Submission No 254

INQUIRY INTO BIRTH TRAUMA

Organisation: The Australasian Birth Trauma Association

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NSW Parliamentary Inquiry into Birth Trauma

Submission

The Australasian Birth Trauma Association

August 2023

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About the Australasian Birth Trauma Association

> *"Women go through some of the worst times of their lives, and society tells you, 'You had a baby, you should be happy.' The reality is that birth trauma affects women long after… the day they deliver. I still carry pelvic floor damage, PTSD and depression from my experience. We rely on support from those who understand, care and recognise the battle we have faced. If I did not have the ongoing support from the ABTA team, I don't know that I would be writing this letter to you today. I don't know that my daughter would have me as her Mum." -*

The Australasian Birth Trauma Association (ABTA) is pleased to contribute to the NSW Parliamentary Inquiry into Birth Trauma and would like to thank the Committee for the opportunity.

ABTA became a registered national charity in 2016. We are the first charity in Australia solely dedicated to supporting women, birthing people, fathers and partners after birth-related trauma – we listen to the consumer's voice and respond to the unmet needs of birthing families across Australia. For seven years, we have helped increase awareness and understanding of birth-related trauma and worked to improve maternity services to ensure people with birth-related trauma have the best care and quality of life possible.

We are committed to achieving safer births and better healing and supporting birthing families to understand the risks of birth and, in the event of trauma, to access timely diagnosis and a pathway to recovery.

Executive Summary

Birth-related trauma remains a significant issue that affects thousands of individuals and families across NSW. Our submission to the *NSW Parliamentary Inquiry into Birth Trauma* contains evidence gained through years of listening to stories from women, birthing people, families, and health professionals, delivering information, training, and support services, partnering with researchers, and working with like-minded organisations whilst working toward safer births and better healing.

Our submission highlights the key issues surrounding the pervasiveness, causes and devastating impact of birth-related trauma in NSW. To form our recommendations, we have drawn upon research from around the globe and grounded it with stories. These stories were bravely shared with us by women, birthing people, their partners and health professionals who have experienced birth-related trauma in NSW.

We define "birth-related trauma" as any injury or trauma, whether physical or psychological, sustained at any time in connection with all stages of the birth journey - from conception and pregnancy, through to labour and birth, and in postnatal care - and can affect the mother, birthing parent, fathers or non-birthing parents.

While some birth-related trauma experiences are unavoidable, many experiences are avoidable and preventable. From personal stories and academic research, we understand that various issues contribute to experiences of birth-related trauma. These issues can be broadly categorised at the personal, healthcare system and societal levels.

> *Personal circumstances* can contribute to birth-related trauma, such as the impact of an individual's history of trauma, pre-existing conditions, identity and social demographics.
>
> *Healthcare system* can contribute to birth-related trauma due to:
> - mistreatment, dismissal and neglect by health professionals
> - inappropriate, disrespectful and abusive treatment
> - lack of informed consent
> - lack of communication
> - lack of comprehensive education for pregnancy, birth and early parenthood
> - misdiagnosis or delayed diagnosis
> - complications, medical procedures and interventions
> - lack of postnatal social and care pathways
> - health system policies and structures that lack a person-centred focus
> - lack of professional collaboration
>
> *Community and Societal norms* can contribute to birth-related trauma including stigma and shame over ongoing psychological and/or physical challenges and the lack of awareness and understanding of birth-related trauma and lack of trauma-informed care.

There is an urgent need for enhanced awareness, support, and reform to address the distressing impact of birth-related trauma on women, birthing people, fathers, non-birthing people and health professionals. Many women, birthing people, and their families report having their experiences dismissed before, during, or after birth.

We recommend that the NSW Government:

1. Review and update terminology
2. Enhance birth-related population-level data surveillance
3. Build the evidence base through policy-academia-consumer partnerships
4. Enhance health professional training and support about preventing and healing from birth-related trauma
5. Provide services to support and recover from birth-related trauma as experienced by health professionals
6. Enhance health service policies and practice for better screening, diagnosis, and response
7. Enhance health services for improved access and inclusivity
8. Enhance antenatal and postnatal education (for women, birthing people, fathers and families)
9. Invest in community-based services to support and improve recovery from birth-related trauma
10. Raise community awareness about birth-related trauma (what it is, how to prevent and recover from it)

Addressing birth-related trauma requires a collaborative effort from health professionals, stakeholder groups, policymakers, and most importantly, people who have experienced birth-related trauma.

By acknowledging the importance of physical, psychological and emotional wellbeing before, during and after childbirth, and implementing targeted reforms, we can alleviate the burden of birth-related trauma and improve the overall birthing experience for families. We understand that the scope of this inquiry seeks experiences and practices in NSW, but the stories and data that ABTA has gathered over the last seven years extend across the nation.

This submission urges parliament to take proactive steps towards preventing birth-related trauma and supporting those affected by birth-related trauma. By prioritising physical health, mental health and emotional well-being, we can pave the way for a safer, more supportive, and trauma-informed approach to maternity care.

The ABTA would welcome the opportunity to discuss our findings and recommendations with members of the NSW Parliamentary Select Committee on Birth Trauma, and with members of the NSW Government.

Sincerely

Amy Dawes, CEO

Amanda Turnill, Board Chair

Structure of the Submission

The ABTA submission provides information on all terms of reference organised thematically as follows:

1. Definitions of birth-related trauma and associated concepts;
2. Prevalence of birth-related trauma;
3. Impacts of birth-related trauma; and
4. The factors influencing and contributing to birth-related trauma.

To assist in the review of this proposal, the following table outlines how our submission aligns with each of the Terms of Reference statements.

Inquiry Terms of Reference	**Relevant section/s**
a) the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")	Section 2 - Prevalence of birth-related trauma Section 3 - Impacts of birth-related trauma
b) causes and factors contributing to birth trauma including: i) evaluation of current practices in obstetric care ii) use of instruments and devices for assisted birth e.g., forceps and ventouse iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth	Section 4 - Why and how does birth-related trauma occur?
c) the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers	Section 3 - Impacts of birth-related trauma
d) exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular: i) people in regional, rural and remote New South Wales ii) First Nations people	Section 4.1 - Personal circumstances

iii) people from culturally and linguistically diverse (CALD) backgrounds iv) LGBTQIA+ people v) young parents	
e) the role and importance of "informed choice" in maternity care	Section 4.2.3 Lack of informed consent in maternity care
(f) barriers to the provision of "continuity of care" in maternity care	4.2 Impact of the healthcare system
(g) the information available to patients regarding maternity care options prior to and during their care	4.2.5 Lack of comprehensive education for pregnancy, birth and early parenthood
h) whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma	See all recommendations
(i) any legislative, policy or other reforms likely to prevent birth trauma, and	See all recommendations
(j) any other related matter.	All sections, including Section 1 - Definitions of birth trauma and associated terms.

Recommendations

Thank you for the opportunity to contribute to the NSW Parliamentary Inquiry into Birth Trauma. Our recommendations are framed around ten themes:

1. Review and update terminology
2. Enhance birth-related population-level data surveillance
3. Build the evidence base through policy-academia-consumer partnerships
4. Enhance health professional training and support about preventing and healing from birth-related trauma
5. Provide services to support and recover from birth-related trauma as experienced by health professionals
6. Enhance health service policies and practices for better screening, diagnosis, and response
7. Enhance health services for improved access and inclusivity
8. Enhance antenatal and postnatal education (for women, birthing people, fathers and families)
9. Invest in community-based services to support and improve recovery from birth-related trauma
10. Raise community awareness about birth-related trauma (what it is, how to prevent and recover from it)

1. Review and update terminology

That NSW Health adopts the term 'birth-related trauma' in maternity health policies and key documents to acknowledge the complex and often compounding nature of traumatic events and experiences in the perinatal period from conception to early parenthood.

That NSW Health explores the development of a definition of 'birth-related trauma' to inform any future updates to NSW Health policies and practices.

That the NSW Government invest in independent, multi-perspective research into the concept of 'obstetric violence', informed by health professionals, parents with a lived experience of birth-related trauma, and individuals with diverse cultural backgrounds to better understand their perspectives and to collaboratively decide on the best approach to understanding, referring to, and addressing 'obstetric violence'.

2. Enhance birth-related population-level data surveillance

That NSW Health enhances population-level data methods to capture instances of birth-related trauma effectively. This data should include population groups, including women, birthing people, fathers and non-birthing people, obstetricians, midwives, and other maternity care providers.

That NSW Health investigates data linkages to comprehend the lasting effects of birth outcomes on postnatal recovery and develop a Patient-Reported Outcome Measurement Study to assess mental and physical well-being beyond six weeks post-birth.

3. Build the evidence base through policy-academia-consumer partnerships

That the NSW Government, in partnership with academia and consumer-led organisations, build the evidence base regarding the prevalence, factors and impacts (such as the family, professional, social, and economic impacts) of birth-related trauma on:

- women and birthing people including:
    - LGBTQI+ populations
    - Culturally and Linguistically Diverse (CALD) communities
    - Aboriginal and Torres Strait Islander peoples
    - people with disabilities
    - people from different socioeconomic backgrounds
    - young parents
    - families in rural, regional and remote areas
- fathers and non-birthing partners
- obstetricians, midwives, and other maternity care providers.

That the NSW Government, in partnership with academia and consumer-led organisations, build the evidence base into the following topics that link to the prevention and recovery of birth-related trauma for women, birth people, fathers and non-birthing partners:

- psychological trauma in general
- post-traumatic stress disorder
- perinatal depression, anxiety
- Suicidality
- Birth Injuries

That the NSW Government, in partnership with the Federal Government, fund a national research priority into the social and economic impacts of birth-related trauma.

4. Enhance health professional training and support about preventing and healing from birth-related trauma

That NSW Health addresses the need for more support, training and workplace cultural change within midwifery and obstetrics to address vicarious trauma. Additional training on birth-related trauma for the perinatal health workforce is critical to ensuring appropriate care for women, birthing people and their partners.

That the NSW Government enhance training and education for health professionals in the maternity care system on both physical and psychological birth trauma, how it impacts people's lives, how they can play a role in better prevention, diagnosis and treatment and improving understanding, identification and response to vicarious trauma among health professionals.

5. Provide services to support and recover from birth-related trauma as experienced by health professionals

That NSW Health enhance awareness raising of vicarious trauma experienced by health professionals as a result of witnessing birth-related trauma.

That the NSW Government explore support, training and workplace cultural change within midwifery and obstetrics to address vicarious trauma among health professionals.

That the NSW Government review the application of the NSW Integrated Trauma-Informed Care framework in maternity settings to ensure maternity services are trauma-informed, inclusive, and accessible.

6. Enhance health service policies and practices for better screening, diagnosis, and response

That NSW Health promotes its Trauma-Informed Care Framework in maternity care settings.

That NSW Health reviews current practices for screening women and birthing parents for pre-existing trauma and considers implementing early screening to assess for birth-related trauma such as the City Birth Trauma Scale; BiTS[1] in line with the recent update to the COPE Perinatal Mental Health Guidelines.

That NSW Health explores mechanisms to increase access to imaging services capable of diagnosing somatic trauma in tertiary maternity hospitals.

That NSW Health undertakes a review of NSW maternity care practices to ensure compliance with current policy and law, with particular consideration of genuine birth mode choice as a routine feature of maternity care; enabling appropriate information on risks be shared antenatally; and practices at the Local Health District and hospital level be reviewed in line with the NSW Consent Manual.

That the NSW Government, in partnership with the Federal Government, enhances coordinated care pathways to support those who have experienced birth-related trauma and provides the relevant information, support and services to help them navigate their recovery. This may include improving continuity of monitoring health outcomes across the hospital and community health divide.

That NSW Health develops policy and practice responses around providing trauma-informed post-SAMM support in collaboration with people with lived experience of SAMM events. further research into experiences of people with disabilities, mental health conditions, and pre-existing trauma in the maternity care system and links to experiences of birth-related trauma.

That the NSW Government explores options to fund routine access to pelvic health physiotherapy, including prenatal and postnatal assessment and support. This may be addressed through state-funded access through models such as the Pelvic Floor Clinic model (St George Hospital, Sydney), or through working with the Federal Government on funding solutions (e.g. through Medicare).

7. Enhance health services for improved access and inclusivity

That the NSW Government review its policies in collaboration to ensure that maternity policies

[1] Fameli, A. et al. (2023). Assessment of childbirth-related post-traumatic stress disorder in Australian mothers: Psychometric properties of the City Birth Trauma Scale. Journal of affective disorders, 324, 559–565.

are inclusive, accessible, culturally responsive, and trauma-informed, as aligned with the recently released *NSW Integrated Trauma-Informed Care Framework*. This review should be in partnership with people from different population groups with lived experiences of birth-related trauma.

8. **Enhance antenatal and postnatal education (for women, birthing people, fathers and families)**

That the NSW Government enhances community access to multi-disciplinary evidence-informed information on a comprehensive range of birthing practices and potential birth complications to enable informed choice.

That the NSW Government, in partnership with the Federal Government, develop standards around consumer antenatal education content and curriculum, which includes appropriate information on risks and common impacts of birth, including information on factors contributing to birth-related trauma.

That the NSW Government review and enhance standard postnatal information provided to birthing families, including pathways to care.

9. **Invest in community-based services to support and improve recovery from birth-related trauma**

That the NSW Government invest in community-based peer support services to support and improve recovery from birth-related trauma, such as community-based trauma-informed support services in the perinatal period and beyond the first year of parenthood.

That the NSW government extend funding for Perinatal Mental Health Services for up to two years postpartum.

That the NSW Government review access to perinatal mental health support for priority population groups, including in regional and rural areas, and continues to invest in additional support services for families outside of metropolitan areas.

10. **Raise community awareness about birth-related trauma (what it is, how to prevent and recover from it)**

That the NSW Government, through social marketing and health education activities, raises the community's awareness and understanding of birth-related trauma: what it is, how to prevent it, how to access support services to enhance recovery.

1. Birth-related trauma and associated concepts

> *"I had already had a previous trauma of having to have a medical termination at 16 weeks due to the baby having a neural tube defect. My midwife sat at the computer pretty much my whole labour my pain was dismissed, my concerns dismissed. I ended up having an emergency c-section my son was born with two true knots in his umbilical cord. He was very stiff when born hard to change, feeding issues but my concerns were dismissed "I'm just a young mum," "I don't know what I'm talking about." it took ten months to get my son a cerebral palsy diagnosis. I ended up with PND, PNA and PTSD from my hospital experience" - ABTA Support Group*

This section explores a range of concepts and definitions associated with birth-related trauma, including:

- birth-related trauma
- inclusivity
- obstetric violence.

1.1 Birth-related Trauma

This section explores:

- definition of trauma
- Definition of birth-related trauma
- elements of birth-related trauma
- stages where birth-related trauma may occur.

1.1.1 What is trauma

Defining trauma can be challenging because it is a highly subjective experience. However, a widely accepted idea is that trauma results from exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being.[2]

At the core of trauma lies a challenge to our fundamental sense of safety, and its definition primarily rests upon our individual responses to it. The American Psychiatric Association DSM-V defines trauma as an array of reactions stemming from specific distressing events or 'stressors'[3]. Responses to traumatic events are diverse and are deeply influenced by personal circumstances and vulnerabilities, such as prior trauma exposure, access to support and coping styles[4]. It is important to note that trauma can occur not only from direct exposure to a traumatic event but also from witnessing or by learning of such events[5].

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[2] Substance Abuse and Mental Health Services Administration. (2014) SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville (SMA) 14-4884.
[3] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA
[4] Ford J. et al. (2015). Social, cultural, and other diversity issues in the traumatic stress field. Posttraumatic Stress Disorder. 2015:503–46.
[5] Kleber R. (2019). Trauma and Public Mental Health: A Focused Review. Front Psychiatry. 25, 10:451.

