Birth Trauma with Jan Smith

Jan Smith: [00:00:00] in the birth narrative for women it's continuum, isn't it that, um, look, you can have the birth pool and the candles and all, um, uh, a really Zen birth on you can have the other end of the scale for that and everywhere in between.

Debbie Sorensen: That was Dr. Jan Smith on psychologists off the clock.

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Yael Schonbrun: From coast to coast, I'm Dr. Yael Schonbrun, a Boston- based clinical psychologist and assistant professor at Brown University.

Jill Stoddard: And from [00:01:00] sunny San Diego, I'm Dr. Jill Stoddard author of Be Mighty and The Big Book of ACT Metaphors.

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Debbie Sorensen: Hi, this is Debbie. Our previous episode was on pregnancy loss. And today we're kind of following that theme. We have an episode that I'm bringing you today with Dr. Jan Smith, who is an expert on birth trauma. In the episode, Jan brings her wisdom and experience to teach us about birth trauma. And I share a little bit of my own personal story with my experience with birth trauma.

And I'm here today with Jill to introduce the episode. And Jill, you said that you listened to the episode and you have a birth trauma story as well.

Jill Stoddard: I do. And you know, w when I listened to this, I was sharing with you earlier. I was sort of tearful, listening to the whole episode. I'm getting tearful right now. It was really triggering, but. I felt like you sharing your story was so important because we know each other pretty well. And I [00:03:00] had no idea that you had been through that.

And I thought, you know what? I bet Debbie has no idea that. Been through this and it felt so validating for me to hear about your experience. And I thought, you know, during this intro, maybe I can share a little bit of mine. And my hope is that our listeners will hear these stories and feel validated too for their experiences.

Um, and also maybe even seek help if they don't realize they need it. You know, I think what became clear for me. So when I had my son, my second child, um, It turned out. I had placenta accreta that was missed. Um, in fact, I was assessed for it. I had an MRI and they said, Nope, you're clear. You don't have it.

And it's a serious problem that can cause a person to bleed out and die unless you get a hysterectomy at the time of the birth. And they said, I didn't have it.

And I had a massive blood loss. Um, And the most traumatic part was my son had to go to the NICU. He had some respiratory [00:04:00] stuff and he had to go to the NICU and they wouldn't bring him to me.

And I was only allowed to see him if I could get myself up out of bed and into a wheelchair and I couldn't do it. So I didn't see him for quite some time. And what's interesting to me about that is when my daughter, my firstborn was born, I felt like I bonded with her instantly. And it was a, it was a, um, you know, normal, easy, like mild complications, but no big deal.

And with my son, it probably took up to a year for us to like truly bond for that, for that bond to grow. Um, and. I never realized that this had a pretty significant and longstanding impact on me. The fact that just listening to this episode had me crying instantly talking about it has me crying and it was eight years ago.

And I've seen multiple medical providers who have asked about the story and just jotted notes [00:05:00] down and never, and I'm crying every time I tell the story and never has anyone said, you know, have you ever thought about talking to someone about. And I realized when Jan was talking about some of the ways that the impacts can show up.

So she talks about engaging in checking behavior or staying very close to your child. And it hit me like a ton of bricks. I had this kind of aha moment. After Liam was born, I developed what would be considered postpartum OCD. And I feel very grateful. I actually am an OCD specialist in my practice, so I knew just what to do so it didn't stick, but I would have intrusive images where I would be holding him.

And he was a teeny, tiny, frail little peanut. He was born a month early and I would walk through a doorway or past. Like the railing to my stairs. And I would have an image of smashing his head against the, the, you know, the pole or the doorway. And it was so [00:06:00] awful and so painful. And I knew that this was OCD, like things, and I knew what to do with it.

So it didn't stick around. But for someone who doesn't have our training, they wouldn't know that. And that this could be something like, or other kinds of anxiety that could result as. could result from a birth trauma, like mine, and, and I think the thing that I really I want to say is because ultimately I was fine and Liam was fine. He was very tiniest first four months of life. And then he just

blew up into this very big, healthy child that I felt like I couldn't get therapy or like, I shouldn't need it. You know, I'm fine.

He's fine. It's all fine. What do I have to be upset about? And I loved the, generally talked about how you can certainly have the, the extreme birth trauma or the, you know, perfect uneventful birth. But there are so many different things that can happen in between those two [00:07:00] extremes and that even if your outcome was okay, that doesn't make the birth experience any less traumatic and that it's okay to reach.

Debbie Sorensen: Jill, I'm tearing up listening to your story and you're right. I had no idea. I think we've met each other when our children were several years old. So we. Really know this about each other, but I do think you're right. It speaks to how we just don't talk about it enough. Right. And I think that that period, whether it's a difficult pregnancy, whether it's a traumatic birth, whether it's trouble breastfeeding or postpartum, depression, postpartum anxiety, and issue with the baby, you know, a premature baby in the NICU or whatever the case may be. I think that there's a lot of different ways in which people who give birth might struggle. During pregnancy during birth, after birth. And I just think that it's important for people to talk about it more so that everyone gets the support that they need, because there are resources out there and support out there.

