this service in “Group C” included birth afterthoughts (n=2), debriefing (n=6), routine postnatal care (n=8).

This highlights the confusion that still exists about the provision of postnatal debriefing with a maternity service with no clear universal model for postnatal debriefing or evidence of benefit. Gamble et al created a midwifery model which was developed for their RCT, which found some effect in terms of fewer adverse psychological outcomes among the intervention group (Gamble et al 2005).

2. Aspects of providing the services

Five themes were identified and are discussed below.

<u>(i).Optimal timing of the postnatal debriefing</u>

Six studies reported that women had a postnatal debriefing session with a health professional before they left hospital. Other studies found that women accessed the service some 12 months later (Inglis 2002) or at other times during the first postnatal year (Bailey and Price 2008).

Some authors commented on the importance of the postnatal debriefing taking place early (within a few weeks of birth) (Priest et al 2003) whilst others suggested the need for a break between the birth and the debriefing (Dennett 2003). However the studies did not provide evidence or explain a rationale for the timing. This is interesting, as the Cochrane review of debriefing interventions in general population groups considers a month to be the minimum time an intervention should take place following a traumatic event (Rose et al 2004). This is also reflected in an earlier NICE guideline (NICE 2005).

There appears to be no consensus on the optimal time for women to access debriefing. Women accessing the service for a discussion should do so when they feel ready (Bailey and Price 2008, Inglis 2002).

(ii) Practitioner (who undertakes postnatal debriefing)

In most of the included studies the postnatal debriefing was carried out by a midwife. Some midwives were provided with additional training such as counselling techniques and how to undertake critical incident stress debriefing (CISD) (Kershaw et al 2005, Meades et al 2011).

The participants in a grounded theory study highlighted valuable qualities of midwives in the context of having a postnatal debriefing (e.g. caring, empathy, understanding) (Bailey and Price 2008). It was considered by these participants that the midwife's professional role facilitates an understanding of childbirth experience.

The importance for the midwife to be present at the birth to undertake the postnatal debriefing was identified in two studies (Dennett 2003, Olin and Faxelid 2003) as this professional would have more knowledge of events. In the Dennett (2003) study the women received the postnatal debriefing from a community midwife who was known to them. Despite not being able to speak with the midwife who was at the birth this same study found that 19/29 participants said they talked with the most appropriate midwife.

(iii). Groups of women offered postnatal debriefing

Whilst in some studies the postnatal debriefing service was offered to all women following birth (Bailey and Price 2008, Inglis 2002, Selkirk et al 2006) in other studies the offer was restricted to certain groups of women (e.g. those who had an operative birth (Kershaw et al 2005, Small et al 2000),or those who exhibited trauma symptoms (Gamble et al 2005, Meades et al 2011).

(iv). The presence of partners during postnatal debriefing

Olin and Faxelid included fathers in their survey of parents' need to talk about their experiences of childbirth (Olin and Faxelid 2003). It is clear that particularly first time fathers have a strong need to talk with a midwife following birth.

Dennett also identified the need for partners to be included in her UK study (Dennett 2003).

(v). Number of sessions

Only one session of postnatal debriefing was offered to women in the majority of studies. However, Gamble and Creedy (2004) warned against a single session debriefing within the first few days following birth or a short time period. They are

concerned that this might not provide sufficient support for a woman whose emotional needs may be overwhelming. In these circumstances the authors argue such an approach can be harmful.

I

3.Women's perceptions of postnatal debriefing

i)Women who give birth value talking about their experience and being "listened to"

Studies found that women frequently needed to tell someone how they experienced the birth (Bailey and Price 2008, Gamble et al 2004a, Inglis 2002). The strong need to discuss their birth experience (Bailey and Price 2008) led some women to try speaking with their friends and family but this was not always successful (Inglis 2002) because they were not able reassurance regarding the birth experience. Gamble et al (2004a) identified that couples came away from the birth experience with differing perceptions of what happened.

Some women reported having negative feelings such as fear, self blame for what happened during the birth experience and members of staff who they felt had impacted negatively on their birth experience (Gamble et al 2004a).

It is of interest that women who were not offered the opportunity to talk with a midwife wanted to (Dennett 2003, Olin and Faxelid 2003). Dennett (2003) highlighted distress in one mother. This woman had blocked her child birth experience from her mind for some weeks and started crying after this point. Other authors have also identified the phenomenon of deliberately not thinking about the childbirth experience immediately following birth (Bailey and Price 2008).

Discussion was reported to be therapeutic for women. Recounting their experiences helped relieve some of their symptoms.

"I was still thinking about it every day and reliving it when I was half asleep....which is a long time, to be, you know thinking about it all the time, playing it over and over again, and probably distorting things on the way"(Bailey and Price p55 Participant 6).