1.1.2 Definition of birth-related trauma

Birth-related trauma involves a woman and birthing person's 'experience of interactions and or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to negative impacts on health and wellbeing'[6]. More simply put, ABTA defines "birth-related trauma" as including any injury or trauma, whether physical or psychological, sustained at any time in connection with all stages of the birth journey - from conception and pregnancy, through to labour and birth, and in postnatal care - and can affect the mother, birthing parent, fathers or non-birthing parents[7].

1.1.3 Stages where birth-related trauma may occur

Birth-related trauma is not isolated to the event of birth alone. *Birth-related trauma* rather than *birth trauma* is therefore used to recognise the complex and often compounding nature of traumatic events and experiences in the perinatal period, extending from conception to early parenthood.

Trauma can occur when *trying* to conceive, including challenges with fertility, conception, and in-vitro fertilisation (IVF). Sometimes termed '*reproductive trauma*.'

> *"It took me six years, four operations for endometriosis and nine rounds of IVF to conceive my first, and then I experienced a traumatic birth that has resulted in lifelong injuries"' - ABTA Community member*

Trauma can occur *during pregnancy* when some mothers and birthing people experience conditions such as hyperemesis gravidarum, pre-eclampsia, gestational diabetes, placenta previa or a prenatal diagnosis, high blood pressure, prenatal depression and anxiety, infections. This may also include preterm labour, miscarriages, induced abortions, and terminations for personal or medical reasons.

> *"The grief overwhelmed me, and then came Hyperemesis Gravidarum (HG). I was 6 weeks pregnant and all of a sudden experiencing constant nausea and vomiting that confined me to my bed, making even the simplest tasks like scrolling on my phone, showering or driving a mammoth effort. The word I used to describe my pregnancies is 'poison'." , ABTA Community member*

Trauma can occur *during labour and birth*. Including but not limited to; preterm births, stillbirth, undiagnosed or rare conditions, inductions, emergency caesareans, instrumental deliveries, postpartum haemorrhages, foetal distress, interactions with health professionals, loss of control, feeling coerced into decisions, shoulder dystocia, and other complications for the child.

> *"I had a great pregnancy and labour, and everything was going really well. I was in a midwifery group care model and had really lovely midwives and felt supported and ready for our baby to arrive. Everything was great until it wasn't. Our son crowned and got stuck (shoulder dystocia) for ten minutes. He had reduced oxygen for ten minutes and was resuscitated before being rushed out of the room into the Special Care Nursery. I remember lying on the bed exposed as about 10*

[6] Leinweber, J. et al. (2022). Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper. Birth, 49(4), 687–696.
[7] https://birthtrauma.org.au/our-story/

people all dressed in blue scrubs rushed in surrounding our baby. My partner stood between us both in shock and not sure who to go to." - ABTA Understanding Your Needs Survey

Trauma can occur in the period *after the birth*. This can include breastfeeding trauma, separation from the baby either in the same hospital or with the baby being transferred to another hospital, birth injuries, mismanaged pain, infected wounds, postnatal complications, such as bowel obstructions, bladder distension, and fistula.

"Baby was whisked away to NICU and I didn't see her for almost 36 hours. When I finally did see her, I wasn't allowed to hold her and was scolded by the NICU nurse for offering donor breast milk from a local nicu mama and was bullied into formula. The nurse told me I was starving my baby and that giving her another mum's milk would give her AIDS. Doctors also treated me like a 2nd class citizen." Anon, ABTA Birth Injuries Report

"We were discharged after nearly a week, and my midwife came around to our home two days later. Concerned about weight loss, my midwife instructed me to pump and top up to speed things up. Between the cluster feedings, pumping, sleepless nights and coming to terms with the birth, I was in a terrible place…and yet again I felt like a failure. After months of what I now recognise was severe Postnatal Depression, Anxiety and PTSD symptoms, I was at the end of my tether. - , ABTA Community Member,

For many women and birthing people we support it is often more than one event in the journey to parenthood which we call 'the cascade of trauma'.

"There's so much I feel I missed out with him in those first 9 days; skin-to-skin, breastfeeding, hospital time to name a few. Whilst I know I am extremely lucky to have a healthy baby now and I am recovered physically, I am angry/upset/bitter/disappointed that I experienced birth trauma as well as going through years of infertility to get my babies in the first place. 2 living babies from 9 pregnancies, 8 losses including an ectopic, 2 surgeries and this pregnancy started out as a twin pregnancy. Now I've added birth trauma to my infertility Bingo card." - ABTA Community Member

1.1.4 Elements of birth-related trauma

Birth-related trauma can be both psychological and physical.

Briefly, *psychological birth-related trauma* may relate to a traumatic experience during pregnancy and/or birth and can impact women and birthing people, fathers, non-birthing parents, support people and maternity care providers. Examples of psychological birth-related trauma can include post-traumatic stress disorder (PTSD) or symptoms of PTSD, postnatal depression and anxiety (PNDA) and suicidal ideation and suicide. Psychological birth-related trauma is discussed further in Section 3.1.2.

Physical birth-related trauma refers to birth injuries that women and birthing people can sustain as a result of pregnancy and/or birth. Examples of physical birth-related trauma can include vaginal and labial tears, anal sphincter tears (i.e. obstetric anal sphincter injuries (OASIS), irreparable pelvic floor damage (e.g. levator avulsion), bladder damage, infected wounds, musculoskeletal injuries or fractures such as coccyx fracture or dislocation, pubic bone stress fracture or pubic diastasis, and hysterectomy. Physical birth-related trauma is discussed further in Section 3.1.3.

1.2 Inclusivity

We believe that every pregnant, birthing and parenting individual has the same right to equitable, kind, and respectful care. We acknowledge that all people can experience birth-related trauma regardless of their gender identity, religious and spiritual beliefs, race, culture, and family structure, including;

- mothers and birthing people
- fathers and non-birthing parents
- friends and family members providing support during the birthing process
- other people witnessing birth or providing care in relation to pregnancy and birth, including health professionals.

In this document, where we can, we refer to women and birthing people, mothers and parents, acknowledging that not all people who give birth identify as a woman or a mother. However, there is also limited research focusing on birthing people other than women, and where the evidence dictates, we may only refer to women.

1.3 Obstetric Violence

> *"My baby had shoulder dystocia and the midwife dragged him out, which resulted in the tear. In spite of these injuries, I was treated by the midwives as having had a normal vaginal delivery and was expected to be back on my feet that day. The fact that I was bullied by the midwives and that I was told I wasn't trying hard enough and has contributed to my ongoing lack of belief in my parenting abilities 9 years later". - ABTA Birth Injuries Report*

This inquiry's Terms of Reference include consideration of "inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as 'obstetric violence'. The term obstetric violence is one that has been predominantly used in global contexts and refers to "harm inflicted during or in relation to pregnancy, childbearing, and the postpartum period. Such violence can be both interpersonal and structural, arising from the actions of health professionals and also from broader political and economic arrangements that disproportionately harm marginalised populations"[8].

Obstetric violence is not a widely used term in Australia, with recent research from Keedle et al one of the first significant studies to identify traumatic experiences of maternity care as obstetric violence. It is also not a term that people who have shared their stories with ABTA commonly use. However, the ABTA notes this may be due to not being aware of the terminology. However, one critical aspect where ABTA has heard people relate obstetric violence are instances of being denied pain relief, unconsented vaginal exams, being physically restrained or held down, the use of forceps and being coerced into decisions.

> *"I was cut and torn from front to back. Kellands rotation forceps with Dr's foot on the bed for leverage. It was horrific" - ABTA Birth Injuries Report*

[8] O'Brien, E. & Rich, M. (2022). "*Obstetric violence in historical perspective*". https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01022-4/fulltext.

The mistreatment of women and birthing people (that may be understood as 'obstetric violence') is a significant theme among experiences of birth-related trauma and is explored in Section 4.2 - Impact of Healthcare System.

This inquiry provides a sector-level opportunity to explore the concept further. As noted by Katz et al., "there is no reason to fear the term "obstetric violence", what we need is to make every effort to eradicate it. If the term causes discomfort to the medical community, it also provides space for us to debate the necessary changes"[9]. ABTA welcomes the opportunity to continue discussions and to learn from people who have experienced birth-related trauma.

2. Prevalence of birth-related trauma

This section explores the prevalence of birth-related trauma among:

- mothers and birthing people
- fathers and non-birthing people
- healthcare professionals.

2.1 Mothers and Birthing People

Birth-related trauma and its prevalence is a relatively new area of research, with limited data on the prevalence across the population. Research suggests that in Australia, between 30% and 48% of women identify their birth as traumatic[10]. With 309,996 registered births in Australia in 2021[11], this equates to over 103,000 women and families potentially impacted by birth-related trauma every year in Australia. Extrapolating with NSW data, in 2021, there were 99,316[12] registered births, which equates to between 29,790 and 47,664 women and families potentially experiencing birth-related trauma each year.

Research also suggests that approximately 60% of first-time mothers experience physical trauma during vaginal delivery.[13] Up to 20% of all women who deliver a baby vaginally will require surgery for pelvic organ prolapse, anal or urinary incontinence[14]. In NSW in 2021, approximately 63% of women gave birth vaginally[15]. Based on 2021 figures, in NSW, approximately 12,221 women each year may need surgery at some point for injuries sustained during birth.

The true prevalence of birth-related trauma in NSW (and Australia) is unknown. Current indicators on maternal health outcomes in NSW include some outcomes, such as type of birth, perineal status, pain relief administered, inductions, instrumental deliveries etc[16]. However, the

[9] Katz, L. et al. (2020). Who is afraid of obstetric violence?. *Revista Brasileira de Saúde Materno Infantil*, *20*, 623-626.
[10] Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Birth, 27(2), 104–111.
[11] Australian Bureau of Statistics, 2021. Births, Australia.
[12] 2021 NSW Mothers and Babies report
[13] Caudwell-Hall, J. et al.(2018). Can pelvic floor trauma be predicted antenatally?. Acta obstetricia et gynecologica Scandinavica, 97(6), 751–757.
[14] Smith, F. et al. (2010). Lifetime risk of undergoing surgery for pelvic organ prolapse. Obstetrics and gynecology, 116(5), 1096–1100.
[15] Australian Bureau of Statistics (ABS) 2021, Birth, Australia.
[16] 2021 NSW Mothers and Babies report

current indicators do not capture data on the full spectrum of injuries or impacts, such as pelvic floor muscle damage (e.g. 'levator avulsion'), pelvic organ prolapse or psychological trauma experiences. More data is needed to fully understand the prevalence of these experiences across NSW. See Section 3 for details on the impact of birth-related trauma on women and birthing people.

2.2 Fathers and Non-birthing Parents

Fathers and non-birthing parents experience birth-related trauma yet are too often forgotten. There is limited NSW data on the prevalence of birth-related trauma for fathers and non-birthing parents. However, it is well known that fathers have similar needs to those of women and birthing people during pregnancy and birth, yet, in Australia, these needs are not being met[17]. This is especially true for first-time fathers[18].

Studies have indicated that depression, anxiety and stress are more prevalent among fathers than among men in the general population[19,6,8] with:

- up to one in ten fathers experiencing paternal depression between the first trimester and one year postpartum[20]
- one in six fathers experiencing anxiety during the prenatal period and up to one in five during the postnatal period, although there was wide variation between studies[21]
- fathers may also experience post-traumatic stress symptoms following the birth.[7,22]

Partners who observe adverse maternal, foetal or neonatal outcomes may experience a higher prevalence of depression and traumatic stress, inclusive of non-birthing parents whose partners experience a termination for medical reasons[23]. Specifically, 83% of male non-birthing parents experienced a prenatal diagnosis of a foetal anomaly as a traumatic event[24]. See Section 3.2 for details on the impact of birth-related trauma on fathers and non-birthing people.

2.3 Health Professionals

> *From a nurse: "To say it's been tough is an understatement. I think I have experienced every human emotion possible. My year of maternity leave has been my year of recovery. Countless specialist appointments that ultimately took that initial bonding period away from me and my*

[17] Healthy Male: Andrology Australia (2020). Plus Paternal, A focus on Fathers: A Case for Change, Melbourne.
[18] Ibid.
[19] Cameron, E., Sedov, I. & Tomfohr-Madsen, L. (2016). Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. Journal of affective disorders, 206, 189–203.
[20] Paulson, J. & Bazemore, S. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. JAMA, 303(19), 1961–1969.
[21] Leach, L. et al. (2016). Prevalence and course of anxiety disorders (and symptom levels) in men across the perinatal period: A systematic review. Journal of affective disorders, 190, 675–686.
[22]Daniels, E., Arden-Close, E. & Mayers, A. (2020). Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma. BMC Pregnancy Childbirth 20, 236.
[23] Kothari, A. et al. (2023). Fathers attending the birth of their baby: Views, intentions and needs. Aust N Z J Obstet Gyn.
[24] Aite, L. et al. (2011). Antenatal diagnosis of congenital anomaly: a really traumatic experience?. *Journal of perinatology : official journal of the California Perinatal Association*, *31*(12), 760–763.

son. I feel let down by the health system, a system that I work for and am a part of." , ABTA Volunteer

There is growing data on the prevalence of birth trauma-related trauma in doctors, midwives, and other maternity care workers who have witnessed or been involved in traumatic births. In this section, we briefly discussed the prevalence among obstetricians and midwives.

Traumatic stress is experienced by ***obstetricians***. A 2019 study demonstrated frequent exposure to traumatic births (96.9% of respondents). Three-quarters of respondents described symptoms of traumatic stress, and one-quarter had symptoms of work-related burnout[25].

Research shows more than two-thirds of ***midwives*** (67.2%) report having witnessed a traumatic birth event and that 17% of midwives met the criteria for probable post-traumatic stress disorder[26]. This equates to almost one in every five midwives who are attending a birth or supporting new parents are doing so while impacted by their own trauma, exposing themselves to re-traumatisation and potentially reducing their ability to support new families. A 2019 study of midwives found 41% had their own traumatic birth experience, while 94% had reported professional traumatic events. This resulted in midwives' fear and decreased confidence when working with birthing parents[27].

A 2014 cross-sectional survey on ***obstetricians and midwives*** in Sweden identified that of the 707 obstetricians and 1,459 midwives that responded, 84% of obstetricians and 71% of midwives reported experiencing at least one severe and "traumatic" event on the delivery ward. 15% of both professions reported symptoms indicative of partial PTSD, whereas 7% of the obstetricians and 5% of the midwives indicated symptoms fulfilling full criteria for diagnosis of PTSD[28]. In other studies, it has been shown that up to 18% of obstetricians may experience PTSD symptoms[29].

[25] Uddin, N. et al. (2022). The perceived impact of birth trauma witnessed by maternity health professionals: A systematic review. Midwifery. 114:103460.
[26]Leinweber, J. et al. (2017). Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives. Women and birth: journal of the Australian College of Midwives, 30(1), 40–45.
[27] Toohill, J. et al. (2019). Trauma and fear in Australian midwives. Women and birth: Journal of the Australian College of Midwives, 32(1), 64–71.
[28] Wahlberg, Å. et al. (2017). Post-traumatic stress symptoms in Swedish obstetricians and midwives after severe obstetric events: a cross-sectional retrospective survey. BJOG, 124: 1264–1271.
[29] Patterson, J. et al. (2019). Disempowered midwives and traumatised women: Exploring the parallel processes of care provider interaction that contribute to women developing Post Traumatic Stress Disorder (PTSD) post childbirth. Midwifery, 76, 21–35.

3. Impacts of Birth-related Trauma

This section outlines the key impacts of birth-related trauma. These include:

- Impact on mothers and birthing people
    - Physical impacts
    - Psychological impacts
    - Baby, family and relationship impacts
    - Emotional and general wellbeing impacts
    - Work, productivity and financial impacts
- Impact on fathers and non-birthing parents
- Impact on health professionals
- Economic and societal impacts.