Um, [00:08:00] we're not trying to scare anyone who's considering having a child or a baby someday, but rather to just say, like, let's talk about it. Let's support each other as we go through this.

Jill Stoddard: Right. And, and I actually think that maybe part of the reason we sometimes don't talk about it, as I know, you know, if I, with somebody who's thinking of having a baby or is pregnant, like, I don't want to tell them about my trauma experience and scare them, but the person who had that traumatic experience sure.

Wishes someone had talked to me beforehand about their, so this idea that we shouldn't scare people, but also that's part of not talking about it. So then people don't know. Um, uh, you know, that these things can happen and maybe happen more commonly. And you know, the other thing I think about as sort of like a trauma after the trauma, you know, that happens a lot.

When someone has a traumatic experience, it's then how someone responds to it can add to the trauma. And I know, I got the support I needed from some

people, one of my best friends flew across the country to help take care of my two year [00:09:00] old, which was just, you know, it's just something I'll never forget, but there were other people in my life.

Who I really needed, who didn't show up for me, even when I asked, um, and I actually treated a patient who came to me for birth trauma specifically, and one of her biggest struggles was the lack of support she got from her spouse and from her family and other loved ones. Um, and so I'm not sure what the lesson is there, cause I want us to talk about it and I want us to reach out and ask for help.

But I think there's also this other piece of like the messaging we get that women have just women have been having babies since the Dawn of time that there's something that's like is also, even if you ask for help, you're not necessarily getting what you need and maybe not to give up at that point, you know, to, to try to figure out like what else you need.

And, and maybe to reach out to a professional rather than a friend or family member.

Debbie Sorensen: Yeah.

Or at least someone who understands it, right. Maybe someone who can have [00:10:00] compassion or who's been there before themselves, or who has an awareness, or, you know, I think if facades, like this one are available to people, maybe more people will get that. And then the next time someone they know, you know, goes through something like this, we'll be able to support them better.

Jill Stoddard: Yeah. They can share the episode.

Debbie Sorensen: That's right.

I'm happy to have Dr. Jan Smith with us today to talk to us about birth trauma. Jan is a chartered psychologist, executive coach, and the director of Healthy You, Ltd.She's worked with individuals and organizations for over 15 years, providing psychological support for trauma, moral injury and stress to individually.

And creating psychologically safe and positive working cultures and organizations in 2014, Jan developed the birth trauma services at healthy U, which supports moms, birthing partners, and staff who are affected by birth

trauma, Jan has extensive experience in [00:11:00] helping families through their litigation process, particularly in cases where their child sustained life-changing injuries at birth. She campaigns to improve safety and maternity services for family and staff. And she's the clinical lead at the national birth trauma campaign make birth better. And the lead for the parliamentary working group for birth trauma. She also provides training in the UK and internationally to maternity students and healthcare professionals on birth trauma and its impact.

She is an expert advisor on a number of committees providing input into maternity services. She has a new book out called nurturing maternity staff and an upcoming book in November called managing PTSD for health and social care professionals. And she also has two more in the works. Is that right? Jan, a birth trauma and perinatal anxiety. Is that correct?

Jan Smith: yeah, absolutely. And, um, both act workbooks for clients.

Debbie Sorensen: Wonderful. Look forward to those. And I've been looking through [00:12:00] your book that's out. Um, thank you so much for joining us. I'm really happy that you're you're here today.

Jan Smith: Yeah, likewise.

Debbie Sorensen: So I'm very curious, this, you are really doing some incredible work in this area, Jan and I just imagined that this must be a passion for you, working in this area of birth trauma. And I was wondering if you could talk a little bit about the values that led you in this direction and maybe some of the rewards and challenges of this.

Jan Smith: Yeah. Um, I guess I a what, when I finished university, I didn't really know what I wanted to do, but what I really value is connecting with people. And also being held. And so actually, and when I look back, maternity has always been a thread through the work that I've done. So [00:13:00] I started off as a mental health coordinator for, um, Homeless people with, um, issues with addiction.

And actually what I was doing there was supported and sex workers and, and women who were substance and alcohol dependent and through their birth injury. Um, so I was their birth partner and, um, would do a lot of the advocacy. So I think that's where it really ignited my passion for, I guess, people who are missed or misrepresented in society to really advocate for their rights and to get

the surface that if you were born a different nationality or a different place, That you would get.

So that really ignited my value [00:14:00] around advocating for people who really needed it. And I just fell into birth trauma really, because I was seeing that a lot of families who were perceived perhaps, uh, in teams that were working with them. Behaviors like they were controlling actually, when you went in and spoke to the families, they were really traumatized and they were trying to make sense of their experience through control, which psychologist is a classic trauma response.

But I think that was really difficult for teams, the teams that they were working with to manage. So. Um, yeah. Uh, some of the challenges, it can feel very heavy work. Um, you know, people aren't coming to see me [00:15:00] as. Okay. They come to see me when things have not only gone wrong, but disastrously wrong to, you know, there has been either death of mom, death of baby, or life change and entries for mum and or baby, um, through negligence, um, medical negligence.

