Submission No 239

INQUIRY INTO BIRTH TRAUMA

Organisation: Centre for Women's Health Research and Australian Longitudinal Study on Women's Health

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CWHR
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Inquiry into Birth Trauma Submission

This submission is made on behalf of the Australian Longitudinal Study on Women's Health (ALSWH) and the Centre for Women's Health Research (CWHR). The following ALSWH and CWHR-affiliated researchers with expertise in women's health have contributed to the recommendations presented in this submission: Professor Deborah Loxton, Ms Natalie Townsend, Ms Isabelle Barnes, Dr Nicole Reilly, and Dr Catherine Chojenta.

This submission focuses on findings from ALSWH, a long-established national study that takes a comprehensive view of health, and the factors that affect health, across a woman's lifespan. Since 1996, ALSWH has collected data from over 57,000 women in four age cohorts using regular surveys and individual record linkage to administrative health databases, including Medicare (MBS, PBS), hospitals, and perinatal data. ALSWH provides evidence to inform policy development and the provision of health services, and to support new and revised clinical guidelines for health professionals. In this submission, we present findings from women in the two youngest ALSWH cohorts (spanning ages from 18 to 48) which are highly relevant to this inquiry.

Submission summary

This submission outlines findings from the Australian Longitudinal Study on Women's Health in relation to:

- The prevalence of potentially traumatic birth experiences among women born 1989-95 and 1973-78, including birth interventions, long labour, emotional distress during labour, and stillbirths;
- Risk and associated factors for potentially traumatic birth experiences; and
- The relationship between potentially traumatic birth experiences and mental health.

Recommendations to improve obstetric and perinatal care are also presented.

Submission contacts

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Potentially traumatic birth experiences

- More than one in three women (35% of women born 1989-95 and 41% of women born 1973-78) living in NSW who had given birth reported having a potentially traumatic birth experience (emergency caesarean, labour lasting more than 36 hours, emotional distress during labour, or stillbirth) [1, 2]:
  - 27% of women born 1989-95 and 26% of women born 1973-78 had experienced emotional distress during labour.
  - 17% of women born 1989-95 and 21% of women born 1973-78 had experienced emergency caesarean.
  - 10% of women born 1989-95 and 1973-78 had experienced labour lasting more than 36 hours.
  - 1% of women born 1989-95 and 2% of women born 1973-78 had experienced stillbirth.
- Around a third of women (34% of women born 1989-95 and 1973-78) living in NSW had a potentially traumatic birth experience the first time they gave birth [1, 2]:
  - 26% of women born 1989-95 and 22% of women born 1973-78 experienced emotional distress during labour the first time they gave birth.
  - 16% of women born 1989-95 and 17% of women born 1973-78 experienced an emergency caesarean the first time they gave birth.
  - 9% of women born 1989-95 and 1973-78 experienced labour lasting more than 36 hours the first time they gave birth.
  - 1% of women born 1989-95 and 1973-78 experienced stillbirth the first time they gave birth.
- At the national level, 46% of women born 1989-95 and 37% of women born 1973-78 experienced a potentially traumatic birth the first time they gave birth [3].
- The reported prevalence of potentially traumatic birth experiences for women born 1989-95 giving birth the first time is slightly lower for those women living in NSW compared to the prevalence reported at the national level (34% versus 46%) [1, 3]. This suggests that there may be some differences in potentially traumatic birth experiences and healthcare practices between states and territories in Australia.

Multiple potentially traumatic birth experiences

- Australian women commonly experience multiple potentially traumatic birth experiences. Among those reporting potentially traumatic birth experiences, more than one in four experienced two types of birth trauma [3].
- Among Australian women, emotional distress during labour was associated with other potentially traumatic birth experiences, including labour interventions, excess blood loss, long labour, premature birth, and stillbirth [1, 2]:
  - Women who had experienced induction were 1.5 times as likely to experience emotional distress during labour than those who had not experienced induction (Risk ratio=RR 1.5, 95%CI 1.3-1.7 for women born 1989-95 and RR 1.5, 95%CI 1.3-1.6 for women born 1973-78).
  - Women who had experienced an episiotomy were 1.3 to 1.6 times more likely to experience emotional distress during labour than those who had not experienced an