Birth-related trauma can impact mothers and birthing people, fathers and non-birthing parents, health professionals and society. Birth-related trauma can impact people's physical, psychological and social well-being.

3.1 Impacts on Mothers and Birthing Parents

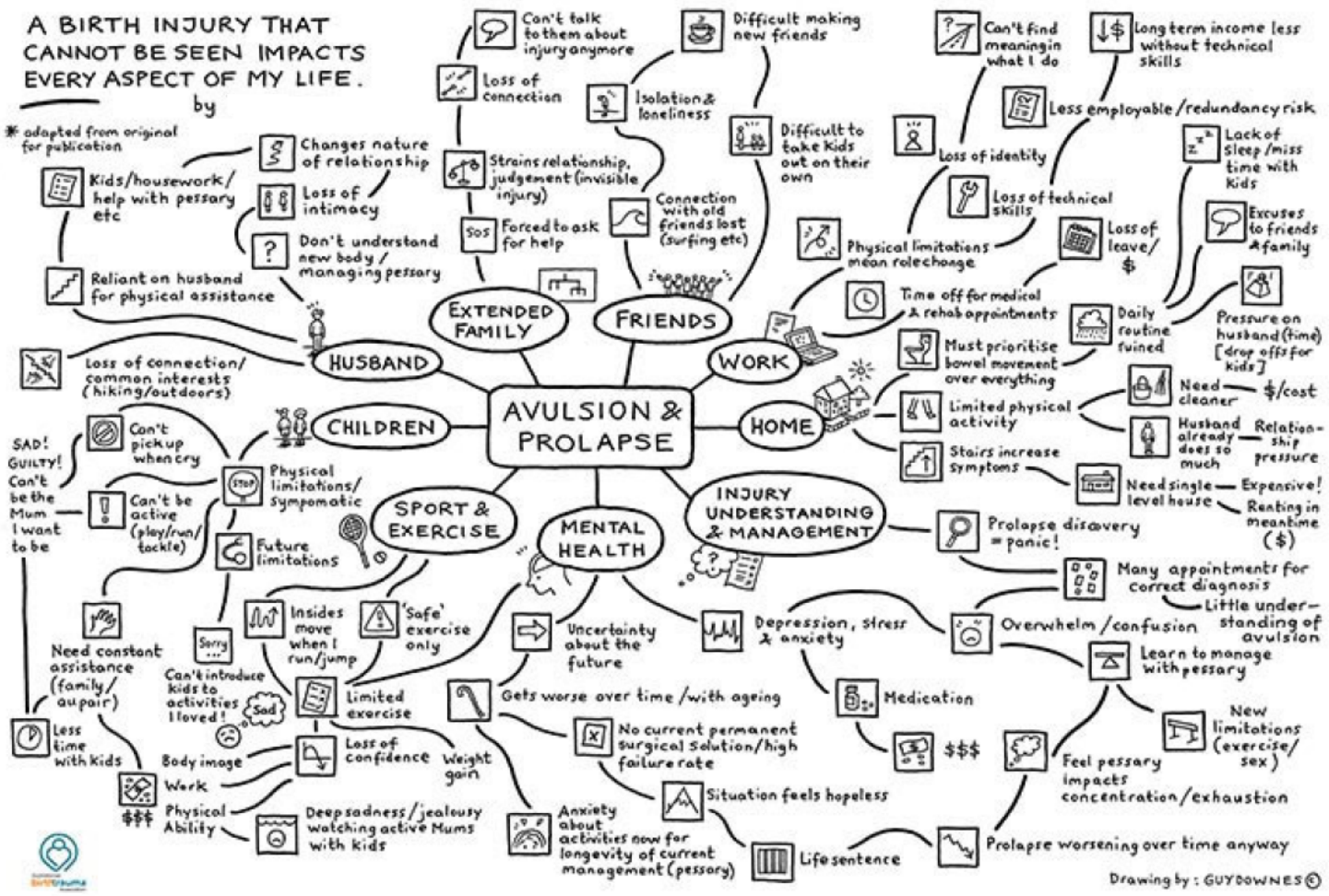
> *"The physical injuries have resulted in me developing significant postpartum depression and PTSD and quite significant anxiety. Especially health-related anxiety and I have a complete loss of confidence in the medical profession. I feel I was lied to and was not given the opportunity to make informed decisions about my care." ABTA Birth Injuries Report*

Many mothers and birthing people leave their birth experience feeling dehumanised, violated, powerless and traumatised.[30] Not all traumatic experiences result in traumatisation; however, circumstances that result in feelings of disempowerment, helplessness, intense fear, or horror may. Traumatising experiences can have profound, at times permanent impact, and may influence brain structure and function[31] as well as physical and mental health, future health service engagement, and social functioning .[32] Births may be experienced as traumatic even when they are perceived as obstetrically straightforward.[33]

ABTA community member expressed her experience of birth injuries using a mind map below. As can be seen, the impact of birth-related trauma on one's day-to-day living and relationships is extensive.

[30] Keedle, H., Schmied, V., Burns, E. et al. (2020). From coercion to respectful care: women's interactions with healthcare providers when planning a VBAC. BMC Pregnancy Childbirth 22, 70
[31] Gvozdanovic, G. et al. (2019). Structural brain differences predict early traumatic memory processing. Psychophysiology. 57:e13354.
[32] Kezelman C. & Stavropoulos, P. (2012). Adults Surviving Child Abuse: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.
[33] National Institute for Clinical Excellence [NICE] (2014). Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines [CG192]. London: NICE.

Figure 1: My experience of birth-related trauma[34]



[34] With permission from Lyn Leger

3.1.1 Physical Impacts

> *"The birth itself was fine - I felt supported even with having to go to theatre for forceps delivery. Communication throughout was ok, they kept me informed, asked consent etc, but I still felt like I had to go with it and do as I was told. The recovery after giving birth was shocking, scary, so unexpected and traumatising. The injuries were painful and horrifying - I was frightened of my body for a long time. While it did heal and get better (so slowly) it never got better 'right' and I was lost for support and information. It has been very isolating trying to deal with the injuries (mainly prolapse) and get help and support. The impact it has had on my life, relationships, well-being has been massive." - ABTA Birth Injuries Report*

The underlying mechanisms that contribute to physical birth-related injury and trauma are well understood, yet they are still largely invisible injuries that women and birthing parents have to carry. Most common physical injuries and impacts as identified in ABTA's 2022 "Birth Injuries: A Hidden Epidemic"[35] report are outlined in Table 1.

Table 1: A sample of physical birth-related trauma and impacts

Physical birth-related trauma and symptoms	
- Vaginal and labial tears - Anal sphincter tears (aka obstetric anal sphincter injuries (OASIS)) - Irreparable pelvic floor damage (e.g. levator avulsion) - Bladder damage - Infected wounds - Musculoskeletal injuries or fractures such as coccyx fracture or dislocation, pubic bone stress fracture or pubic diastasis - Hysterectomy	- Pelvic organ prolapse - Urinary or faecal incontinence - Urinary or faecal urgency - Heavy dragging feeling in the vagina - Unable to control wind - Abdominal or back pain - Pain in the vagina/vulva - Neuralgia - Episiotomy problems - Painful sex/Sexual dysfunction

A sample of these common physical impacts are discussed below.

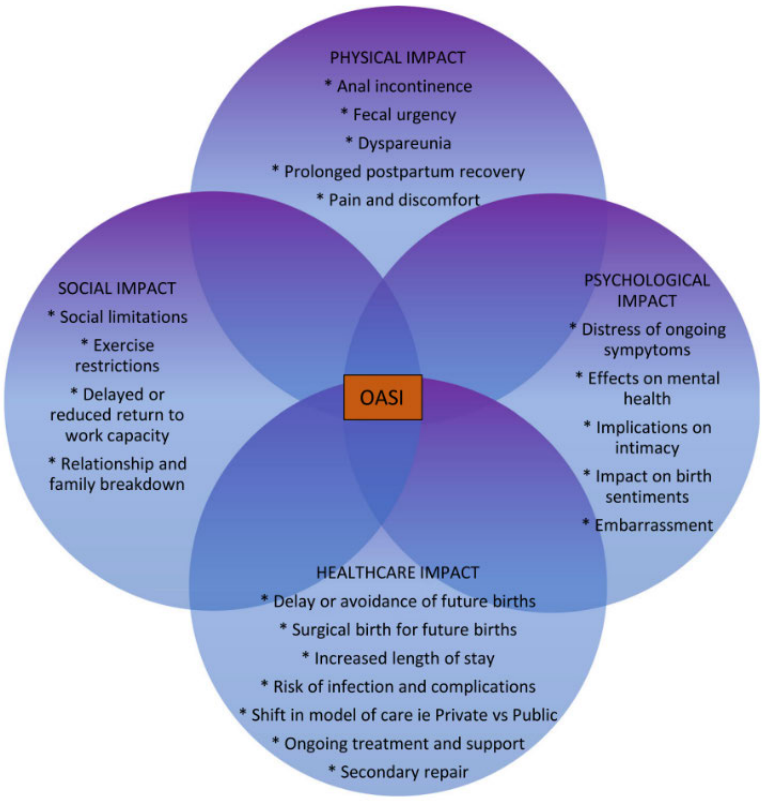
Anal sphincter tears (aka OASIS): Anal sphincter tears, or obstetric anal sphincter injuries (OASI), occur when a perineal tear extends into the internal anal sphincter and sometimes the external anal sphincter. Understanding the long-term impact of OASI is challenging because OASIS is not always identified or repaired at the time of birth. Repair at birth may also leave a residual sphincter defect which may be a factor in anal incontinence. OASIS is a significant form of physical

[35] Australiasian Birth Trauma Association (2022). Birth Injuries: A hidden Epidemic.A summary of insights from an international survey conducted by ABTA, Birth Trauma Association (BTA) & Make Birth Better (MBB).

birth-related trauma occurring in approximately 6.4 in 100 first births[36]. Anal incontinence occurs in 24 in 100 women following vaginal birth[37] .

> *"The hospital that diagnosed my sphincter tear said that it can't be fixed now, but it could have been fixed if it was picked up at time of delivery. If it was fixed in a timely manner or even prevented I would not be incontinent.", ABTA Birth Injuries report*

More than half the women who sustain an OASI will have ongoing symptoms an average of 4 years post birth[38]. The impact on daily life is substantial, as are the ramifications for the health care system. In 2022, researchers from Curtin University in WA created a 'web of morbidity' to illuminate the widespread and interrelated impacts that an OASI can have (See figure below).



[39]

[36] Caudwell-Hall, J, et al. (2018). Atraumatic normal vaginal delivery: how many women get what they want? Am J Obstet Gynecol.219(4):379.
[37] Tholemeier L, et al. (2022). Seeking the Truth About Primary Elective Cesarean Delivery and Pelvic Floor Disorders: A Systematic Review and Meta-Analysis. Female Pelvic Med Reconstr Surg, 28:e108-e114.
[38] Evans, E, Falivene, C, Briffa, K. et al. (2020). What is the total impact of an obstetric anal sphincter injury? An Australian retrospective study. Int Urogynecol J 31, 557–566.
[39] From: Evans, E, Falivene, C, Briffa, K. et al. (2020). What is the total impact of an obstetric anal sphincter injury? An Australian retrospective study. Int Urogynecol J 31, 557–566.

Irreparable pelvic floor damage, levator avulsion and pelvic organ prolapse: In those who experience a vaginal birth that does not result in long-term physical trauma (approximately 33% of first-time mothers), pelvic floor muscles successfully stretch and then recover their prenatal length/position[40]. However, in approximately 5.6 in 100 planned vaginal births, the stretch forces are excessive, causing the puborectalis muscle (part of the pelvic floor) to be irreparably separated from the pubic bone[41]. This is known as ***levator avulsion***. The rates of avulsion are much higher in forceps deliveries[42]. Unfortunately, there is still a lack of awareness of levator avulsion, and formal diagnosis of levator avulsion requires specialised imaging, which is typically administered in an outpatient setting. For this reason, levator avulsion goes largely unrecognised in the postnatal period, resulting in delayed access to important services such as pelvic health physiotherapy.

> *"I used to be very active, in particular I was a keen weightlifter but as I live with some degree of pain and fear of further injury I have not been able to exercise like I used to. This has affected my physical and mental well- being. My injuries made me feel disgusting, destroyed, and undesirable. I also had PTSD from the birth, which the injuries made worse too." ABTA Birth Injuries Report*

Alternatively, the pelvic floor muscles may successfully stretch during birth but not recover their prenatal length/position. This phenomenon is known as ***levator overdistension*** which occurs in approximately 6.8 in 100 first vaginal births[43]. Pelvic floor damage is a strong predictor of pelvic floor morbidity later in life, such as pelvic organ prolapse[44].

Approximately 14.6 in 100 people experience symptomatic ***pelvic organ prolapse*** following vaginal delivery[45]. Depending on the number of vaginal deliveries, between 1.4 and 3.9 in 100 proceed with surgery for pelvic organ prolapse later in life, suggesting that vaginal birth results in significant lifetime morbidity[46].

Anal or urinary incontinence: The causes of urinary incontinence are complex and multifactorial[47]. It is suggested that 26 in 100 experience urinary incontinence following vaginal birth[48]. Depending on the number of vaginal deliveries, between 0.9 and 1.5 in 100 proceed with surgery for urinary incontinence [49].

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[40] Caudwell-Hall, J, et al. (2018). A traumatic normal vaginal delivery: how many women get what they want? Am J Obstet Gynecol.219(4):379
[41] Ibid.
[42] Friedman, T, Eslick, G. & Dietz, H. (2019). Delivery mode and the risk of levator muscle avulsion: a meta-analysis. International urogynecology journal, 30(6), 901–907.
[43] Caudwell-Hall, J, et al. (2018). Atraumatic normal vaginal delivery: how many women get what they want? Am J Obstet Gynecol.219(4):379
[44] Handa, V. et al. (2019). Pelvic organ prolapse as a function of levator ani avulsion, hiatus size, and strength. Am J Obstet Gynecol. Jul;221(1):41.e1-41.e7.
[45] Gyhagen, M. et al. (2013). A comparison of the long-term consequences of vaginal delivery versus caesarean section on the prevalence, severity and bothersomeness of urinary incontinence subtypes: a national cohort study in primiparous women. BJOG. 120:1548-55.
[46] Larsudd-Kåverud J, et al. (2023). The influence of pregnancy, parity, and mode of delivery on urinary incontinence and prolapse surgery-a national register study. Am J Obstet Gynecol, 228:61.e1-61.e13.
[47] van Geelen, H. & Sand, P. (2023). The female urethra: urethral function throughout a woman's lifetime. Int Urogynecol J.34(6):1175-1186.
[48] Tholemeier L. et al. (2022) Seeking the Truth About Primary Elective Cesarean Delivery and Pelvic Floor Disorders: A Systematic Review and Meta-Analysis. Female Pelvic Med Reconstr Surg 2022; 28:e108-e114.
[49] Larsudd-Kåverud J, et al. (2023). The influence of pregnancy, parity, and mode of delivery on urinary incontinence and prolapse surgery-a national register study. Am J Obstet Gynecol 228:61.

There are many factors which contribute to the urinary continence mechanism including passive tissues, the pelvic floor, the intrinsic urethral sphincter and hormones. Physical birth-related trauma can result in damage to the passive and dynamic tissues of the urinary continence mechanism, while menopausal can cause a significant change in hormones (i.e. reduction in oestrogen) which further impairs the continence mechanism[50].

> *"It was devastating for me to having to use adult nappies after the birth of my daughter and to have the long wait time to see someone who might be able to help... was heartbreaking. My women's health physio ended up referring me to a mental health service as I was crying every day and couldn't cope with wearing incontinence aids 24/7"- ABTA Birth Injuries Report*

New research from Griffith University [51] showed that three months after giving birth, one in three women struggle to control their bladder, one in ten suffer faecal incontinence and one in two experience pain with sex.