So it's kept the work can feel really hard. I guess one of the rewards, um, on, when I think about it, it is, and you'll know as a psychologist is in that real dark space where people are grieving or adjusting to life , and you are able to provide a Ray of hope and they hold on to that. No matter how small light.

And they roll with it. That is totally like a [00:16:00] thought is my heart. That is what I do. And that is an incredibly rewarding part of the work that I feel really privileged to, to do and share that space with them.

Debbie Sorensen: Yeah, it's very meaningful. I just happened to have. A period of time recently when grief was showing up in my practice unexpectedly a lot, all of a sudden, and I thought this is, it feels hard. And it also just feels really special to be with people at that place where they just need support and you're able to provide something.

Jan Smith: Absolutely

Debbie Sorensen: one thing I think is really interesting is that you work both with families who experienced birth trauma and also with staff with maternity staff. And I had never really thought much before I started looking at your work about how the two of those can really go together. Um, and Yeah.

and also [00:17:00] how maternity staff also can.

Be traumatized and how it really impacts them as well. I mean, I know healthcare workers, you know, the it's stressful in general right now to be in a healthcare profession, but I think there's some special, um, stressors related to that. So I was just wondering if you could share a little bit about why it's important to talk about both sides and what are some of those stressful aspects of working with maternity staff?

Jan Smith: Yeah. And I think Debbie, as you say, it's really important to draw attention that actually, the impact on staff and the impact on families. The other side of the same coin. and actually, especially in the UK or for the last year, probably there has been a huge, huge drive in maternity around patient safety.[00:18:00]

And we can't have a conversation about patient safety in the absence of having a conversation about the mental health and wellbeing of staff. Because if we're tired, if we are fatigued, if we haven't eaten in a 12 hour shift or had those basic needs met, that is significantly going to impact on people's judgment.

Um, under clinical judgment as well, and things get missed, but also when you ask about some of the stressors within maternity. There was some research done a few years ago in Australia, by Hannah Dahlen and looking up in particular, what, um, midwives fear the most in their jobs. And for them, it was ranked one to 10, 10 being the most primary thing that they're fearful of [00:19:00] and the death of a baby or.

Um, the bullying culture, they're Colombian maternity, a huge bullying culture between staff and not being able to deliver the kind of care that they've been trained to do. So when we here in the UK, we know that for every 30 midwives that are trained. Two years later, there will only be one midwife still practicing.

So there is a massive in that first two years, there is a massive, a mind of midwives that leave the profession. And when the research has looked at exactly what's going on in that two year period, there are a number of things, high levels of anxiety. Depression. And also the pressures on midwives who self identify as having a [00:20:00] disability.

But actually what I hear in practice are those things, but also something different that midwife means to be with women. That's the literal translation of it. And actually when midwives qualify, what they realize is they're not with

women. They're with paperwork. There with the system. So there is a mismatch between what they thought the role was going to be under actually what it is for them.

And in that process of that mismatch, um, they're not able to deliver the care that they're trained to do that moral code that they have of being able to deliver women centered care. Irrespective of race. Um, eh, the background off the person, what they realize is they're not able to deliver that [00:21:00] care because of lack of resources, the lights.

Staff shortages or it's just not possible. And so that's where I see they're becoming morally injured. So this range of moral distress that they ban because their professional values are compromised. Um, we know to know as, as practitioners. When you move away from what is really important to you in not only your personal point, of course, your professional life and your professional identity, that's wounded, that's bread that breaks some part of you and the shame and guilt that that can create in a lot of the maternity staff that are.

Debbie Sorensen: Yeah, it's so such an important point. You're making here. The two go together and for everyone to be safe, we have to take care of our, maternity staff and people who are working in health [00:22:00] care. We, we actually did an episode of if anyone's interested a little over a year ago in the early days of COVID about

healthcare, professional wellbeing. And I think in the case of maternity, it, it, it is a very high stakes situation. And for everyone to be coming from a place where they're getting the resources they need and they're able to do their best work. Um, and yet it's so stressful that that's not always the case.

Jan Smith: Yeah, absolutely. And, um, I think particularly in maternity, there's something there's a huge contradiction. Uh, really supposedly nurturing and profession that actually they're not nurtured themselves. They don't feel valued. A lot of them.

Debbie Sorensen: That's a sad. Yeah. So let's talk about some of the basics here. I'm very curious. how would you define birth trauma? What is it? What are we [00:23:00] talking about here? And what are some of the things? Maybe some examples are the things that we might consider to be traumatic birth.

Jan Smith: Yeah. what comes to mind straight away is the Cheryl Beck who coined the phrase, um, traumas in the eye of the beholder. So, um, for birth

trauma and it is a very subjective experience of trauma. So what might have obstetrically looked very straightforward for in terms of a birth. So there was no emergency and it was a vaginal birth.