However it was not only women with trauma symptoms who felt they had benefited. Other women also needed to have their voice heard and air their feelings about their birth experience (Inglis 2002).

ii) Postnatal debriefing provides women with information and a greater understanding of their birth experience

One woman explained how debriefing helped her understand why she was not able to have a vaginal birth. She reported:

"Or you weren't able to push him out because of this, and sometimes that happens. And that fact was really helpful to me"

(Bailey and Price 2008 p 56 Participant 2)

This is also supported by Gamble and colleagues (2004a) who also suggested that an understanding of events and why they happened helps women reconcile their birth experiences.

The need for clarification of terms, events, times and facts from the woman's view point was identified in several of the studies (Bailey and Price 2008, Dennett 2003). One example was an explanation of the mechanism of labour given to women by a midwife using a doll and pelvis (Inglis 2002).

Postnatal debriefing also provided an opportunity for midwives to offer women a detailed breakdown and explanation of the events that occurred during their labour and birth using the maternity case notes (Dennett 2003, Gamble et al 2004a).

This might imply that women were left with gaps in their memory. Although not explicitly stated by any of the authors it might explain the fervour among some women to talk and gain an understanding of events. Whether women have gaps in their memory is unclear however as described above studies have found that women struggle to understand what happened.

iii). Postnatal debriefing provides women with validation of the birth experience

The theme *"Postnatal debriefing provides women with validation of their birth experience"* was identified from the studies included in this review. This forms part of a dynamic process dependent on the two other themes identified from the review and described above. If women are not offered the opportunity to talk and be listened to and if they are not provided with an understanding of their childbirth experience it is not possible for their birth experience to be validated.

Many of the studies reviewed discuss these outcomes from women's experience of postnatal debriefing, therefore it is fitting that these outcomes (that featured as "categories" during the analysis) are situated under this theme. Furthermore three of the authors have already alluded to validation in their work (Bailey and Price, Gamble et al 2004a, Inglis 2002).

Two sub themes form the body of this theme and are described below and together comprise the meaning of the main theme.

- A sense of relief when understood what happened

Speaking with a professional allowed women to have their story acknowledged and validated (Gamble et al 2004a, Inglis 2002). Acknowledgement of having had a hard time was of importance to some women (Bailey and Price 2008). These women were relieved when they understood what happened and to learn that their experience had been genuinely difficult. Talking with a midwife enabled women to gain an understanding of what happened. This provided relief to women.

"I felt reassured that it wasn't me being pathetic....that, you know, actually what I went through was quite tough, and it um, I wasn't a complete wimp"
(Bailey and Price 2008 p 56, Participant 3)

- Reassurance when understood what happened

Postnatal debriefing helped women come to terms with what had happened to them (Bailey and Price 2008, Dennett 2003). Women were reassured after speaking with a midwife and understanding what happened to them. For those women who had experienced a traumatic birth debriefing provided them with the reassurance that birth is not always traumatic (Gamble et al 2004a). This provided further reassurance for future birth experiences.

"Knowing about how your last birth could have been different is in a way planning for the next one" (Joan, Gamble et al 2004a)

One study identified that women found closure to their experience of childbirth (Bailey and Price 2008) leading them to no longer feel the need to talk about their birth experience. The present literature review placed the phenomenon of 'closure' under the subtheme of reassurance and the main theme of validation i.e. reaching closure occurs following validation of the birth experience.

One study referred to the "positive and cathartic" experience that postnatal debriefing provided women (Bailey and Price 2008 p 55). However these authors do not explain why the women find the experience of postnatal debriefing cathartic. The present literature review suggests the experience is about validation.

iv) Midwives' perceptions of postnatal debriefing

There is limited literature on this topic, with only two studies identified.

The three themes identified in the qualitative paper (Gamble et al 2004b) were; "Opportunities to talk about the birth", "Developing an understanding of events" and "Minimise feelings of guilt". There was consensus amongst the midwives that postnatal debriefing should be unstructured and led by women. The midwives felt women needed to come to terms with a past negative birth experience to prevent an adverse effect on a subsequent pregnancy. According to the midwives women need a clear picture of what happened to them and it is the role of the midwife to answer questions and fill in "missing pieces". The midwives also stated the need to ameliorate the women's feelings of guilt.

The second study was a survey within a RCT (Kershaw et al 2005). Seven out of 16 midwives felt postnatal debriefing benefited women following traumatic delivery and two midwives felt that postnatal debriefing was beneficial to some women. The views of the remaining seven midwives remain unclear on this point. Twelve of the midwives felt comfortable undertaking postnatal debriefing. Of three midwives who were not comfortable, one offered the postnatal debriefing on the first postnatal visit to the woman and two midwives felt they required more training. Continuity of care, the training for the postnatal debriefing intervention (as part of the RCT) and

quietness in the woman's home all helped the community midwives to undertake the process. Factors that prevented the midwives from undertaking postnatal debriefing were lack of time (n=5), women not wanting it (n=6) and inappropriate referrals (n=2).

These two studies found that a significant proportion of midwives considered postnatal debriefing to be beneficial to women. The survey showed that seven midwives felt that postnatal debriefing was beneficial to women following traumatic childbirth and a further 12 per cent considering the intervention beneficial to some women. The qualitative paper identified an unequivocal feeling amongst the participants that postnatal debriefing was beneficial to women.