Vaginal and labial tears: A labial tear is a tear of the skin or soft tissues that form the vulva. This can include the labia minora or majora or the clitoral hood. While they occur commonly during vaginal birth they are not talked about as often as other types of vaginal tears. This injury may also be referred to as '*grazing*,' or a *first-degree tear*.

> *"I am almost 8 months pp, internal tears, episiotomy and labial tear, and just can't bear to have sex again, or anything along those lines. We have tried, and at best it is physically uncomfortable and emotionally and psychologically agonising. " - ABTA Community member,*

3.1.2 Psychological Impacts

> *"I am a different person compared to before I gave birth. I have bad PTSD, I am so triggered so often by any mention of babys birth or hospitals. I mourn the months of my life,the time I missed with my newborn, where I was so depressed and traumatised I refused to hold her. I would breastfeed her then give her back to my partner, or my parents who had to take leave from their jobs to move in with me to help because I couldn't cope." , ABTA Birth Injuries Report*

Psychological birth-related trauma typically involves exposure to a traumatic event in relation to pregnancy and/or childbirth. However, there is emerging evidence that some women and birthing people may experience the birth event as satisfactory but go on to experience negative emotional retrospective responses to the birth.

Psychological impacts of birth-related trauma include:

- Birth-related post-traumatic stress disorder (PTSD) or symptoms of PTSD
- Postnatal Depression and Anxiety (PNDA)
- Suicidal ideation and suicide

[50] van Geelen H & Sand, P. (2023). The female urethra: urethral function throughout a woman's lifetime. Int Urogynecol J. 34(6):1175-1186.
[51] https://www.abc.net.au/news/2023-08-03/women-birth-trauma-pelvic-health/102643754.

Post-traumatic Stress Disorder from the birth experience (Postnatal PTSD):

Postnatal PTSD is a growing field of concern for perinatal mental health clinicians[52]. PTSD from the birth experience can result from a range of experiences, including (but not limited to) previous trauma, lack of informed consent, unplanned interventions, loss of control, poor communication, separation from baby, retained placenta, undiagnosed conditions, postpartum haemorrhage.

> *"2 epidurals failed, the third worked but tentatively but then bub went into distress. Emergency button pressed and rushed into c-section. Given a very large amount of drugs due to anaesthetist worried about epi. Bub out, not breathing. Thought he was dead. No one would answer me when I asked. Bub was resuscitated but taken to NICU. I spent a long time in surgery and recovery as I had a uterine rupture. Partner went with baby and I was alone." ABTA Birth Injuries Report*

Studies suggest postnatal PTSD can occur in up to 15% of birthing parents in the first six months postpartum[53]. PTSD can have a significant and adverse impact on all life domains and is well-accepted as an important health condition facing women during the postpartum period[54] as well as impacting the infant[55].

Postnatal Depression and Anxiety (PNDA): PNDA describes severe and prolonged symptoms lasting more than 1-2 weeks. Both postnatal depression and/or anxiety can occur as a result of, or alongside, experiences of trauma. Factors contributing to PNDA include issues with fertility and conception, stressful life events, traumatic birth, birth disappointment, pregnancy complications, previous pregnancy loss, relationship difficulties, history of abuse and trauma, and difficult childhood experiences[56]. Studies suggest PNDA can occur in 1 in 6 women in the first postnatal year/year following the birth of their baby[57].

Postnatal suicidal ideation and suicide: Postnatal suicidal ideation is a major health problem globally, with recent research indicating that one in every ten women experiences suicidal ideation following birth[58]. Suicide in the perinatal period is a leading cause of maternal deaths in Australia[59], although the total rate of postnatal suicidal ideation is not well understood [60]. The relationship between birth-related trauma and suicidal ideation/suicide has not been fully investigated,

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[52] Watson, K. et al. (2021) Women's experiences of birth trauma: A scoping review, Women and Birth, Volume 34, Issue 5, 417-424.
[53] Zaers, S, Waschke, M, & Ehlert, U. (2008). Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. Journal of psychosomatic obstetrics and gynaecology, 29(1), 61-71.
[54] Grekin, R. et al. (2022). The role of prenatal posttraumatic stress symptoms among trauma exposed women in predicting postpartum depression. Stress Health. 38(3):610-614.
[55] Van Sieleghem, S. (2022). Childbirth related PTSD and its association with infant outcome: A systematic review, Early Human Development, Vol 174, 105667.
[56] PANDA, https://panda.org.au/articles/contributing-factors-postnatal-anxiety-and-depression/
[57] Beyond Blue, https://www.beyondblue.org.au/media/statistics
[58] Amiri, S & Behnezhad, S. (2021). The global prevalence of postpartum suicidal ideation, suicide attempts, and suicide mortality: A systematic review and meta-analysis, International Journal of Mental Health, 50:4, 311-336,
[59] Austin, M, Kildea, S. & Sullivan, E. (2007). Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. Medical Journal of Australia, 186: 364-367.
[60] Xiao, M, et al. (2022). Prevalence of suicidal ideation in pregnancy and the postpartum: A systematic review and meta-analysis, Journal of Affective Disorders, Vol 296, 322-336.

however, emerging research suggests birth-related trauma may be a risk factor for postnatal suicidal ideation.

> *"Suicide is actually a pain management option and I never thought I would consider this as an option." ABTA Birth Injuries Report*

Factors associated with suicidal ideation in postpartum include stressful events/complications during pregnancy/birth[61],[62], severe vaginal tear (i.e., anal sphincter injury), and birth-related trauma, in general, was reported as a common theme among pregnant/postnatal women experiencing suicidal ideation[63]. Women who died by suicide in Sweden (between 1980-2007) within 1 year postpartum, approximately 45% experienced a complication during delivery[64].

A 2023 study[65] of over 139 women identified that shame was a significant predictor of suicidal ideation in the postnatal period. Other key themes in women's experiences of suicidality included violated expectations, where women's experiences of pregnancy and early parenthood, including their experiences of healthcare, violated their expectations of themselves as mothers and humans. Psychological isolation was also an issue and the distinction of a 'good mother' was found to play a role in perinatal suicidality.

> *"I spent a lot of time blaming myself for the outcome of the birth, which really affected my mental health. Going through the investigation process with the hospital was awful and so difficult to relive it all again, but it did give me some closure and made me realise that it wasn't my fault. Honestly, I have been in a very dark place and there have been times I have been in so much physical pain and so much mental stress that I have made plans to end my life." ABTA Birth Injuries Report*

3.1.3 Baby, Family and Relationships Impacts

It is extremely common for women who have birth-related trauma to tell us that their experience impacted their ability to bond with their babies, impacts their ability to parent other children, and creates difficulties in their relationships with their partner.

> *"I struggled for the first year of my son's life. I still struggle, all of these things happened to me and affected my whole life and nobody is held accountable." ABTA Birth Injuries Report*

> *"My eldest two children have been separated from me again and needed to go to Sydney to be cared for by grandparents. My daughter has missed more school and my son more preschool. Their routine has been disrupted and they miss me. I miss them." - , story shared with ABTA*

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[61] Bodnar-Deren, S. et al. (2016). Suicidal Ideation During the Postpartum Period. Journal of Women's Health, 25(12), 1219–1224.
[62]Gelabert, E. et al. (2020). The role of personality dimensions, depressive symptoms and other psychosocial variables in predicting postpartum suicidal ideation: a cohort study. Arch Womens Ment Health 23, 585–593.
[63] Tabb, K. et al. (2013). Views and Experiences of Suicidal Ideation During Pregnancy and the Postpartum: Findings from Interviews with Maternal Care Clinic Patients, Women & Health, 53:5, 519-535.
[64]Esscher, A. et al. (2016). Suicides during pregnancy and 1 year postpartum in Sweden, 1980-2007. The British Journal of Psychiatry: The Journal of Mental Science, 208(5), 462–469.
[65] Biggs, L. et al. (2023). Pathways, Contexts, and Voices of Shame and Compassion: A Grounded Theory of the Evolution of Perinatal Suicidality. Qualitative health research, 33(6), 521–530.

Challenges bonding with baby: The impacts of birth-related trauma can have a profound effect on early bonding between a mother and her new baby. Parents report that they are struggling to connect or to provide the care and support they feel they should. Women talk about missing out on the baby stage of parenthood because they were so traumatised by their birthing experience. All this impacts upon their understanding, their feelings of control, birth experiences and, ultimately, their psychological and emotional wellness when they reach parenthood.

> *"I was extremely traumatised by my birth and could not bond with my baby for a very long time. It was weeks before I felt anything but resentment for her because I was blaming her." - ABTA Birth Injuries Report*

Relationship strain: The impact of birth-related trauma extends beyond the individual to affect relationships, including strains on marriages and intimacy due to physical pain during sex and fear of further injuries.

> *"It affected my relationship of 7 years. Not only can we NOT be intimate, I won't even let him look at it. I'm so ashamed of how I've been left to feel and look." ABTA Birth Injuries report,*

> *"I felt like I failed as a woman as I wasn't able to give birth naturally. I suffered with PTSD and required therapy when pregnant with my second. Friends took away my right to feel traumatised by saying "at least you've got a healthy baby" It has greatly affected my sex life as I don't have lot of sensation due to the severity of tearing." ABTA Birth Injuries Report*

3.1.4 Emotional and General Wellbeing Impacts

There is a lack of comprehensive, population-level research on the broader impacts of birth-related trauma in Australia. The ABTA has collated the following themes from our 2022 Birth Injuries Report.

> *"My feelings didn't matter, my emotions didnt matter, my pain didn't matter. I was just this baby maker and all that mattered was my son. When I could barely walk and my hips were in so much pain, I refused to leave until I got a x-ray request for my spine. I have spina bifida, the GP that day told me that I am a mum now, I should get used to the fact that my body will never be without pain. I gave up. I never got that x-ray. I went back to work. He is 2 now. I still suffer mentally and physically, but let's face it. No one cares" - ABTA Birth Injuries Report*

Increased distress due to misdiagnosis, being dismissed, not believed and suffering with prolonged pain: Women who experienced prolonged physical pain due to misdiagnosis or delayed diagnosis of birth injuries, report increased mental distress. This lack of proper medical attention and understanding contributes to ongoing feelings of frustration, helplessness, and uncertainty. Many women and birthing people describe feeling like "they are going crazy" or that their concerns are "all in their head" when they are not taken seriously by health professionals when they report their symptoms and complaints about pain, pressure in the vagina, and incontinence are frequently dismissed as *"normal"*, are minimised or not believed at initial consultations. This contributes to feelings of isolation and abandonment and prolongs unnecessary daily suffering without access to medical help.

"My partner and I both describe that time as traumatic, and I believe the neglect contributed to my physical issues become worse due to lack of support."

"It affected me as every doctor thought I was crazy and it would fix itself. It impacted me as I had to time toilet to make sure I didn't wet myself. There may have been something that could have been done if picked up and believed by Drs in the beginning."

"None of them listened to me. I was told several variations of 'that's normal' and 'it'll pass with time, all women hurt after birth'. Despite being able to feel a bulge in my vagina, and having done my own research to determine it was a prolapse, I was dismissed and gaslighted for 3 years with medical professionals trying to make me believe I was imagining problems that weren't there."

"I felt inadequate, silly and totally dismissed. I felt like the doctors wanted me to go away and not cause a fuss and were trying to convince me that what happened to me was normal. In my GP's exact words "it happens" with a shoulder shrug."

"None of them listened to me. I was told several variations of "that's normal" and "It'll pass with time, all women hurt after birth". Despite being able to feel a bulge in my vagina, and having done my own research to determine it was a prolapse, I was dismissed and gaslighted for 3 years with medical professionals trying to make me believe I was imagining problems that weren't there."

Impact on mental health: Women report feeling a sense of shame, feeling disabled in their bodies, symptoms of postnatal depression and anxiety, trauma symptoms and PTSD, and feelings of inadequacy, leading to emotional exhaustion and even suicidal thoughts.

"My pain level increased by the day and the waiting and not knowing, accompanied by the... psychological distress I was experiencing following a traumatic birth led me to being put on a mental health care plan, referred to a Perinatal Psychologist and diagnosed with Postnatal depression, anxiety and PTSD from birth trauma."

"Birth trauma led to immediate severe Postnatal Anxiety & Depression with PTSD. I was admitted to a Mother Baby Unit 3 weeks postpartum."

"I felt like my body had let me down and was continuing to do so. I was scared to pick up my baby in case I made things worse. I was embarrassed about my symptoms and felt disconnected from my body…Having ptsd and then needing to have regular internal examinations for treatment was incredibly challenging and triggering. "

Fear of subsequent pregnancies: Women mentioned being fearful of going through childbirth again due to the traumatic experience of their previous births and the potential for further complications.

"[My injuries] have affected almost every area of my life. Very few people know about them. It is something I am embarrassed about and keep hidden from others. After the birth of my baby I

thought I would never get better, I was very down and felt hopeless. Now things have definitely improved but I will never have another baby as I could not go through it again."

"My birthing injuries have impacted my life in many ways from ability to participate in sport, sex life and general day to day pain and discomfort. But the biggest impact was after discovering I was unexpectedly pregnant, I decided to terminate the pregnancy. I simply could not put my body through the horror of labor again and the potential risks were just too great for me to even consider going through it all again."

"Due to a PPH with my first birth I had to have a hysterectomy. The main effect is that I will not be able to have any more children when I wanted a large family."

".... once some of the shock had passed and day to day life went on, I realised how very different my life was going to be going forward. I'm fearful of everything, from sex to exercise. There is a constant worry that I'm going to get a hernia, or my bag will need changing or even worse, leak, in a meeting at work or on a busy train. My life will never be the same, it has impacted my relationship to the point of counselling and now considering not having another child."

Decrease in quality of life and self-confidence: Women reported experiencing chronic pain, incontinence, and restrictions on daily activities, which affected their quality of life. Birth injuries have a significant impact on respondents' lifestyles, including limitations in physical activities and negative effects on their self-confidence and body image.

"Although the injury was physical, the psychological impact has been significant. I felt broken and out of control. I feared going to the toilet, going out in public (in case of an accident) and was anxious that having a baby had changed me forever (not in the way I expected). I was so worried that I would never be able to hold my bowel or return to work or walk normally."

"I was an elite age group athlete. Not anymore. I can't run after my kids when they ride their bikes. (I own a bike shop) I am a triathlon coach and can't warm up with my run groups. Sex isn't what it should be. My whole way of life has changed"

"I'm permanently disabled now - something I never thought would happen from giving birth. Not a day has gone past where I haven't been in pain and I don't feel I have my independence anymore. I've been robbed of my livelihood, motherhood that I envisioned for my son and intimacy with my husband.

3.1.5 Work, Productivity and Financial Impacts

Work and Productivity: It affects relationships, ability to work and productivity, ability to exercise, to care for children, to contribute to home life, and naturally has severe impacts on sense of self, and mental health. The impacts of injuries resulting in incontinence are particularly detrimental as people do not feel able to work while needing to manage access to bathrooms, and the ongoing shame and embarrassment associated with their symptoms.

"I can't work, I used to work in retail, I still can't hold wind. My son was not given the proper care because of my injuries, pain, surgeries, medication and the issues that arose in my relationships with my husband and his family." Birth Injuries report

"I am a completely different person. I have PTSD and GAD, I can't sleep well and after returning to work I cannot operate at the same capacity as before."

"I feel worthless because clearly my word doesn't matter to anybody. I still have nightmares over a year later. So much time money and effort has been put into my recovery and all of my relationships have suffered extremely."

Personal financial impact: The financial impact of birth-related trauma can be almost devastating, with costs for treatment mounting into the thousands. Ongoing psychological support, GP appointments, access to specialists, and surgery all cause financial strain, with limited subsidies available unless you are privileged to have access to private health insurance. Being based in rural or regional areas also adds costs when you have to travel and take time off work to access specialised support.