And. It looked at there wasn't any, anything on toward obstetrically then a lot of women then feel like I don't really know why I'm feeling the way that I do. However we know that [00:24:00] your interpersonal and. A reactions with your caregiver. So those maternity stuff, if you're on kind as a maternity worker, if you have, um, being hostile that that person birth in person will be able to, that might have been traumatic at that time.

Like, if you can imagine how vulnerable. You are when you are in labor and then someone is really mean to you, the person that you trust. So if there is an element of trust being broken, that can be it, it can also be your labor was very quick. Do you know? So that was women. I think on a societal level, we are totally given a really false narrative that giving birth is best after life.

Do you know, on it is for some women, however, it's [00:25:00] not for many others. And also a quick labor is what you want. A quick labor can be very traumatizing for someone. Also, if you don't feel like you got the support that you needed during your birth, and it could be things like there is more obvious obstetric interventions.

So the more interventions that are introduced in birth, the higher you are susceptible to experience in your birth as traumatic. If there was an emergency, if you thought you were going to die or your baby, or you thought your baby was going to die, those are all examples of trauma or birth trauma.

Debbie Sorensen: It seems like there's a really pretty big range of what can be a stressful or [00:26:00] traumatic scenario. Um, and it's interesting. I'll just tell my own quick personal story. Yeah. My first birth, I have two kids. My first birth was kind of in the gray area of this, where I didn't think of it as traumatic at the time, really, because I didn't have a frame of reference, but when I started reading your work and I heard you speak on a panel at a conference, I thought to myself, Actually mine kind of was because my, my first baby weighed nine pounds when she was born and I'm only five foot three.

And so she kinda got stuck and it was kind of a, I didn't really understand what was happening in that moment, but it was a very hard birth, very hard. And. I, it took me a very long time to recover physically, but since I didn't have a frame of

reference, like you said, it's in the eye of the beholder. I just thought that was how birth is.

And then when I had my second baby, it was so much easier when she was smaller. She was born a little bit earlier. I had [00:27:00] already had a baby. I felt better. The day I gave birth, then. months after my first birth. And I thought, well, No.

wonder I was struggling so much. I felt terrible. I mean, for a long time.

And it was very hard.

Jan Smith: Yeah. And, and how do you think Debbie, if someone at that time had said to you. Could it be, or that this is a thing. How do you think your experience might have been, or your recovery might've been different?

Debbie Sorensen: I think it would've made more sense to me because I just think I didn't. I just didn't feel good for so long physically. I think I was struggling. Like everything kind of just felt harder to me and overwhelmed. Like even I remember just like trying to give my daughter her first bath and it just felt like this monumental ask.

I think it would've helped me make more sense of my struggle.

Jan Smith: for sure.

Debbie Sorensen: And so I think it would have. it would have just helped my frame of [00:28:00] reference to know that at the time instead, I just, I didn't know that that's why it was so

Jan Smith: Yeah. Yeah, absolutely. And I think that's a huge part in birth stories. Do you know, in the birth narrative for women it's continuum, isn't it that, um, look, you can have the birth pool and the candles and all, um, uh, a really Zen birth on you can have the other end of the scale for that and everywhere in between.

Debbie Sorensen: Yeah, Yeah. And there's some, I think you're right about the false narratives about how it's supposed to be, that sometimes we have, we compare to some sort of ideal version of it and it can feel very disappointing if it doesn't go the way

Jan Smith: Yeah, absolutely. Yeah, for sure. I mean, for me, I, my bursts were fine, but in my west, my first child, what I am do, [00:29:00] again, the movies and what you hear a lot is around. You know, you pick your baby up on, you have this instant feeling of like overwhelming love. And I was like, uh, I mean, I felt the evolutionary pole of protecting her, but I didn't get that.

I am so in love with this, that was a grower for me. Do you know? So when. I guess somebody just said it to me in an off comment about, oh yeah. Most people don't love their babies straight away. I do know. I was like, oh, thank goodness. I am not normal. And this is also with our knowledge on psychological. Do you know?

I had burst even while I was doing this work. Do you know? So it's yeah.

We need to talk [00:30:00] more

Debbie Sorensen: yes, normalizing that. I saw an article about how a certain percentage of parents sometimes have doubts if they should have had kids or something like this. And just that question pops to mind. And I think. We should be talking about that more. That's not that abnormal, but there's almost a shame around this that

Jan Smith: for sure.

Debbie Sorensen: to not be like that, but it's, you know, it's hard.

Jan Smith: Absolutely on, I guess it's reaching rather than being the perfect parent. It's the good alpha parent

Debbie Sorensen: Yeah, yeah, yeah. Being kind to ourselves in that.

Jan Smith: for

Debbie Sorensen: I think, you know, you, you mentioned that I think you have passion around. Ensuring that quality care is available to everyone. And I learned on your panel at the conference that I watched that there are disparities in the outcomes and [00:31:00] also the care that's given.

And particularly as an example, there's racial disparity in birth outcomes. And I think that's really important. Could you talk a little bit about that and what's going on there?

Jan Smith: Yeah. So, um, we have in the UK, this statistics are incredibly alarming where women are five times more likely to die in childbirth. Um, um, and, um, Hey, Brian women and Asian women are three times more likely to die. So there are massive disparities, although it has dropped down to four times more likely to die for black women.