4. Discussion

The findings of this literature review suggest that women's responses to receiving postnatal debriefing are generally positive, a finding from quantitative and qualitative studies. This review found that women appeared to value talking and being listened to by a midwife following birth, with a strong need to have their story heard. The opportunity to discuss their birth also enabled the women to have questions answered and information given where necessary. The whole process placed a seal on a woman's birth experience which is validated.

The findings concur with studies on women's responses to accessing postnatal debriefing services for example Bailey and Price (2008), Inglis (2002) and Olin and Faxelid (2003). This positive reaction by women during the postnatal period to the discussion with a midwife is similar to the reactions of people in the general literature on debriefing (Raphael et al 1995, Rose et al 2004). However, the evidence is lacking for other benefits gained such as a reduction in psychological morbidity.

The background of women recruited to the studies varied with regards to their birth experiences. Some studies included only women considered to have experienced a traumatic birth such as an emergency caesarean section or a forceps vaginal delivery. However a definition of the meaning of traumatic was not always provided. Other services offered the debriefing to all women who had given birth. This study has identified the need to understand what it is about the birth experience that causes individual women to feel traumatised. The type of birth (e.g. emergency caesarean section) has been considered a trigger for women considering their birth experience as traumatic and some researchers have included only this group of women in their sample. However it is known that women can experience signs of trauma following an uncomplicated spontaneous vaginal birth. One finding, as a result of conducting this literature review, is the need to understand more fully women's subjective experience of birth and recognise that women's definition of birth trauma or complications of birth may not coincide with those of health professionals. Women may have lower thresholds in the definition of birth trauma than those defined by health professionals.

It is unclear whether midwives consider that holding a postnatal debriefing with women about their birth experience is beneficial. Only two papers identified the

views of midwives (Gamble et al 2004b,Kershaw et al 2005). These papers differed in their findings on whether midwives considered a postnatal debriefing to be beneficial to women. Further research is required to understand the views of midwives to holding a postnatal debriefing with women.

There is the need to consider whether midwives require further training to undertake postnatal debriefing. Some midwives believed that the training they received helped them in developing the skills necessary to deliver debriefing (Kershaw et al 2005). However the authors of another study (Gamble et al 2004b) were concerned that the depth of exploration of the women's emotions, required todeliver such a service was beyond the remit of a midwife's training. Midwives were concerned that women were experiencing feelings of guilt. For this reason they took steps to ameliorate the guilt. This can be linked to the views of the women on having a postnatal debriefing in a sister paper. These women felt that by gaining an understanding of alternative ways they may have progressed through the first labour provided them with confidence to planning a successive future birth experience.

Few theoretical frameworks were identified from the papers identified. Gamble and Creedy (2004) in their literature review of content and processes of postpartum counselling identified a model that these authors consider explains emotional distress after childbirth. The model stems from earlier work with survivors of childhood sexual abuse. The key elements of the model are physical damage, stigmatization, betrayal and powerlessness. This does not assume that trauma is caused by the same event for all women and that personality and interpersonal factors also play a part. The same authors commented that providing women with an opportunity to discuss their birth experiences also draws on Rogerian humanistic psychotherapeutic principles which involve interpersonal counselling skills, such as active listening, paraphrasing and reflection of feeling.

Olin and Faxelid (2003) in their survey in Sweden on parents' needs to talk about their experience of childbirth identify that individual women cope differently with the demands of childbirth. A woman with a strong sense of coherence (SOC) is more aware of her feelings and may express them better than someone with a weak SOC. These authors also draw on stress theory adapted for pregnancy and childbirth where three elements become essential: "comprehensibility", "manageability" and "meaningfulness". "Comprehensibility" is about ensuring women understand the process of childbirth and "manageability" refers to an individual woman having resources to meet her needs during pregnancy and the entire childbirth journey. When considering "meaningfulness" this suggests the need to find a meaning to giving birth.

Whereas some of the underlying principles are consistent with postnatal debriefing neither of the theoretical frameworks described above are a perfect fit or serve as a conceptual model. It appears this theory is still awaited.

Most of the nine non-research papers identified in this review considered postnatal debriefing with a midwife as an opportunity to review the labour and birth. Most of these were commentary articles published in midwifery journals. It was also recognised that many women leave their experience of birth with unanswered questions and the postnatal debriefing with a midwife facilitates the answering of

these questions. The importance of listening and talking was also identified by these other papers. It is of interest that the authors of three of these non-research papers mention validation. This concept was also identified in the synthesis of the research papers.

It seems from this literature that at the end of their birth experiences some women find that their expectations have not been met. Feeling discontented in this way can lead women to making complaints. However some authors were clear that the process of having a service where women can access postnatal debriefing with midwives following birth can counteract this and reduce the number of complaints made. The same authors do not provide evidence of this in terms of statistics. It appears the process of offering women to meet with a midwife to discuss their birth experiences may have been set up as a risk management tool to protect the organisation from negative publicity. To highlight this three of these papers recognise the competing priorities between the individual women who use the service and the organisation.

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