"When you plan for pregnancy, birth and early parenthood, you don't budget for the thousands upon thousands of dollars required to manage either psychological and/or physical birth-related trauma". Amy, ABTA co-founder and CEO

"Financially very costly having regular women's health physio appointments, musculoskeletal physio appointments, urogynaecologist, and GP"

3.2 Impact of Birth-related Trauma on Fathers and Non-birthing Parents

Fathers who observe adverse maternal, foetal or neonatal outcomes may experience a higher prevalence of depression and traumatic stress, inclusive of fathers whose partners experience a termination for medical reasons .[66]

Studies indicate that depression, anxiety and stress are more prevalent among fathers in the perinatal period than among men in the general population[67], and up to 1 in 10 fathers experience depression between the first trimester and 1 year postpartum[68]; 1 in 6 experience anxiety during

[66] Kothari A, et al. (2022). Dads in Distress: symptoms of depression and traumatic stress in fathers following poor fetal, neonatal, and maternal outcomes. BMC Pregnancy Childbirth. 22(1):956.
[67] Cameron et al (2016) Prevalence and associated factors of paternal stress, anxiety, and depression symptoms in the early postnatal period
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9768414/
https://www.sciencedirect.com/science/article/abs/pii/S0266613817303893
[68] Paulson & Bazemore (2010) Postpartum Depression in Men
https://www.google.com/url?q=https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6659987/&sa=D&source=docs&ust=1692097634579145&usg=AOvVaw0HPv-ypQZ8Po1oahiybcuF

the prenatal period and 1 to one in 5 during the postnatal period, although there was wide variation between studies [69].

Fathers may also experience post-traumatic stress symptoms following the birth[70]. In ABTA surveys, fathers and non-birthing parents report experiencing a loss of control or fear for the life of their partner or baby[71].

> *"Early on, there was an obstetrician appointment where there was a very big sense of "what are you doing here"? As in "this appointment is for your partner — why are you here?, These feelings continued during the birth. My daughter had to be taken into an intensive care unit after my partner's emergency C-section, and I was barely told anything!" - ABTA Volunteer,*

Almost half (45%) of new fathers are not aware that men can suffer perinatal depression and anxiety yet 43% saw anxiety and depression after having a baby as a sign of weakness[72] which creates a barrier to men seeking support services.

> *"I was angry all the time, I was a snappy, shitty dad and I wasn't the person I wanted to be," he says. "My wife and I had the discussion. She's like, 'You need to go and see someone. You need to go and talk to someone. There's something going on.'" - , ABTA Community Member*

> *"The beautiful birthing experience we had been promised was a distant memory, and feelings of confusion and fear had immediately taken over. I felt completely powerless and scared as I watched the hospital staff insert a cannula in my hours-old daughter's hand and place her into a humidicrib with a CPAP machine. I had no idea what was happening and again felt like I was in the way. Nobody updated me on both my fiancé or daughter unless I asked." - Community Member*

3.3 Impacts on Health Professionals

> *From a midwife; "At 35wks, I presented to the maternity ward concerned about reduced movements - after a few hours, the midwife wanted to send me home as everything seemed ok, but I refused. I had a gut feeling something was wrong. I had a very strange back pain and felt off. I continued to have fevers. 2 nights later, I woke to my waters breaking. I went to the bathroom, and there was blood and meconium in the amniotic fluid. I hit the emergency button. By the time the midwife arrived (my colleague) I was white and my body was shutting down - she called a code. Almost 2 years on, I'm preparing to return to work, I am definitely not the mother nor the midwife I once was, but I am adjusting to my new normal, a change in pace and being the best I can be despite the challenges." - Katherine, ABTA Community Member*

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[69] O'Brien AP, McNeil KA, Fletcher R, Conrad A, Wilson AJ, Jones D, Chan SW. (2017) New Fathers' Perinatal Depression and Anxiety-Treatment Options: An Integrative Review. Am J Mens Health. Jul;11(4):863-876 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5675308/

[70] Daniels et al. (2020). Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma. *BMC Pregnancy Childbirth* 20, 236 https://doi.org/10.1186/s12884-020-02902-2

[71] Moran, E. et al. (2021). The Paternal Experience of Fear of Childbirth: An Integrative Review. Int J Environ Res Public Health. 18(3):1231.

[72] Beyond Blue: https://www.beyondblue.org.au/media/statistics, accessed August 2023.

According to a recent mixed-method systematic review[73], witnessing traumatic birth events was associated with profound emotional and physical impact on the healthcare professional. Five impacts emerged from the research: negative emotions and symptoms, responsibility and regret, impact on practice and care, challenging professional identity and team support being essential.

A 2017 survey of Australian midwives identified that exposure to birth trauma among women for whom midwives provide care may contribute to the development of posttraumatic stress. Further to this, the experience of posttraumatic stress in midwives can have implications for practice, including a lack of empathy and emotionally distant care, an overestimation of clinical risk and defensive practice by health professionals, and tendency to leave the profession[74].

The previously mentioned 2019 feasibility study on birth trauma in health professionals also identified that 'obstetricians experience substantial trauma', and that there is a 'culture of blame in obstetrics'[75]. This feasibility study was originally proposed due to little information being available on the impact of birth-related trauma on the Australasian obstetric workforce, an issue demanding further research and understanding.

3.4 Societal and Economic Impacts of Birth-related Trauma

> *"I have been diagnosed with PTSD from the traumatic birth and postpartum period. I had to extend my leave from work (unpaid) which has put so much extra stress on my family. Physically, I have not had a day without pain since the birth and my daughter is now 16 months old." - ABTA Birth Injuries Report*

A 2019 report on the costs of perinatal depression and anxiety in Australia estimated the costs to the health system economy and wellbeing of those impacted as $877 million in one year.[76] This includes health system costs, economic costs attributable to productivity losses, and monetised social and wellbeing impacts on children and families. Beyond this are estimated lifetime impacts of $5.2 billion[77].

Examining only one impact of birth-related trauma, incontinence a 2011 report assessing the economic impact of incontinence estimated the overall cost of incontinence in Australia at $66.7 billion in 2010, equating to $14,014 per person with incontinence.[78] This includes health system expenditures of approximately $271 million and productivity losses totalling $36.8 billion (including for those experiencing incontinence and those friends and family caring for those with incontinence).[79]

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[73] Uddin, N. et al. (2022). The perceived impact of birth trauma witnessed by maternity health professionals: A systematic review. Midwifery. 114:103460.
[74] Julia Leinweber, Debra K. Creedy, Heather Rowe, Jenny Gamble, (2017) A socioecological model of posttraumatic stress among Australian midwives, Midwifery, Volume 45, Pages 7-13, https://doi.org/10.1016/j.midw.2016.12.001.
[75] Walker, A. et al. (2020). Impact of traumatic birth on Australian obstetricians: A pilot feasibility study. *The Australian & New Zealand journal of obstetrics & gynaecology*, *60*(4), 555–560.
[76] Gidget Foundation. (2019). 'The Cost of Perinatal Depression and Anxiety in Australia'. Prepared by PwC Australia.
[77] Ibid.
[78] Continence Foundation of Australia. (2011). 'The economic impact of incontinence in Australia'. Prepared by Deloitte Access Economics.
[79] Ibid.

4. Why and how does Birth-related Trauma Occur?

Birth-related trauma is a complex experience with a multitude of contributing factors. Trauma can be associated with all stages of the journey to parenthood, and often across multiple stages - from conception and pregnancy, through to labour and birth, and postnatally.

Many experiences of birth-related trauma can be due to, or linked with, unavoidable conditions or medical emergencies that can occur during pregnancy, labour, and birth. Experiences of severe acute maternal morbidity (SAMM) conditions or events include significant blood loss from postpartum haemorrhage (PPH) or secondary PPH; near-fatal experiences of uterine ruptures and placental abruptions; severe hypertensive disorders, such as pre-eclampsia and eclampsia; and stillbirth or medical emergencies with babies who spend prolonged periods in neonatal care units are commonly identified as experiences of birth-related trauma. However, many of these experiences are underpinned by how mothers, birthing people, fathers and non-birthing parents were treated during this process.

While many birth experiences are unavoidable, it is critical that there is ongoing monitoring and understanding of the prevalence and outcomes of these events, including regular review of the rates and outcomes in every hospital across NSW and the country.

> *"After labouring for 5 hours my babies heart rate dramatically dropped. Within 30 seconds of the red button being pushed the entire room was full of medical staff, my husband had scrubs thrown at him and was asked to sign a form acknowledging that there was a chance either our baby or myself would not make it and I had no idea what was happening. An emergency CS later, I was diagnosed with pre-eclampsia and HELLP syndrome and taken into ICU for 24 hours with minimal contact with my baby. I was later told that I was within 10 minutes of total organ failure and that they had about 6 minutes from the red button being pushed to get my baby out or he may have died". - ABTA Birth Preparation Survey*

Conversely, whilst many experiences are unavoidable, there are a significant number of avoidable or preventable experiences that contribute to and may cause birth-related trauma, particularly in the sense that things "should have been different".

Based on ABTA surveys conducted in 2019 (419 participants) and 2021 (147 participants) responses and stories shared, ABTA identifies a range of themes that can contribute to experiences of birth-related trauma, and which, if managed differently, make up instances of preventable trauma. These can be broadly categorised at the personal, healthcare system and societal level, and factored in at any point in the birth-related journey:[80]

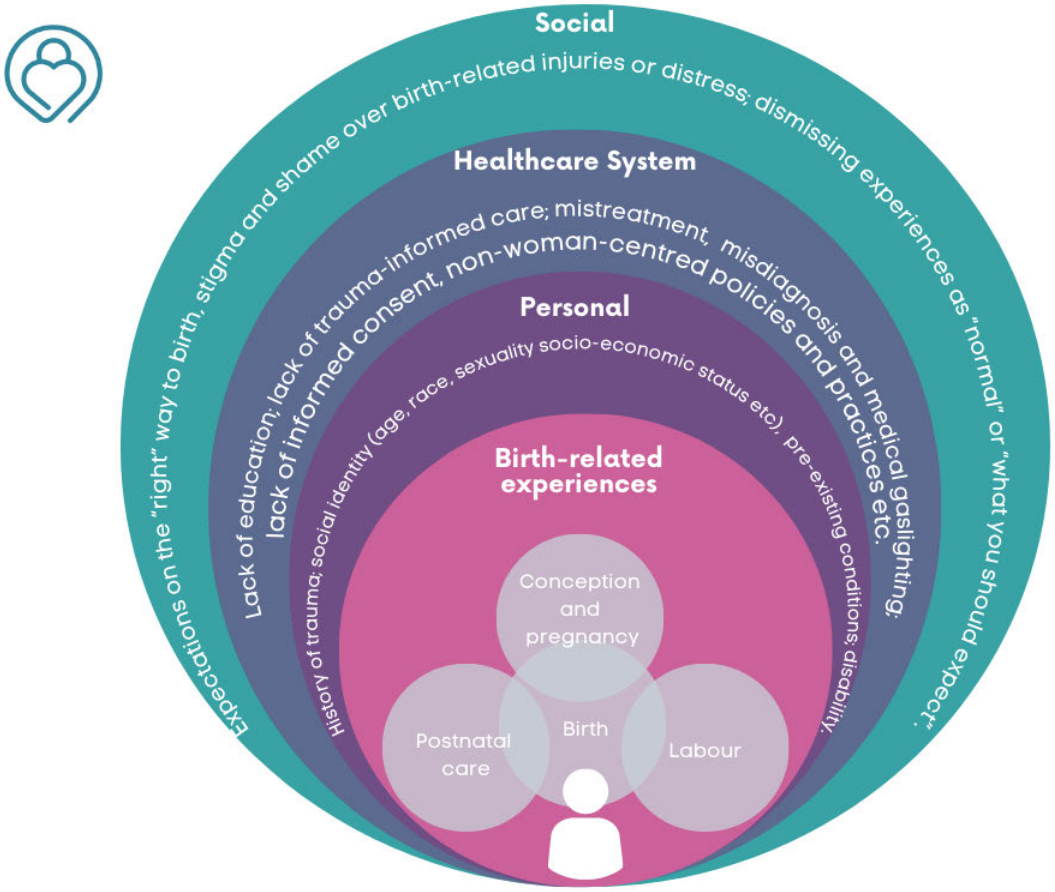
- **Personal circumstances** (i.e. an individual's personal circumstances), which includes: impacts from an individual's history of trauma; pre-existing mental health conditions; race, ethnicity, sexuality, socioeconomic status
- **Healthcare system** (i.e. impacts of engaging with healthcare and birthing support systems), which includes: unable to access desired model of care, mistreatment, dismissal and neglect by health professionals; inappropriate, disrespectful and abusive treatment; lack of informed consent; misdiagnosis or delayed diagnosis; impacts of interventions; ;

[80] ABTA 2021 Birth Injuries Survey; ABTA 2022 Birth Injuries Survey

non-person-centred health system policies and practices; lack of professional collaboration; and lack of postnatal social and care pathways

- **Social** (i.e. impacts of societal norms, values and expectations), which includes expectations of the "right" way to birth, and stigma and shame over ongoing birth-related issues, including injuries or psychological distress.

These areas of preventable factors are explored in further detail below.



4.1 Personal circumstances

What I wish I'd known:
"That the midwives/hospital would refuse to put me in a wheelchair so I could meet my baby in SCN while he awaited transport to the NICU. That I would feel like a visitor not a parent in NICU. That my baby could even end up in NICU, obvious but not really something anyone considers. That I would be left entirely alone after the birth and I wouldn't meet my baby for more than 24 hours and no one would check on ME. That I'd be so heavily medicated that I wouldn't even remember the first few days with my baby.

That breastfeeding is not possible for all women and that I would be made to feel guilty about that by other mums, doctors, nurses, social media and myself." - ABTA Understanding Your Needs Survey

It is critical to understand what a person 'brings' into their pregnancy, labour, and birth can have a profound effect on their experience and whether it results in trauma. Pre-existing mental health conditions, previous experiences of trauma such as sexual assault or abuse, and an individual's background or identity can also be a factor in determining how their birth is experienced. This section provides additional detail on how these factors can impact experiences, with a focus on:

- Previous trauma experiences and pre-existing conditions
- Identity and social demographics

4.1.1 Previous trauma experiences and pre-existing conditions

Previous trauma experiences are relatively common, particularly in the context of leading up to and impacting on the experience of birth. The 2023 Australian Child Maltreatment Study found that 28.5% of Australians (16-60) experienced child sexual abuse before the age of 18 and that 1 in 3 girls experienced child sexual abuse[81]. These experiences create significant risk factors for triggering a trauma response during birth experiences, particularly with regard to physical examinations, induction procedures, and experiences where there is a loss of control or lack of consent. Most complex trauma is experienced within relationships[82] and involves a fundamental betrayal of trust[83]. There is a profound parallel between the complex trauma of sexual assault/abuse and the iatrogenic harm and traumatisation that occur through the provision of maternity services.

"My panic was rising, and I asked if I could have a support person with me. Unfortunately, this was not allowed (due to covid). I needed someone to comfort me, take care of my emotions and worries. The staff seemed so focused on my physical damage they couldn't see the mental and emotional turmoil I was in. I felt scared, vulnerable, weak and alone. Something felt familiar in a terrifying way. I had no control. I was powerless and uninformed….I can't remember the main surgeon ever speaking directly to me as he lifted my legs and propped my feet up. I felt the bed tilting and moving. The students talked to each other about cocktails and overseas holidays.