That's still massive. And I guess for those, um, that I say, especially around, um, where race has been a large part of the trial, It [00:32:00] is huge assumptions that are made around from maternity staff that they're higher risk, that they, um, mightn't speak English. Um, and. Yeah, I think that confirmation bias on those biases that we hold aren't really part of training.

Do you know when maternity in health care or do you know? We all hold stereotypes. We all hold biases. And rather than. Hoping that we don't have them on that. It doesn't play out and how we act and behave towards people. It's actually, we need to understand what our own biases are in order to put things in place, to safeguard against them.

I'm not impacting on the judgments that we make and staff might make when they're caring for these women. And it's heroine to [00:33:00] hear some of these women's experiences.

Debbie Sorensen: Yeah, I think that's another thing that needs to be talked about more is that, you know, when there is a disparity in care and when assumptions are made and how that impacts people's lives, um, in these, these really sad, horrible ways.

Jan Smith: Yeah, absolutely.

Debbie Sorensen: what are some of the potential longterm, you know, psychological impacts of traumatic birth that you might see and work with in your practice?

Jan Smith: Um, so some of the long-term are dependent on the type of birth trauma. And also if it's psychological and physical, do you know if women have had a life-changing physical injury as well? Or that they have had a birth trauma and their child has handed up with a life-changing injury. I think that all

components, the [00:34:00] trauma and we know was as an psychologist, you know, you have the core trauma and then the layers that component are trauma.

And so sometimes the, the clients that I see in the issues that they present with are. Far, do you know that, uh, upon a play off of and difficulties, that could be, they come as a couple and there's relationship issues. So, um, prompts with intimacy or sexual problems. It could be that, um, the birth partner or the family member who was their witness in the, before.

Is traumatized so that the carious trauma. So yeah. The woman might feel like she hasn't had a trauma, but actually the observer house, it could be, um, not being able to bond with their baby or connect with her [00:35:00] baby, or it could be actually that really overly check and behaviors, making sure that their baby is okay, Nathan them to be very, very close to them.

Even Juno, this is years down the line. Again, thought behaviorly thought might be perceived unexperienced by the other person I was control and. Oh, we know, right. Don't we, uh, you know, when you go into hospital or, um, wherever you give birth, you expect everything's going to be fine. You expect that you're going to come out.

It's all gone. I've been fine. And you'll come out with your baby. And when that doesn't happen on there's a massive breach of trust between that those people who were supposed to have cared for you haven't and you've ended up with a [00:36:00] psychological or physical injury or your baby hunts or a death that fundamentally breaks a trust.

That then can become generalized and relationships in systems and people don't feel like they can take a risk and go out into the world in a way that they had done before that happened.

Debbie Sorensen: Yeah.

Jan Smith: And then there's more physical things, you know, for some women who have perhaps ended up with a colostomy bag, Or, um, life-changing physical injuries that again is adjusting on monitor and mat on their sense of identity and confidence in themselves return into work and may not happen. So what [00:37:00] comes that sounds like such a long-winded I'm just hearing myself, it sounds like such a long-winded way.

Of answering your question, that people can come with a vast array of difficulties and that they would never necessarily come with John. I've had a birth trauma. It's not all from people will come with that as the primary issue.

Debbie Sorensen: Oh, I could see that. First of all, that it, there are so many different responses to birth trauma. That, to answer that question, you can't do it justice in two sentences. And that sometimes the way that's showing up might not be an obvious. It might not be obvious that it's rooted in the trauma, that it's a trauma response because it's more something that's happening in the person's life.

Jan Smith: Yeah, yeah. Especially if the baby is okay.

Debbie Sorensen: Yeah.

Jan Smith: Do [00:38:00] you know, what's not the thing of some sin. It might come through their responses and trying to regulate themselves. It could be, you know, I'm just drinking a bit too much, or whenever my partner comes on, we begin to initiate intimacy or any kind of sexual relations together.

I go really rigid on something, happens to me. And I'm not really sure what.

Debbie Sorensen: Yeah. Yeah.

I I'm glad you had acknowledged the partner who's involved, that it can be traumatic For them as well. And I've actually known a couple of people where, um, it was a male partner and the, the wife giving birth was kind of wheeled off in an emergency and the. The husband is sitting there thinking, I don't know if my baby's going to make it, or if my wife's gonna make it.

Um, I just, I'm just grateful that you acknowledged that that is also traumatic.

Jan Smith: [00:39:00] For sure. Absolutely. Absolutely. And it's, I guess there's, that's a different narrative for if the partner is male, do you know? Because, um, if his wife and baby then, or partner and baby then are okay. There is that narrative around? Well, I should just be fine. I should just be able to get on with it. So actually a lot of what in those instances, um, Dodds might present with a is I just feel really, really angry a lot of the time, and it's really out of character for me.

So. There is, or I'm due to go to the GP or the hospital. And something really weird happens to me and I just end up avoiding it. I'm not sure why.[00:40:00]

Debbie Sorensen: Yeah. And connecting those dots, maybe part of the challenge.