episiotomy (RR 1.6, 95%CI 1.3-1.9 for women born 1989-95 and RR 1.3, 95%CI 1.2-1.5 for women born 1973-78).
  - Women who had experienced forceps or a vacuum during labour were 1.6 to 2.4 times more likely to experience emotional distress during labour than those who had not experienced forceps or a vacuum (RR 1.6, 95%CI 1.4-2.0 for women born 1989-95 and RR 2.4, 95%CI 2.1-2.7 for women born 1973-78).
  - Women who experienced an emergency caesarean birth were 2.5 to 3.1 times more likely to experience emotional distress during labour than those who had not experienced an emergency caesarean (RR 2.5, 95%CI 2.1-2.9 for women born 1989-95 and RR 3.1, 95%CI 2.8-3.4 for women born 1973-78).
  - Women born 1973-78 who experienced excess blood loss were 1.4 times as likely to experience emotional distress during labour than those who had not experienced excess blood loss (RR 1.4, 95%CI 1.3-1.7).
  - Women who experienced a labour lasting more than 36 hours were 1.3 to 1.8 times more likely to experience emotional distress during labour than those who had not experienced a labour lasting more than 36 hours (RR 1.3, 95%CI 1.1-1.5 for women born 1989-95 and RR 1.8, 95%CI 1.6-2.1 for women born 1973-78).
  - Women born 1973-78 who experienced a premature birth were 1.7 times more likely to experience emotional distress during labour than those who had not experienced a premature birth (RR 1.7, 95%CI 1.5-2.0).
  - Women who experienced a stillbirth were 2.1 to 3.5 times more likely to experience emotional distress during labour than those who had not experienced a stillbirth (RR 2.1, 95%CI 1.3-3.2 for women born 1989-95 and RR 3.5, 95%CI 2.7-4.6 for women born 1973-78).

Risk and associated factors for potentially traumatic birth experiences

- Some labour interventions have been associated with other maternal health factors. For women born 1973-78 [4]:
  - Episiotomy and/or instrumental labour interventions (forceps/vacuum) were more likely among those with chronic hypertension than women who did not have hypertension.
  - Emergency caesareans were more likely among those who were overweight or obese before pregnancy than women who were a healthy weight before pregnancy.
- Mode of delivery (i.e. vaginal birth, planned caesarean, emergency caesarean) the first time a woman gives birth is a strong predictor for the mode of delivery for subsequent births [5], indicating that women who have experienced some potentially traumatic birth experiences may be at increased risk of experiencing this again for subsequent births.

Relationship between potentially traumatic birth experiences and mental health

- Potentially traumatic birth experiences are associated with an increased risk of postnatal depression and anxiety, even when controlling for sociodemographic factors and antenatal depression and anxiety [3]:
  - Among women born 1989-95, those who had experienced a traumatic birth were 74% more likely to be diagnosed with postnatal depression and anxiety, compared to those who had not experienced a traumatic birth.

  - Among women born 1973-78, those who had experienced a traumatic birth were 63% more likely to be diagnosed with postnatal depression and anxiety, compared to those who had not experienced a traumatic birth.
- Stillbirth and pregnancy loss (including miscarriage, termination due to medical reasons, and ectopic pregnancy) is associated with sadness or low mood and excessive worry during later pregnancies [6].

Recommendations

- The definition of birth trauma used in research settings, policy and practice guidelines vary greatly. Building consensus on how physical and psychological birth trauma should be defined would provide a valuable framework for ongoing monitoring, evaluation and reporting. This activity requires active consultation with women who have lived experience of physical and/or psychological birth trauma, policymakers, researchers, and practitioners.
- Current maternity services strategies and clinical practice guidelines have prioritised the delivery of safe, respectful woman-centred maternity care, and the needs of women at risk of, or who have experienced, physical and/or psychological birth trauma [7, 8, 9]. To inform ongoing monitoring, evaluation and reporting of outcomes against these initiatives, there should be investment in robust quantitative and qualitative research that:
  - Captures the lived experience of women who have experienced physical and/or psychological birth trauma, to assist in identifying what women experience as trauma during birth, what helps women cope with the trauma, and what assisted in recovery from the experience.
  - Increases the evidence base relating to risk and protective factors for physical and psychological birth trauma, which may include (but not be limited to) pre-conception health, models of maternity care, community and practitioner knowledge, awareness and training, and autonomy of decision making.
  - Informs the development of appropriate care pathways for the prevention and management of physical and psychological birth trauma that are well-resourced and accessible.
- Existing longitudinal studies, such as the Australian Longitudinal Study on Women's Health, should be utilised to monitor, evaluate, and report on the incidence, prevalence, and short- and long-term outcomes for women who experience physical and/or psychological birth trauma, and to examine the impact of policy and practice initiatives over time. ALSWH data have been previously used to evaluate the impact of universal perinatal mental health screening [10] on referral and engagement with care, and to monitor adherence to clinical practice guidelines over time. Using existing established longitudinal studies is cost effective, and offers a depth of data not available elsewhere (27 years of data, including linkage with MBS, PBS, and other administrative datasets including perinatal data collections). Longitudinal data is also captured over time, offering a unique ability to follow and evaluate changes in policy and practice guidelines.
- There is a need to increase healthcare providers' understanding of traumatic birth experiences, the risk factors for having these experiences, and the long-term consequences for women who have these experiences. Therefore, investment in strengthening the workforce and training health practitioners in providing trauma-informed maternity and obstetric care, including aftercare and referral pathways, is needed.

- There is a strong association between traumatic birth experiences and poor perinatal mental health. This underscores the need to include past traumatic birth experiences in psychosocial risk assessment in subsequent pregnancies.
- Although the definition of birth trauma is varied, it is clear that potentially traumatic birth experiences are common among Australian women. Therefore, there is a strong need to integrate evidence-based recommendations for the prevention and management of physical and psychological birth trauma into maternity-related policies, clinical practice guidelines and training and professional development packages.

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