I felt and heard splashes of water as they cleaned me. The water, the smell and my lack of control triggered my emotions. A memory of swimming training flashed through my mind. As I squeezed my eyes shut, I saw an image of a burning man. I opened my eyes, and the surgeon told me to stop shaking. I closed my eyes again and saw the same man on fire. The smell of the room was making me feel sick. It felt like a ton of bricks were on top of me; I felt exposed, cold and scared but I couldn't move. I got the sense that if I just laid still, it would be over soon. More water splashed onto me, reminding me of the swimming pool again. And that's when I realised who the burning

[81] Mathews, B. et al. (2023). The prevalence of child maltreatment in Australia: findings from a national survey. The Medical Journal of Australia, 218 Suppl 6, S13–S18.
[82] Finkelhor, D, Ormrod, R & Turner, H. (2007). Poly-victimization: a neglected component in child victimization. Child abuse & neglect, 31(1), 7–26.
[83] Kezelman C. & Stavropoulos, P. (2012). Adults Surviving Child Abuse: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.

man was, and why I felt so scared. I begged for it to be over; they told me the procedure was about halfway done. I wished I would pass out." - ABTA Community Member

There are also previous experiences of birth-related trauma, including previous loss, such as stillbirth, miscarriage, or terminations for medical reasons; and previous experiences of a traumatic birth, including SAMM events or other traumatic birth experiences. These experiences heighten anxiety and fear ahead of birth and can establish a foundation of vulnerability on which further experiences can build and exacerbate.

"When I first found out I was pregnant with number 2 I was terrified. Terrified of ending up in a situation like my first birth." ABTA Community Member

The same can be said for women and birthing people with pre-existing conditions, including neurodivergence, mental health conditions, and disabilities. The ABTA has not collected specific data on these experiences, but relatively recent research on experiences of women with disabilities in maternity services in Australia identifies that women with a disability have poorer perinatal outcomes but also that most hospitals (65% of surveyed hospitals) are unable to estimate the number of women with a disability seen at their hospital, most (68%) do not offer specialised services, and only 13 % have specialised training for staff in disability identification, documentation and referral pathways[84]. An interview with a deaf and blind midwife identified: "I saw time and time again how policies and healthcare professionals negatively impact the birthing experiences of women with disabilities"[85]. As this is a new area of research, it is critical that more work is done to understand any experiences of birth-related trauma among people with pre-existing conditions and disabilities.

4.1.2 Identity and Social Demographics

"The nurse said, you're in recovery. I remember feeling incredibly cold and warm towels were placed on me. I then asked the nurse " is my baby alive"? She then said to me " I have no idea, I'm not a midwife". My heart sank. Then she asked me if I was indigenous. I said no. She then asked if my partner was white to which I replied yes. She then said "oh you must have the most beautiful baby". I'm my head I thought, well I don't know if she's dead or alive." - , ABTA Community Member

The experiences leading up to and including birth and becoming a parent can be some of the most vulnerable times in a person's life. The way you are treated and the experiences you have during this time can all factor into whether the experience becomes traumatic. There are existing inequities in the healthcare system that play out in maternity care as well and contribute to traumatic experiences.

For example, at the population level, Aboriginal and Torres Strait Islander women face an increased risk of experiencing perinatal depression and/or anxiety due to their collective and individual experiences of colonisation, trauma, racism, and other social determinants of ill health. Studies show that Aboriginal and/or Torres Strait Islander women are more than twice as likely to

[84] Benzie, C. et al. (2023). Exploring disability prevalence among childbearing women attending a tertiary maternity service in Melbourne, Australia using an audit and cross-sectional survey. Midwifery, 122, 103697.
[85] ABC "https://www.abc.net.au/news/2022-11-24/5050-birthing-for-women-with-disability/101688646"

experience perinatal depression and/or anxiety than their non-Indigenous counterparts.[86]

The disproportionate rate of child removal in Aboriginal and Torres Strait Islander families (e.g. 2019-2020, 46.6 per 1000 First Nations infants aged under the age of one were admitted to out-of-home care – a rate 10 times higher than that for non-Indigenous infants[87]) it also contributes to the fear and anxiety that some First Nations mothers will experience in going into hospital, many of which are staffed by predominantly non-Indigenous staff, and where they must give birth separated from their country and culture.

Women from Culturally and Linguistically Diverse (CALD) backgrounds also face additional complexities in Australia's maternity care system. Evidence states that people from some CALD backgrounds can face greater challenges when navigating the healthcare system, including language and cultural barriers and not knowing where to seek help or how to access services[88].

People who identify as LGBTQIA+ are also a group that is more likely to report having negative experiences with healthcare, and a disproportionate number experience poorer mental health outcomes and have a higher risk of suicidal behaviours[89]. The maternity system is also geared towards using terms such as "women" and "mother" and the ABTA has had this raised as an issue for birthing people who do not identify as women or as mothers and find the language more isolating.

> *"While any medical professional should treat all patients and their families equally, that is far from the reality. On multiple occasions I have been asked who I am, constantly reminding others that I am "the other mother." My favourite was, "which one of you is the mother?" The answer is C: All of the above."* *ABTA Community Member*

More research is needed to fully understand how identity contributes to experiences in the healthcare system, and particularly with regards to birth, and as factor contributing to birth-related trauma.

4.2 Impact of Healthcare System

One of the most common themes from all the stories and data shared with ABTA over the years is how women and birthing people and their partners are treated during their birth experiences and the impacts of their interactions with the healthcare system. Many of these are also the most preventable issues that contribute to birth-related trauma.

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[86] Buist, A. et al. (2005). Recognition and management of perinatal depression in general practice--a survey of GPs and postnatal women. Australian family physician, 34(9), 787–790

[87] Australian Institute of Health and Wellbeing, 2019-20 Child protection Australia 2019–20: https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2019-20/summary

[88] AIHW (2022). "Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper" https://www.aihw.gov.au/reports/cald-australians/reporting-health-cald-populations/summary

[89] Monash University (2020) LGBTQI, stigma and community barriers to healthcare. https://lens.monash.edu/@politics-society/2020/05/15/1380399/lgbtqi-stigma-and-community-barriers-healthcare

"My trauma boils down to a few key issues. I went into the hospital with total trust that the staff would have enough knowledge to tell me what my body was doing and coach me through the birth. I didn't fight when I knew my baby had turned resulting in an undiagnosed posterior baby. The communication from the staff was very poor. My husband was told to leave as the staff did not believe that I was in labour as I have a high pain threshold.The staff panicked as they had neglected me and then rushed to get my baby out, not even stopping to give me anaesthetic before the episiotomy.I was not offered a debrief but had midwives come to my room and offer negative opinions on my birth. Eg. If you're impatient and have an induction then that's the kind of birth you're going to get." - ABTA Birth Injuries Report

The factors in the healthcare system that cause or contribute to birth-related trauma explored in this section are:

- Mistreatment, dismissal and neglect by health professionals
- Inappropriate, disrespectful and abusive treatment by health professionals
- Lack of informed consent in maternity care
- Misdiagnosis or delayed diagnosis
- Impacts of interventions
- Lack of postnatal social and care pathways
- Health system policies and structures
- Lack of professional collaboration

These issues can occur for a number of reasons, many of which are linked to systemic challenges in the maternity care system, such as lack of clinical supervision, high workloads, under-resourcing, and clinical approaches that do not put the mother or birthing person's physical and psychological safety at the forefront, all of which contribute to burnout and compassion fatigue, and result in mistreatment of women and birthing people, and experiences of birth-related trauma.

4.2.1 Mistreatment, dismissal and neglect by health professionals

"After about 14 hours of labour I told the midwife I was in a lot of pain: she told me I wasn't coping and that "this isn't even labour, if you're not coping now how will you actually cope when this is labour". She proceeded to tell me "I've just called your doctor and asked if you can have an epidural because you aren't coping you just need to sleep". He and the midwife began discussing what would happen with me and the midwife said (at the doorway of my room) "she's going to be induced tomorrow, it will probably end up being a csection" - they didn't think to consider me being right there"
"One nurse told me I wasn't allowed to touch my baby when she was 13 hours old in case she requires resettling, during that time another nurse said to a colleague in front of me "she looks terrified, how will she cope with the baby.
Little did they know that by this point another nurse and my bub's paediatrician had began helping me seek help for mental health concerns. After everything the midwife and anaesthetist said to me, I ended up in such a bad mental state thinking if this isn't labour, I obviously can't cope and need to stop this. In that moment I had worked out exactly how I was going to kill myself, all because I didn't think I was "coping" because people kept telling me I wasn't in labour." – - ABTA Community Member

Mothers and birthing people who have shared their stories with ABTA describe experiences where health professionals did not provide adequate care, and they were left feeling unsupported,

ignored, neglected, and mistreated by medical staff during labour and postpartum care. This can result from:

- a lack of information or communication from health professionals,
- a lack of compassionate care,
- being spoken to rudely or inappropriately while pregnant, in labour, or trying to care for a new baby, and
- being dismissed or not believed by health professionals when they report their symptoms.

> *"When I was in labour with my son he was facing the wrong way and in an awkward position. I pushed for 3 hours trying as hard as I could and was becoming exhausted and distressed so the midwives called in a doctor. The doctor walked in, looked at me and said "You'll just have to push harder". She kind of laughed when she said it too like I was just being silly and now the real pushing needed to start" - ABTA Community Member*

> *"During birth, it was so horrendous that I seriously thought that I was dying. The midwife told me off for having the wrong-shaped bump for a baby heart monitor to be strapped to. Also told me off for not pushing right. This was upsetting. Then she told me that my baby would probably be born not breathing. It is this last comment that traumatised me the most. It was said so bluntly and I panicked.*
> *After birth in the night they made me get up to go to the toilet. I collapsed and had a sort of fit. The midwife told me off, I was called "a nuisance", she walked off and told a student to watch me as I shook and thrashed about.*
> *Post birth I saw my GP as things felt so wrong - I had an undiagnosed severe third degree tear - he refused me a physical exam, told me I was just depressed, and tutted when I asked for antidepressants (I was on them whilst pregnant so was vulnerable). The dismissal of my feelings makes it hard for me to trust doctors." ABTA Community member*

Stories shared with ABTA report nurses, midwives, and doctors not listening to people; speaking harshly or rudely, and even being sworn at; and use of terminology that is demeaning, and characterises outcomes as linked to maternal effort or ability. For example, terms such as "failure to progress", "lack of maternal effort", and even "maternal exhaustion" can lead to mothers and birthing people feeling judged and unsupported during a difficult experience.

> *"I felt that the midwives and special care staff didn't listen to me because I was a first-time mum. I knew my baby wasn't coming out through pushing because she didn't feel like she was in the right position, but they had me pushing for 4 hours before admitting me to surgery with 'maternal exhaustion'. Maternal exhaustion is not the reason my baby wasn't coming out, and I resent that it is documented that way on our official medical records". - 2019 ABTA survey*

> *"During the pushing phase of my birth, the midwife was so rude to me, I asked her 'why are you being so mean to me?' and she replied 'because you're not pushing and we want to go home'. ABTA Community Member*

ABTA has reports of these experiences in almost all stages of the birth experience, including in pregnancy, labour, birth, and postnatal care settings. They cover both physical and psychological

symptoms, with many mothers and birthing people being told that what they experience is *"normal"* or "*part of pregnancy/ birth/ being a mother"*. Psychological distress can be dismissed as "the baby blues" or "being an anxious mum". With physical symptoms, ABTA has surveyed women and common themes are frustration and distress at not being taken seriously by health professionals when they report their symptoms, having them dismissed as "normal", and complaints about pain, pressure in the vagina, and incontinence frequently minimised or not believed.

> "*I felt inadequate, silly and totally dismissed. I felt like the drs wanted me to go away and not cause a fuss and were trying to convince me that what happened to me was normal. In my GP's exact words "It happens" with a shoulder shrug". - ABTA Birth Injuries Survey 2022 (respondent experienced symphysis pubis dysfunction resulting in an inability to walk, faecal and urinary incontinence).*

4.2.2 Inappropriate, disrespectful and abusive treatment by health professionals

> *"During preparations for my emergency CS a registrar performed a Vaginal exam without consent when he thought I had effects of a spinal and I wouldn't be aware; I felt everything. I'm a sexual assault survivor, and this had ruined all the work I'd done to cope/live with that. Now I'm back to having PTSD with twin newborns to take care of and a partner who hasn't got a clue what's going on with me mentally". - Anonymous, ABTA 'Understanding Your Needs' survey*

Mistreatment by health professionals, including "inappropriate, disrespectful or abusive treatment before, during and after birth" can include being denied medication, including pain relief; not being asked or giving consent for invasive procedures, such as vaginal exams; and feeling coerced into procedures with minimal choice. We know that being subjected to disrespectful or abusive care can lead to birth being traumatic and that from recent research into these cases (and in the research termed "obstetric violence"), 11.6% of respondents positively identified with experiences of obstetric violence with results categorised into impacts of: "I felt dehumanised," "I felt violated," and "I felt powerless."[90]

Many women who have shared their stories with ABTA have also reported instances where they felt coerced into particular interventions or even modes of delivery, suggesting that they were lied to and misinformed, and a number describe procedures performed without consent.

> *"I wish I was told the truth about my ultrasound; that there was nothing wrong instead of lied to and coerced into an induction by a doctor saying they were concerned about perfusion to baby's brain." - Anonymous, ABTA Understanding Your Needs Survey*

> *"The fact I had an unconsented episiotomy has left me so mentally scared that I am afraid of seeking medical help due to the fear of not being listened to. It's so burnt into my head that I can't even get a Pap smear. I can't speak to my GP about sexual health or contraception out of fear". - ABTA Birth Injuries Survey*

[90] Keedle, H., Keedle, W., & Dahlen, H. G. (2022). Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. Violence Against Women, 0(0).

4.2.3 Lack of informed consent in maternity care

Informed consent is an important topic in maternity care and links to the experiences described above. A 2023 ABTA survey[91] undertook explored experiences of informed consent and psychological birth-related trauma and of the 271 women who reside in NSW, when considering a traumatic birth experience:

- 43.6% (118/271) of participants agreed or strongly agreed that: *"complications arose during birth, and interventions were applied so quickly that I didn't have the time to receive risk information or consider the risks/benefits."*
- 27.3% (74/271) of participants agreed or strongly agreed that: *"I felt like the doctors/midwives made decisions about my birth/interventions without consulting my partner or me".*
- 51.7% (140/271) of participants agreed or strongly agreed with the statement, *"I felt a complete loss of control during the birth experience".*

These are alarming statistics, particularly given that all Australians have a right to receive clear information regarding risks and benefits of treatments and their alternatives to enable informed decision-making, i.e.; 'informed consent.'[92] Obtaining valid informed consent in health care is a requirement for all NSW Health employees, as set out in the Consent to Medical and Healthcare Treatment Manual[93]. In the maternity care setting, obstetricians are required to undertake antenatal and intrapartum discussions with women and parents to ensure they have an understanding of the risks before them[94][95]. Unfortunately, there is evidence to suggest that the practice of obtaining informed consent is inadequate in the NSW maternity system. Up to 20% of women who experience birth complications report a lack of informed consent in birth[96], suggesting the need for urgent inquiry and reforms.

> *"I attended birth classes provided by a public hospital and I vividly remember the midwife hiding the forceps under a cloth saying look if you want but they're scary and you don't want to see them. Then created a c-section scenario and made a number of people stand around a table saying "imagine this many people staring at you, not something you want". I mentioned I wanted a c-section and she scoffed at me" - , ABTA Community Member*

[91] ABTA 2023 Birth experience survey
[92] Australian Charter of Healthcare Rights (second edition) - A4 Accessible. Australian Commission on Quality and Safety in Health Care. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-charter-healthcare-rights-second-edition-a4-accessible
[93] Consent to Medical and Healthcare Treatment Manual, NSW Department of Health. 2020, NSW Government: St Leonards NSW 2065; Available from URL https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx
[94] Consent to Medical and Healthcare Treatment Manual, NSW Department of Health. 2020, NSW Government: St Leonards NSW 2065; Available from URL https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx
[95] Dietz H, Caudwell-Hall, J & Weeg, N. (2021). Antenatal and intrapartum consent: Implications of the NSW Consent Manual 2020. Aust N Z J Obstet Gynaecol 61:802-805.
[96] Ely S, Langer S & Dietz H. (2022). Informed consent and birth preparedness/complication readiness: A qualitative study at two tertiary maternity units. Aust N Z J Obstet Gynaecol.62:47-54.