Jan Smith: Yeah, absolutely. Absolutely.

Debbie Sorensen: So one other piece, I just want to kind of highlight this, um, is. The NICU, the NICU experience when the baby maybe is premature or has a complication. And I actually had a NICU experience myself as well, which I, I'm kind of telling a little bit of my own story here too.

Mine was actually when. Same first daughter was 13 days old. She got an infection and had to go on IV antibiotics that took a couple of days to figure out why she had a fever. So wasn't a premie, you know, again, she was nine pounds, um, when she was born, but it wasn't a premiesituation, but I can really relate to just how difficult it was to be in the NICU with this tiny baby.

And it's very stressful. Is that something that you all see? [00:41:00] Work with in your practice? Yeah,

What, what are some of the stressors around that?

Jan Smith: I mean, Annie at the most obvious thing is to know us women. We are evolutionary program to have our little babies close to us. So that separation. Do you know, is a massive and difficulty and really difficult to navigate because Rashmi, you know, that your baby needs that support. I'm not healthcare. And however, that's not what your body and your brain are programmed for.

Your brain and body are programmed to have that little person really close to you a lot of the time. And also. The intensity, what parents share with me is that intensity of being in a situation of not knowing just [00:42:00] as you say it, those two days of what's happening to my baby. Do you don't is my baby going to be okay?

Have I done something? I didn't really know what I was doing anyway. The common apparent do you know or not transition? Did I do something? Did I not do something? Do you know? Come calm, internalized a skilled, um, and. Never rarely find a night, the answer as well. Do you know if like example your

baby was in there for however long and you never really find out why she had the infection?

I think what that can do then is what if that little person is able to return home, it increases the anxiety of check-in those check and behaviors. Are they. What am I doing? So that hypervigilance that we know is present in [00:43:00] trauma anyway, becomes personified, Arden, sleep deprivation on that, you know, we know sleep and disrupted sleep is another probably universal symptom of trauma.

And so add that in, on top of that, it is just a cocktail off potentially become quite unwell mentally.

Debbie Sorensen: Yeah.

it was, uh, in my experience. So we were there for about two weeks and it was so exhausting on top of the regular newborn, you know, sleep deprivation. And it was the most just emotionally, I mean, I don't think I've ever cried more in my whole life than I did during that period, because it's so sad to see your little baby there.

And you're so terrified and

Jan Smith: um,

Debbie Sorensen: doing all the things you have to do to. You know, take care of the child, but it's just, yeah, it's very, I feel for people and I think a big value for me behind conversations like this is helping people know they're [00:44:00] not alone, that it is hard. And that if you're in that situation, I feel for you. It's just a very tough place to be some glad there are people Jan, like you who are out there supporting folks who have had these kinds of experiences.

Jan Smith: Yeah, yeah. On a text, you know, I think for them to acknowledge that there they have needs in that space as well. Do you know, like, what I will say to parents is have you had a drink today? Have you had anything to eat? Do you know that basic need of it's okay. To tend to your needs on. Be there for your little person on nuts, not high.

Most parents see the beginning of third journey into parenthood with that child. So what's also making sense of that. This isn't what, this isn't what I signed up for. This isn't what I thought it would be.[00:45:00]

Debbie Sorensen: exactly. It's um, it's different than you had hoped. I,

Jan Smith: Mm.

Debbie Sorensen: I had to buy a father's day. Card for my husband. It was his very first father's day. I had to buy the card and the gift shop of the hospital because I was just there all the time. And I thought this is so sad. His first father's day.

And we're sitting here in children's hospital, you know, just, that was another teary moment for me. Cause I think it was just so not what I expected.

Jan Smith: absolutely. Yeah,

Debbie Sorensen: So you've, you've highlighted a few of the themes in your work to help people, you know, the avoidance and control. And I know that you take an act approach and we talk in this podcast a lot about acceptance and commitment therapy. Um, and I'm sure again, it's, there's a huge range in what you're seeing in your practice, but are there just a couple of things you might want to highlight that are.

Maybe helpful from the act approach in working with people who have [00:46:00] experienced birth trauma.

Jan Smith: Yeah. Um, I guess, I mean, you know, yourself, Debbie, that could be a whole podcast in itself.

Debbie Sorensen: a big question,

Jan Smith: absolutely am. Right. I suppose to actually that come, that straightaway, came to my mind were. Picking your values as a parent. So what I do say to people is don't get too hung up on the detail off it, just pick two or three that come to mind as the kind of parent that you want to be and what behaviors you might demonstrate.

That align with those values. So for example, it could be, if, if we take, um, the situation that you were in, um, Debbie, and your experience around [00:47:00]

band and NICU, do you know, how do you square the type of parent? You want to be a NICU when your little person isn't as accessible to you as if you were at home.

So it could be, you show. And you show up, you connect with them. So let's perhaps then get more creative and how you connect with them. It might be, you still do redone. The stories that you thought you might be doing. It could be that you stroke their little hand or other. It could be you talk to them. It could be you show them photos.

It could be your scent. So you start to then broaden the night. Okay. This definitely isn't the situation that I thought I was going to be in as a parent. However, how can I still do it in a way that is meaningful and valuable and connects with, um, the type of [00:48:00] parent that I want to be, or if you are a parent of a child with a disability.

I guess there's a huge amount of, care that goes care in jobs, care in tasks, and it could be the way you do those tasks. So it could be, do you know, you do those? Um, and rather than on this could be not necessarily just with the disability, it could be anything. You talked to your little baby, you try and make eye contact you and kiss them.

You do all of those things in a way while still doing those jobs that you need to do. So I think connecting with your values and what, what that is, and that can be whatever you need that to be. Another one is expect that your mind. Is going to just be very, [00:49:00] very light, very light in the sense of it is going to show up and say things to you that are incredibly unhelpful.

I mean, I'm sure you'll have things Debbie, that your mind said to you. I remember when I was a parent for the first time. And I couldn't get the promise. It's Heinz really simple, doesn't it? But my mind just spatially doesn't work like that. So what I would do is avoid going out because, you know, I'm not even a good enough mom, that I can put my baby into a stroller or prom and walk.

And so I'll just stay inside. And actually what that was doing was taking me further away from being the parent that I wanted to be, which was go, I chew my baby, the trees on. All it needed for me to do I say all. No, actually it [00:50:00] took an immense amount of courage at the time for me to do was to say to my twin not came up.

I don't know how to put up the pro and this was a huge thing. So I think it's expecting that our minds are going to be really loud and how we can be compassionate in that space. So it could be okay if one of my friends or family came and said, John you're useless because she can't even put up. I would never respond and the way that I responded to myself.

So what's Mabee then right. What would my best friend voice say right now in this space, in this moment? So I guess those are two things that jump bite.

Debbie Sorensen: Yeah.

the kind of being a little kinder you're to yourself, but I also love that you acknowledged it and got some support around the, the prime example. Like. Just that reaching out piece. I mean, whether it's to [00:51:00] someone like yourself, a professional who could help with some very serious distress about it, or getting support from the people in your life that you care about.

And I think again, the more people acknowledge their struggles around this, the better.

Jan Smith: absolutely. Absolutely. And stay off social media. Because actually that is such a false, there's some things on that that are really false on how it should be. So it's all kept on mute from that and actually find the space where you feel more safe on.

Debbie Sorensen: Yes, social media is ripe for comparison with

Jan Smith: Yeah,

Debbie Sorensen: people's experience. Yeah, Well, in one, one thing that I think. It's very interesting to think about from your work is the relationship between the person giving birth and the maternity staff, um, sort of during and after the process.

And I think sometimes there's a breach of trust there [00:52:00] as you talked about, I'm also. Just aware that, you know, for instance, sometimes if there is a problem there's like an abrupt end to the relationship. Um, I was wondering if you could just talk a little bit about that impact and also, you know, if you have any suggestions around that,

Jan Smith: Yeah. I mean, I think that's a fantastic question because, a lot of my work is supporting families through the litigation process and, um, No family that I've met in all the time that I've been doing this, they all come with two of the fundamental reasons why they are pursuing litigation.

It's never for the monetary value. It is. They want an acknowledgement. And an apology for what has happened. So that sense [00:53:00] of right. A wrong, even though it won't change the eye calmness surly, and they don't want to, to happen to another family. And so I have mediated actually, between, when you sit down with the maternity staff, the midwife and the obstetricians and the family.

On time, incredibly repairative that can be because if something fundamentally has gone wrong and you're either psychologically traumatized, your baby has died perhaps, or you or your baby have been left with life-changing injury. So your, your life is never going to be the same again. You want an element of being able to have that closure?

Did that person know the [00:54:00] impact that they have had on me? Did they know that in that moment, what they did had a life-changing effect and have they learned from it and in the absence of that, those conversations. I think that is something that a lot of families are left, wondering, have they learned? And are they truly sorry?

So they might get an apology from the hospital, but is that midwife or that obstetrician? Sorry. And I also hear it from the midwives and obstetricians side where they are like, we just want to say, sorry, we just need that acknowledgement. And to explain why we made those decisions or why we didn't make those decisions and say where, sorry, do you know no healthcare [00:55:00] professional gets into their line of work to cause harm.

Do you know? Certainly, thankfully not in my career to date. Have I met any staff who want to cause harm? That is furthest from what is important to them. And so being able to have that space where they can try and begin that repairative process for both, I think is massive. And in the absence of doing that, that's a lot of what my work is trying to hold that for the families that they may not have.

Get the answers that they need and for the staff that they may never get the forgiveness from the families that they desire.

Debbie Sorensen: Hmm. Oh, wow. Yeah.

I mean, I think there is something so healing to have that human to human connection. It's hard for both sides. And I just [00:56:00] would really love to see that be more commonplace where there are opportunity. Can I'll tell one more quick personal story. If I might've not. Well, I promise I'll stop talking about myself so I had to go into for a follow-up visit for myself, with my OB while my daughter was in the NICU.