At the present time, informed consent practices in NSW maternity care are inadequate. The NSW Consent Manual is the primary statewide policy mechanism to guide and improve consent practices. To our knowledge, this is the most comprehensive statewide healthcare consent policy in Australia. While current NSW statewide policy settings have mechanisms to improve consent practices, there is a lack of compliance at the local level.

Health services must ensure compliance with the NSW Consent Manual through structural reform and local policy development and implementation. However, maternity services may need a helping hand. Maternity care is an exceedingly complex environment from a clinical, ethical and legal perspective and will likely need specific consideration to ensure a consistent approach to informed consent. With the appropriate funding, health services can make the necessary changes including promotion of genuine birth mode choices, structural reform, and local policy development and implementation.

4.2.4 Lack of communication

> *"There was a lack of communication between teams no one told me if my son was even alive." ABTA Understanding Your Needs Survey*

Many of the stories that ABTA sees include reference to poor communication from health professionals during their birth experience, and being spoken about rather than spoken to (particularly in emergent situations). Fathers and non-birthing parents also tell ABTA that they receive very poor communication from health professionals when the birth becomes difficult; often the non-birthing parent is left with little information on their loved one.

> *"My poor husband had looked on in shock. He was not given any support or information about how I was. He was given a newborn baby and watched as his wife was rushed off to the theatre. The powerlessness my husband felt in those hours has stayed with him. He has been traumatised by the birth to the point that he does not want to look at photos of our daughter as a newborn and he doesn't think he could cope should we fall pregnant again". - , ABTA Community Member*

In one study, fathers shared they needed a better understanding of what had happened.[97] Many suggested that 'nothing could prepare them' for the experience. One father said: "At no point was there any explanation to either my partner or myself to calm the situation." Another stated: "The antenatal classes are too positive and preparation for all eventualities was poor." Some fathers felt like they were 'merely a passenger'. One dad said "I felt I had no control at all, as there was nothing I could do to fix the situation. I just had to wait for the doctors to sort things out."

4.2.5 Lack of comprehensive education for pregnancy, birth and early parenthood

> *"The biggest thing for me was that in hindsight I didn't prepare for birth very well and so didn't go in feeling empowered and knowledgeable. It left me voiceless when this emergency arose and I didn't know what questions to ask, who to seek support from, etc. I was passive and in shock and I blamed myself for what happened. I had mentally prepared for a physical injury to myself but not*

[97] Daniels, E. et al. (2020). Be quiet and man up: a qualitative questionnaire study into fathers who witnessed their Partner's birth trauma. BMC pregnancy and childbirth, 20(1), 236.

one to my child. I was so worried he'd have a lasting brain injury from the ten minutes he was stuck (thankfully he doesn't) and I will never forget the silence of that room filled with people when he was born.
I just got on with things but was hyper-vigilant with his development until I was sure he was doing everything he should be at every 'milestone age' and I couldn't see someone else's smiling photo of them with their newborn just delivered without bursting into tears. I was happy for them but I mourned missing those first moments and not getting to hold our baby for two days." - ABTA Understanding Your Needs Survey

The reality is that very few parents go into their birth and postnatal experience fully informed of potential outcomes and with inadequate support for recovery and pathways to care in the event of a traumatic experience. This lack of understanding and support often compounds many experiences of birth-related trauma, as evidenced by the stories shared with the ABTA over the last six years.

> *"Like many other expectant mothers, I had aspired to the empowerment of natural childbirth. I had learned about the dangers and disappointment that tracked the spiralling cycle of medical intervention. I learned about breathing through the pain…..My experience gave rise to questions that I still have no answers to. Given the significant impact on my quality of life why had no one discussed the risks with me before the procedure? Why were there no checks on the damage after it? Why was I sent home unprepared for the fear and confusion that plagued me as my expectations of a full recovery failed to materialise?" - ABTA Community Member*

Many stories mention feeling like 'they did all the right things' to prepare for birth by attending antenatal classes and/or private birthing courses and yet they feel completely uninformed about the possibility of the birth 'not going to plan'. The education in antenatal classes seems to be different depending on the hospital or health district, and incomplete with little education about potential treatments or interventions that may be encountered. Receiving incorrect or biased information impacts decisions and outcomes, and many people feel unprepared and lack knowledge about their care and birthing options, which affects people's ability to advocate for themselves during their experience.

In ABTA's 2021 *Understanding Your Needs Survey*, a sample of responses from NSW birth experiences to the question "What do you wish you had been told about giving birth but weren't", include:

> *"That things can go wrong and what are the consequences of this. I had zero information and was left in total shock. After reading my yellow card after birth I found out how serious my pregnancy complications were and that I should have been given much more information and time to prepare for such situations. If I hadn't been so naive and done research I would have felt more prepared of the situation. And also able to deal with the decisions that were made for me by the OB."*

> *"What was special care, what is pumping, that I will have to leave baby in special care."*

> *"A c-section is not a failure. There's a lot worse that can happen. Prolonged pushing can lead to serious irreversible damage that could leave you incontinent."*

"That birth isn't always a positive experience and that you might not feel the instant love and connection with your baby due to your birth."

"Forcep damage and prolapse. I would have opted for a c section had I known I would be permanently damaged."

"The potential possible outcomes preterm labour, c-section. That my birth plan would be put in the bin and told you did n't need to bother with that let it go"

"That NOT all bodies can birth naturally; not all labour's are the same - everyone is different; your body, the babies position changes the pain levels of labour; you are not a failure if you can't 'just breathe your baby out'; that many many women don't experience birth as the best day of their life. That the bond will come. That I will feel better."

"The severity of tearing, never was told how bad tearing could be."

"I wish I was more educated in the what ifs, what may happen, what injuries could arise as a result."

"I would have loved more information about things that might go differently to "normal". My body dilated to 10 but never felt the urge to push and waters didn't break. She turned around and around instead of going down and it caused incredible pain."

This is a small sample of responses but demonstrates the need for consistent, comprehensive information provided to birthing parents heading into the birth experience, especially for first-time parents.

4.2.6 Misdiagnosis or delayed diagnosis

"It was exceptionally difficult to get a diagnosis for birth trauma, and injuries addressed and a formal diagnosis for PTSD. I sought assistance from two (2) hospitals, five (5) psychologists, two (2) counsellors, twenty (20) doctors, four (4) gynaecologists, four (4) pain specialists, a women's out-patient clinic, three (3) physiotherapist(s), a pelvic pain diagnostic clinic, multiple ultra-sound clinics most not specialised in treating women with chronic pain, multiple MRIs from clinics not specialised in treating women in chronic pain. I also presented to an emergency department on multiple occasions in extreme pain, being barely able to walk. The medical staff laughed at my extreme reaction of pain to a physical examination and dismissed me as a stupid woman who should see her GP." Anon - ABTA Community Member

"The hospital that diagnosed my sphincter tear said that it can't be fixed now, but it could have been fixed if it was picked up at time of delivery. If it was fixed in a timely manner or even prevented I would not be incontinent." ABTA Birth Injuries Report

"The wound at my perineum wasn't healing so my GP sent me to a specialist who wasn't entirely sure what had happened. She luckily went to a talk by [a urogynaecologist] who I then saw and

[diagnosed me] with a near complete avulsion of both levators. This whole process took 6 months" ABTA Birth Injuries Report

As outlined in the impacts of birth-related trauma (3.1.4), misdiagnosis or delays in receiving a proper diagnosis are common themes in ABTA surveys and stories. For example, in our 2022 survey for the Birth Injuries Report [98], participants highlighted their struggles to access care due to their concerns being dismissed or not believed. While 25% had their injuries diagnosed immediately after birth, a quarter of women had them diagnosed at different times and 10% of participants had to wait over a year before receiving a diagnosis. In some cases, misdiagnoses or insufficient monitoring led to emergency situations during labour.

"I wish I'd found the women's health physio straight away instead I found her over a year after my son was born." ABTA Birth Injuries Report

Common experiences are misdiagnoses of pelvic injuries, including prolapse, levator avulsion, and the severity of tears. There are also cases of undiagnosed retained placenta, requiring further postpartum medical procedures and causing further pain and trauma for women. These occurrences could be due to health professionals not thoroughly examining or understanding the extent of the injuries and linked to the cases above of having reported symptoms dismissed or ignored, leading to prolonged pain and mental distress for the affected individuals.

" I was told it was all normal until I saw a women's health physio who told me my birth had caused the issues I was having and it wasn't normal. I'm a physical education teacher who can now no longer lift, run, jump. It's ridiculous." - ABTA Birth Injuries Report

Obtaining a diagnosis for birth injuries is often complicated and a number of different types of health professionals might be involved in a person obtaining a diagnosis, many women we support have to travel interstate to get specialist care for their needs. Based on ABTA's Birth Injuries survey, it is most common for physical injuries to be diagnosed by an obstetrician (27%), but almost one in five (18%) received a diagnosis from a pelvic health physiotherapist.

"The impact wasn't acknowledged by any professionals except a women's health physio. It was a very isolating and shameful experience." - ABTA Birth Injuries Report

Survey responses highlight the importance of access to pelvic health physiotherapy to identify injuries and to provide treatment for symptoms such as pain and incontinence, with 77% of survey respondents accessing pelvic health physiotherapy for ongoing treatment. This highlights the important role of this group of specialists in the diagnosis and care of women postpartum.

'We would like to ensure women are accessing effective care for birth-related trauma in a timely manner. Too often women have been suffering with symptoms without knowing where to seek appropriate healthcare and support. If we can allow earlier access to pelvic health physiotherapy, we can reduce the overall impact of birth-related trauma.' Dr Angela James FACP, Sydney Pelvic Clinic

Pelvic health physiotherapy can assist with birth preparation by teaching how to relax the pelvic floor and push in labour and can help identify those at higher risk of pelvic floor muscle

[98] ABTA Birth Injuries Survey, 2022.

dysfunction.[99] This can support better birth outcomes and reduce rates of postnatal urinary incontinence, and may have psychological benefits including increasing a sense of control over labour. This supports increased self-confidence and a reduction in birth-related anxiety, whilst helping to prepare women for a physiological birth.

However, access to perinatal pelvic health physiotherapy can be hard to come by; over three-quarters of women in our 2022 Birth Injuries Report were required to access this type of care privately, spending thousands of dollars on out-of-pocket expenses for treatment of physical and psychological injuries. Access to postnatal care is especially difficult for those in remote and rural areas and those from culturally diverse backgrounds.

> *"There were insufficient public appointments so I paid to see a physio privately which was an added cost during my maternity leave.'*

> *"Both my mental health and physical health treatment have cost thousands upon thousands of dollars. I am lucky that I have been able to rely on help from my parents as there's no way I could afford it otherwise. It's extremely inaccessible."*

The cost of preventative or early intervention physiotherapy appointments for women birthing in Australia has a much better economic value than the future interventions that they might need, including surgery, and the inability to return to work due to their pelvic floor symptoms. However, there is minimal access to physiotherapy support (as referred to earlier). Most pelvic health physiotherapy is provided in private practice, and at the moment, it is hard for GPs to refer people for subsidised physiotherapy, except under a chronic disease management plan. As it stands today, pelvic organ prolapse or other symptoms of birth injuries are not recognised as a chronic disease.

However, you usually need to see a physio before attaining a diagnosis of a 'chronic disease' and therefore, there is no subsidised pelvic health physio in the private setting (outside of private health insurance).

> *"Referral to the physio at the hospital I birthed was declined, there was no interest of the hospital to follow up birth injuries. I avoided going out socially for months as I couldn't sit for more than a few minutes." ABTA Birth Injuries Report*

These debilitating health issues affect not only the physical, mental and emotional health of the women dealing with them but also their partners, families and children. These statistics are alarming, as is the fact that the systematic collection of national data about pelvic floor health after childbirth has been neglected for so long.

4.2.7 Complications, medical procedures and interventions

Respondents report traumatic experiences due to the use of forceps, episiotomies, inductions, surgical errors and failed procedures, including failed episiotomy procedures and revisions. Some mothers experienced birth injuries and complications during birth, leading to long-term pain and

[99] Shek, K. & Dietz, H. (2010). Intrapartum risk factors for levator trauma. BJOG: An International Journal of Obstetrics & Gynaecology, 117: 1485-1492.

difficulties in subsequent pregnancies. However, many people were not aware of the common complications associated with childbirth, including in routine procedures.

In 2020, the rate of instrumental births (forceps and vacuum extraction) in NSW was 11.7%.[100] We know a major contributor to birth injuries arises from instrumental intervention.[101] The rates of episiotomies have also increased over the last 15 years (from 16% in 2004 to 23% in 2021 for non-instrumental vaginal births in first-time mothers, and from 61% in 2004 to 81% in 2021 for instrumental vaginal births). While health professionals may identify clinical indications for an episiotomy to support birth outcomes, there must be a greater understanding of the impacts of these procedures and appropriate care to support healing and recovery.

> *"My episiotomy was not stitched back together properly resulting in 2yrs of pain before it could be fixed." - Anonymous, ABTA Birth Injuries Survey*

> *"My episiotomy stitches popped before I even left the hospital so midwives/nurses examined it and did nothing except draw me a picture of what it looked like. It would not heal and I had an open wound on my perineum for weeks. I could not sit and had to breastfeed, eat, and do everything either standing or lying down." ABTA Volunteer*

> *Not a day goes by without residual episiotomy pain. Also feel strained after forceps delivery which causes sadness for me. - Anonymous, ABTA Understanding Your Needs Survey*

Many of these procedures and interventions are used as standard care with minimal education and understanding among health professionals and parents of the long-term impacts of these interventions.

4.2.8 Lack of postnatal social and care pathways

Many parents also report a lack of available resources for postnatal recovery, mentioning: frustration with the lack of proper postnatal care, including not receiving an opportunity to debrief and ask questions about what has happened to them; lack of emotional support as a new parent; barriers to access to specialised care, such as mental health clinicians, urogynaecologists or pelvic health physiotherapists, and other necessary treatments.

Limited access to these services may have hindered their ability to receive timely and appropriate treatment, and insufficient support and guidance during the postpartum period may have exacerbated physical and mental health challenges. There is also trauma experienced during the postnatal period, including due to paediatric health issues and difficulties in breastfeeding, particularly where breastfeeding parents do not receive adequate support or feel pressured or stigmatised by health professionals.

Women that seek support for our services range from having their births, weeks, months, years and even decades ago. Many women we support have been so focused on taking care of their babies that they do not even think about themselves until the initial busy 12 months have passed.

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[100] Type of birth (vaginal, caesarean, forceps etc) for 2020, NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.
[101] Shek, K. and Dietz, H. (2010), Intrapartum risk factors for levator trauma. BJOG: An International Journal of Obstetrics & Gynaecology, 117: 1485-1492.

This means that they are no longer able to access free support services provided by Perinatal Mental Organisations.
Research suggests that it takes an average of seven years for someone to seek support for their trauma.[102,103] It is extremely common for many women we support to contact us when they are thinking about another pregnancy or pregnant a second time. Some may not have recognised that they have experienced birth-related trauma until this point. For fathers and partners, they may never seek support.

> *"I am in a really hard place, my birth trauma is coming to the surface as we approach my son's first birthday. He is unwell at the moment having caught hand, foot and mouth and I have been trying to get him to sleep, not helped by my husband and I having a significant argument just as he was nodding off after trying for an hour." ABTA Community Member*

4.2.9 Health System Policies and Structures that lack Individualised Care

The concept that 'natural birth' is the safest and 'best' method of delivery is an enduring belief often reflected in policies and practice[104]. Many people who share their stories with ABTA reflect that elective caesareans or 'maternal request caesarean' are not fully supported or encouraged, suggestions that the decision to forgo vaginal birth is somehow a 'cop-out' or even selfish due to potential neonatal risks of caesareans[105].