And I had a, the physician who delivered my baby was not the one I had been seeing during my pregnancy. she, she was on call that night. So she came in and. So I had my followup with her and when I told her what was going on, but my baby had an infection or was in the NICU, her eyes teared up a little bit and she gave me a hug

Jan Smith: Um,

Debbie Sorensen: was so, I mean, it wasn't the situation where she was involved in, you know,

Jan Smith: yeah.

Debbie Sorensen: Th the problem, but I felt that felt so wonderful to me.

I switched nothing. There was nothing against my [00:57:00] previous OB, but I just felt like so understood by her. And I think in medicine, sometimes the culture is that, you know, we have to be clinical And we can't be expressing that kind of thing, but it just meant a lot to me. It was just so kind of her, um,

Jan Smith: I think the kindness is something that we massively can show because we all want to not moment of vulnerability. Someone on it signs like what that obstetrician done is she seen you, she seen your eyes squish and your pain, and she was willing to get alongside you with it. That takes a vulnerability and her to reach out, to do that.

Debbie Sorensen: Absolutely. Yeah. I really appreciate it to this day. I'm very grateful to

Jan Smith: Um,

Debbie Sorensen: that nine years later.

Jan Smith: Yeah on it. Is those small acts of kindness [00:58:00] for sure.

Debbie Sorensen: In your book, you write a lot about the systemic and culture factors that are important to address here. I think in, in healthcare, in general, and specifically in maternity, And I know that you do some work with organizations creating psychologically safe and positive working cultures.

How do you create that in your team and in your life? How do you, um, create an environment like that? Because perhaps the ways in which you and your team, care for yourselves could be a good example for others.

Jan Smith: Yeah. Yeah. Yeah, I suppose I'm thinking, oh, I hope my team do feel that, that, you know, the cared for and safe. So I guess, I very much, try to have a flattened hierarchy. So although I, I'm the director of the service. We have very peer led things. [00:59:00] Do you know, on it feels very collaborative.

What I always say is we don't have to feel kind to be kind gentle. Kindness is a verb. Love is a verb, so we can act and behave and wares that show each other. That we're kind, but it's also acknowledging we work in a really hard space. Do you know, undone doing that. I set up things so that staff know that they are following you down, they're cared for.

So for example, if we are doing, an intense am project, what I will do is I will set up weekly drop-ins for everyone to come with cakes, with tea on. They can just share whatever is needed to share. And also we, I make myself [01:00:00] available from actually block and I time people can go on there and just, you know, bookend to see me.

They've got my calendar. They can. And book themselves in and I do that more in small ways as well. So when I check in and say, hi, how are you? It's not a, oh, how are you on, we start talking about something else it's creating the space for. I I'm able to spend time and really listen to how they are. Also with being civil, do you know, what's been respectful and, when someone acknowledges and, we have, um, success and the team it's a shared success.

Do you know, everyone massively champions one another own, which is so incredibly, great to be part of it's [01:01:00] I feel really lucky to be part of the team and we have fun. Do you know? So we have everybody as a WhatsApp

group and I don't, they, so we share a lot of lightness on a lot of laughter on there as well.

Debbie Sorensen: some humor.

Jan Smith: Yeah, absolutely.

Debbie Sorensen: Well, you do hard work, challenging work. I'm sure.

it's very, um, you know, emotionally exhausting at times. And I think there's, you know, there's that high level structural change. There's the individual, you know, support that people need. But this is a very important level. Just like having a supportive team, having people you can go to during the ups and downs and laugh with and be, be honest with. Yeah.

Jan Smith: And it's also been able to give feedback to one another, you know, honest feedback, but actually it's fed back in a way that is respectful, unkind.

Debbie Sorensen: Wonderful. Okay. The final question here, [01:02:00] I'm concerned about people who might be listening to this episode who are pregnant or who may someday plan to give birth. Um, again, you're not alone. It's the words I read. It's hard and you can do it right.

Jan Smith: Yeah, absolutely.

Debbie Sorensen: hard, but it can be very hard and you can do it and scary.

Do you have any advice for people who might have birth in their future?

Jan Smith: Yeah.

Um, I think it goes back to what I was saying at the beginning of our conversation. Debbie birth is on a continuum. Do you know on where? All on my continuum somewhere, what I would say. What people share with you there? I dunno what it was like for you, but in my pregnancies, whenever people say that I was pregnant, it was like they had no filter.

They just started to talk about their own births. Do you know, every respective of Hyatt was it's okay to put in boundaries. Do you know? You don't [01:03:00] need to absorb everyone else's experiences, but also what support do you need?

To enjoy your anti-natal experience to enjoy your birth and experience on tough, that support that you would need to postnatally as well.

Debbie Sorensen: That's great advice. Yes. Yes. well.

Jan, Thank you so much for coming on the podcast today. Um, and congratulations on your multiple books that you have. And in the works and really appreciate the work that you're doing.

Jan Smith: Thank you for inviting me and for having the conversation, I've really enjoyed it.

Debbie Sorensen: Me too. Thank you, Jan.

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