> *"Just reflecting on the antenatal education my husband and I did through the (public) hospital… it very much echoed the pro/positive rhetoric around vaginal birth and covered none of the risks. Consequently, I think it fed my own misconceptions around 'positive natural' births" - Adelle, ABTA Community Member*

It is possible that a combination of natural birth ideology, ingrained ideas regarding the safety of caesareans and concerns about health economics, have stalled any progress regarding birth mode choice. Consequently, vaginal birth remains the default mode of birth in public tertiary maternity care in NSW. While many might see this as an innocuous feature of maternity care, a lack of genuine birth mode choice is a factor in many people feeling a loss of control and can contribute to trauma.

In a model of care that includes genuine birth mode choice, healthy first-time pregnant women are freely offered a choice between planned vaginal birth and planned non-medically indicated caesarean. They would be informed of the pros and risks of both birth pathways including maternal and neonatal risks, and physical and psychological outcomes of planned vaginal birth including emergency caesareans and instrumental delivery. In the current model of care, vaginal

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[102] Sayer, N. et al. (2007). Use of mental health treatment among veterans filing claims for posttraumatic stress disorder. J. Traum. Stress, 20:15-25.
[103] Wang, P. et al. (2005). Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication. Arch Gen Psychiatry. 62(6):629–640.
[104] Ely, S, Shek, K & Dietz, H. (2020) 'Normal birth': Time to change our tune? Australian New Zealand J Obstetrics Gynaecol.
[105] King J. (2021). Are there adverse outcomes for child health and development following caesarean section delivery? Can we justify using elective caesarean section to prevent obstetric pelvic floor damage? Int Urogynecol J. 32:1963–1969.

birth is considered the default, and healthy low-risk pregnant women are presumed to want or prefer a vaginal birth, so risks regarding birth mode are not routinely discussed. 'Healthy' does not take into account a person's pre-existing history and the impact that may have on a physiological delivery.

Yet, if there is any indication of a request for a caesarean, risks are disclosed and in some cases, mothers feel like they are forced to reconsider a vaginal birth which is promoted as the safest birth mode. In order to truly address the inadequacies in consent practices in NSW, it is imperative that genuine birth mode choice is a routine feature of maternity care.

The model of care that places primacy on one birth mode can have devastating unintentional outcomes, as in UK, when results from the Ockenden inquiry into maternity services at the Shrewsbury and Telford Hospital NHS Trust in the UK identified that repeated failures in care likely led to the deaths of more than 200 babies and 9 mothers, as well as more than 100 instances of devastating, lifelong injuries[106].

A theme identified in the Ockenden Report is the unintended harm that can come from imposing 'normal' (aka vaginal) birth targets on individual women. The report identified that the Shrewsbury and Telford Hospital Trust had a focus on reducing caesarean rates and was, at one time, lauded for having one of the lowest caesarean rates in the UK. We now know that, for many women and babies, this came at a cost, with lifesaving interventions called too late. Many of the themes in the Ockenden Inquiry surrounding healthcare failures are also present in Australia, including inadequate resourcing, low staff morale, and lack of collaboration between obstetricians, midwives, and managers.

The Ockenden report is a sobering reminder of the importance of well-staffed and resourced maternity units, and collaborative, multidisciplinary care. It is also a timely reminder that population-wide birth 'targets' – be they for 'normal' (vaginal) birth, or any other mode of delivery – ultimately can do more harm than good. What matters is informed, person-centred care where women and birthing parents are listened to and their own values, desires and risk factors are put front and centre. There is no best, one-size-fits-all way to birth.

> *"If a group of people promote normal birth as better than another form of birth, that's not putting women at the centre of care,"* - Chief Executive of the Royal College of Midwives, Gill Walton.

In NSW, there have been similar attempts to impose targets aimed at reducing caesareans. As far as we know, most of these policies have been abandoned or put on hold, but anecdotally we regularly hear from women who say they felt pressured to birth a certain way and believe they were injured or traumatised as a direct result. There are other instances where arbitrary targets guide practice, such as aiming to reduce prescriptions of pain relief for example.

> *I've since learnt brag they hand out the least drugs in Maternity saying it's all about support - I wish I could attend and explain it's because they just don't give them out*

[106] Independent Maternity Review. (2022). Ockenden report – Final: Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.

when you ask/beg. They put you off then pretend there is no choice. - ABTA Community Member

It is important to consider how system-wide health policies that focus on data-led targets impact on individuals, and this demonstrates the need to have policies and practices informed by people with lived experience and by prioritising choice and person-centred care.

4.2.10 Lack of professional collaboration

One of the issues in the provision of care reported by parents in the ABTA community is the limited collaboration between health professionals and the competing and contested space between obstetricians and midwives. There is international evidence that the best way to help mothers and birthing people feel supported and involved in their pregnancy, birth and beyond is to have continuity of care(r) throughout pregnancy and labour, provided by someone they know and trust. However, with the current workforce and system challenges, this is out of reach for most people.

Considering birth-related trauma can be linked to all stages of the birth experience (from conception through to birth and postnatal care), it must also be considered that true "continuity of carer" is not feasible in many situations and that a more supportive, integrated multidisciplinary approach may be more effective.

There is a history of midwifery and obstetric relationships being characterised as adversarial[107]. More recently, cultural problems have been identified as a major barrier to high quality maternity care[108].

In practice, this plays out as tension between midwives who may advocate for both women and 'normal' or intervention-free birth and obstetricians who bear primary legal responsibility for the care of the patient. The conflict between health professionals does not support contemporary woman-centred care or promote autonomous decision-making, and it fails to regard the mother or person as the primary decision-maker at birth.

"The politics within the hospital were toxic and every midwife wanted to tell you their best way of doing things. I went through 7 different midwives from induction to birth already."

This lack of collaboration is a concern in the process of birth, where it is highly unlikely, if not impossible, to have one provider offering continuous care throughout your entire pregnancy, birth and postnatal experience. At present, the only ways to do that are through a private obstetrician to look after you during pregnancy and during labour/delivery, or a private midwife who can effect delivery in up to 70% of cases. Of course, this is only possible for people with the resources (financially and geographically) to access private care. There is much that needs to be done to improve maternity services, which are even more scant in regional and remote areas where attracting and retaining staff is proving more difficult than ever before..

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[107] Ely, S, Shek, K. & Dietz, H. (2020). 'Normal birth': Time to change our tune? Australian New Zealand J Obstetrics Gynaecol.

[108] Ananthram H, Vangaveti V, & Rane A. (2022). Have we lost sight of the women? An observational study about normality-centred care in Australian maternity services. Australian New Zealand J Obstetrics Gynaecol, 62:40–46.

> *"We are ready to try for #2, and I don't think we will be able to afford to increase private health to cover pregnancy. My daughter is incredibly attached to me, so I'm also worried about being able to travel for appointments (she does not travel well), we have no local family or support at all, and I'm worried I will have preeclampsia/premature baby (both were unrelated) again.*
> *It was so hard, even being in a beautiful, new hospital with all the bells and whistles.*
> *Our local is awful, I have PTSD from a night there with my baby when she was baby and then going to the city 2.5 hours away because the care/experience was just so bad.*
> *I'm really scared of giving birth there, but we don't really have any other choice. The next public hospital is in a town 40 minutes away and they will not take people who live outside the area." - ABTA Community Member*

Publicly funded services may include midwifery group practice where one of a team of midwives can look after a woman so there is some continuity of care, but where there is any need for obstetrician involvement, it will be supplied by an unknown person at precisely the time a woman most needs a known and trusted care provider.

The roles of the family GP and local Maternal Child and Family Health Nurses are also important to consider, as most postnatal visits will be delivered by these units, depending on resourcing and availability. GPs may be expected to do the baby checks as well as manage any maternal issues like care of perineal stitches or caesarean wounds, as well as keep an eye on mum's mental health. Many GPs can no longer afford to bulk bill their services, so many women who can't access a government-funded postnatal carer simply don't have postnatal visits.

> *"There was no follow up at all after my 2nd degree cervix tear and PPH. I then felt the prolapse and my GP referred me to a physio who suspected an Avulsion. I then had to ask for a uyrogyno referral and because I live in regional NSW I had to wait for an appointment in Sydney." - ABTA Understanding Your Needs Survey*

The other role, as mentioned earlier, is for pelvic health physiotherapy and consideration of referral pathways for specialist care for birth injuries (e.g. urogynaecologists, colorectal surgeons etc). A truly trauma-informed, patient-centred system would ensure integrated multidisciplinary care that has processes and practices to support continuity of that care through improved interdisciplinary communication and support for mothers and parents.

4.3 Community and Societal Level

> *" I was so surprised at the stigma associated with admitting I had a less than perfect birth experience. My birth trauma left me feeling physically and psychologically weak and scared. I would share my story, seeking acknowledgement and support. Instead, my vulnerability seemed to make people feel uncomfortable. When I admitted to people that I was finding it physically and mentally challenging to recover, I'd be told "all that matters is that you have a healthy baby", or "your expectations were too high", or "oh yes, that's what it's really like". , ABTA Community Member*

Attitudes to childbirth in Australia are influenced by a number of factors, and there is formal understanding and acceptance of diverse childbirth approaches. However, attitudes in society at large are often more nuanced, particularly at the individual level, and can impact on how healthcare is provided on the ground. This can then contribute to birth-related trauma as mothers

and birthing people are made to feel their experience is invalid, further compounding the trauma, and sometimes impacting on the ability or willingness to seek help.

Much of this comes back to a lack of awareness and understanding of birth-related trauma. Below are details on the factors of:

- Stigma and shame
- Lack of understanding of trauma, and trauma-informed support.

4.3.1 Stigma and shame

> *"While I had suffered from depression before, what I felt after the birth was different. I couldn't figure out what the feeling was and why it wouldn't go away, and I certainly couldn't articulate it to anyone else. I was constantly overwhelmed by feelings of guilt, shame, jealousy, and anger." - , ABTA Community Member*

Previous generations have an understanding of birth that is still rooted in the prevailing attitudes of society when they or people in their age cohort gave birth. Cultural and religious differences influence attitudes as well, with unique practices being prioritised for different cultural backgrounds.

All of this can contribute to the internalised beliefs and attitudes that parents take into their own birth experience. How a parent gave birth, the experiences of friends or siblings, and the local community with whom you identify will all influence one's own attitudes. Unfortunately, when things don't go according to plan, this can translate into complex emotional and psychological impacts caused by shame and stigma.

Mothers and birthing people reported feelings of regret, disappointment, and 'failure' after a traumatic birth, which were not as positive as they had hoped, and many experienced feelings of grief over "not getting the birth they imagined". Common themes are the idea of a caesarean not being a "real" birth, failed attempts at a 'natural' VBAC, breastfeeding challenges and bonding difficulties with the baby due to the impact of trauma.

> *"I expected it to be the best experience of my life, instead it was the worst and I was so lost for so long. I couldn't understand why I felt that way and I don't think anyone else around me did either!" - ABTA Understanding Your Needs Survey*

> *"I was proud until I realised I had prolapse in all 3 compartments. Now I'm full of regret." - ABTA Birth Injuries Report*

> *"I couldn't understand why I was in pain and being so affected after birth, when everyone else I know with babies were totally fine and getting back into their usual activities. It altered everything in my life, while trying to adapt caring for a newborn" ABTA Understanding Your Needs Survey*

> *"'Failure' following attempted 'natural' VBAC - shame and depression" - ABTA Understanding Your Needs Survey*

In health systems, there is growing recognition and value placed on autonomy and choice for women and birthing people, and there are options for elective caesareans as well as non-medicalised midwifery-led birth, and home-birthing practices. However, prevailing attitudes can still influence clinical practice on the ground.

Many mothers and birthing people go through a process of grieving for the birth they wanted, without being given the tools or validation to navigate those feelings. There is often a focus on the "healthy baby" over the wellbeing of the mother or birthing parent, which then undermines feelings of loss, and contributes to shame and a sense of not being a "good mother".

> *"That every mother and birth and baby is different. Don't think your mum's experience will be yours. (My mum only had grazes from vaginal births). Also, to learn how to relax but be informed as it can go the other way as well, your mum may have had a terrible experience but that doesn't mean you will." - ABTA Understanding Your Needs survey*

> *"Significantly effected my postpartum period, my physical recovery took a toll on my mental health. I look back on the weeks after birth with sadness and grief at what I feel I missed out on". - Birth Injuries Survey*

> *"I can't wear some pants for long days because they rub and cause pain or discomfort. I can't wear some clothes at all (particular underwear has a line at exactly the wrong spot). I notice discomfort in the scar every day. I mostly tune it out but sometimes it is stressful. It reminds me of the grief of what happened in the hospital when I was taken away from my care team and plan, and the stress of the emergency C-section. It makes me feel so angry about the inadequate care I received after my operation. I feel like it probably didn't have to be this way, that they should have cared for me better." - Birth Injuries Survey*

4.3.2 Lack of awareness and understanding of birth-related trauma, and lack of trauma-informed care

It is estimated that 75% of Australian adults have experienced a traumatic event at some point in their life (Productivity Commission estimates using ABS 2009).

There is still a lack of awareness and understanding of trauma-informed care in maternity services and a fragmented and unsupportive postnatal care system that seems to be based on supporting mothers and parents who have experienced straightforward and uncomplicated births. In instances of birth-related trauma, people often encounter an increased *lack* of support where there should be an increased *level* of support.

ABTA has observed that until more recently with the establishment of the new LEAAP Guidelines there was limited recognition of birth-related trauma in relevant national health policies, which has translated to:

- A lack of pathways to care in health systems and neglect to ensure the provision of collaborative care and/or continuity of carer
- Inadequate training and awareness of birth-related trauma amongst perinatal health professionals lead to delayed diagnosis and suboptimal care

- A lack of evidence-based antenatal education and information on birthing practices and potential birthing complications

Whilst birth-related trauma isn't always preventable. ABTA believes that more can be done to identify those at risk of psychological trauma with the application of trauma-informed practice.

> *"My 6 week check was a horrendous experience with no care given to someone who had experienced birth trauma - in the questions asked and the physical exam." - Birth Injuries Survey*

> *"Feeling doomed. Hopeless. So sad. Abnormal. Like no one cares. I hate having to retell my story over and over hoping someone will care and understand". - Birth Injuries Report*

Trauma-informed practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma that emphasises physical, psychological, and emotional safety for everyone and that creates opportunities for survivors to rebuild a sense of control and empowerment[109]. Put into practice, this approach can reduce the likelihood of stressful interactions and helps reduce the effect of prior traumas.

Trauma-informed care requires an individualised approach to caring for mothers and birthing people. It requires acknowledging and understanding a person's prior birth experience or personal histories, and consideration of how past traumatic experiences can impact a present birth journey. A trauma-informed approach requires asking the woman or birthing person about what will help her/them feel safe (and unsafe) in their antenatal care, birth and delivery. It means women and birthing people have access to unbiased approaches to birth experiences and ensure that people feel in control during the process. It involves recognising triggers, avoiding re-traumatisation, and providing a supportive environment that promotes healing and empowerment.

The principles of trauma-informed care include safety, collaboration, empowerment, choice and trust.[110] Without the explicit incorporation of these key principles, a clinician is not practising in a trauma-informed way. For consumers of maternity services to have a truly trauma-informed experience, these individual practices must occur within a trauma-informed service where principles are reflected in the service's values, practices and governance including in leadership and management, extending to evaluations, responses and inquiries into care shortcomings.

[109] Hopper et al. (2010) Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. https://www.researchgate.net/publication/239323916_Shelter_from_the_Storm_Trauma-Informed_Care_in_Homelessness_Services_Settings

[110] Fallot, R & Harris, M. (2015). Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol.