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INQUIRY INTO BIRTH TRAUMA

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NSW Parliamentary Inquiry into Birth Trauma

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Name: Ms Alysha-Leigh Fameli

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To The Committee;

I am submitting this response from several positions; a consumer of the maternity care system in NSW (a birth in the NSW public system in 2016 and a homebirth with a private midwife in 2019), a registered psychologist who works with families including women and people in the perinatal period, specifically in the context of psychological birth trauma and as a PhD candidate at the University of Sydney. My PhD research, 'Adverse Childbirth Experiences and the mother-infant relationship' focusses on psychological birth trauma and the rippling sequalae for mothers and infants. I am happy to be contacted and to give evidence at a hearing.

I will address the following items from the terms of reference;

1. (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")

Due to a lack of funded research, we do not have a good estimate of Australian prevalence rates. International research suggests that approximately 1 in 3 women report an element of their birth experience was psychologically traumatic. Recent research from the Western Sydney University (Birth Experiences Study) suggests that obstetric violence is reported by 1 in 10 women. In a recent paper published by my colleagues and I at the University of Sydney, 28% of women surveyed (N = 705) reported that they experienced their birth as traumatic. This sample was focussed on traumatic birth and symptoms of childbirth-related post-traumatic stress disorder (CB-PTSD). While women who experienced traumatic birth may have been more likely to complete this research, we found that 12.5% of our sample met full criteria for PTSD in the twelve months following birth (Fameli, Costa, Coddington & Hawes, 2023). This study aimed to validate a routine screening measure for CB-PTSD that can be used with Australian women, the City Birth Trauma scale. Our findings suggest that this measure is valid for use in research and clinical settings, and a majority of participants (88.9%) found the measure to be acceptable and would be willing to complete it during routine healthcare.

(b) causes and factors contributing to birth trauma including:

Our study suggested that the highest rates of CB-PTSD occur with women and people experiencing instrumental vaginal and emergency c-section births. This suggests that this cohort requires special care and attention in the intrapartum and postpartum period. We also found that induction status was correlated with symptoms of birth-related PTSD, indicating that women and people who are induced during labour should also be provided with

additional care and attention including screening for CB-PTSD in the postpartum period. Substantial research has been dedicated to the obstetric and social factors that are correlated with psychological birth trauma.

(iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

• Women in the perinatal period can access 10 Medicare rebated psychological sessions under the Better Access to Mental Health Care Plan with a valid referral from their GP per calendar. These sessions are often used in 2-3 months, depending on the clients distress/presentation and then women must pay the full fee for psychological care. The Australian Psychological Association recommends a fee of $267 for a fifty-minute consultation. The Australian Associate of Psychologists Inc suggests that 10 sessions is insufficient given the sensitivity of this period for both the mother and infant, and recommends that 40 sessions should be available for women in the perinatal period.

• Some primary health networks provide perinatal programs; however, this is not consistent in and local health districts in NSW and places are often limited.

• Waitlists for psychologists with expertise in the perinatal period can exceed six months in some areas.

• Routine mental health screening in the perinatal period is insufficient. Screening typically includes screening for depression and anxiety, and does not include screening for CB-PTSD, though a recent study published by my colleagues and I suggests that the City Birth Trauma Scale is a feasible and reliable measure that could be used in routine health care (Fameli et. al, 2023).

• Research around interventions for psychological birth trauma remain scarce, though well-validated trauma therapies including trauma-focussed cognitive behavioural therapy and eye movement desensitization reprocessing therapy have indicated promising results.

• Interventions should include the mother-baby dyad and focus on the wellbeing of the mother, infant and parent partner. There is currently no funding for this type of intervention.

(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

There is evidence to suggest birth trauma:

• Has potential adverse effects on infant development including cognitive development, feeding and sleeping (Cook et al, 2018)

• Impacts breastfeeding (Beck and Watson, 2008; Beck 2009)

• Places strain on partner relationships (Ayers, Eagle, & Waring, 2006; Beck, 2011; Nicholls & Ayers, 2007)

• Creates difficulties in the mother-infant bond (Handelzalts et al, 2022)

• Creates subsequent fear of childbirth and impact on reproductive choices (Jomeen et. Al, 2021)

• Can result in psychological disturbance including symptoms of PTSD and depression for the woman (see the work of Ayers, Dekel, Beck and many others over the past 20 years)

(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 (iii) people from culturally and linguistically diverse (CALD) backgrounds (iv) LGBTQIA+ people (v) young parents

It is crucial to note here that due to a lack of funding for research, much of the research around birth trauma (in Australia and internationally) there is a lack of representation across diverse groups. For this reason, it is difficult to examine exactly how traumatic birth experiences may affect people from the various groups mentioned above, and the prevalence at which birth trauma occurs for people within these diverse groups. There is substantial research from the UK and USA that suggests that people of colour may be at greater risk of experiencing obstetric violence.

Suggestions for change

• Increased access and funding for continuity of care models during pregnancy and birth, such as the midwifery group practice (MGP) program

• Increased training for healthcare providers regarding trauma-informed care in practice

• Routine screening for childbirth-related PTSD in the postpartum period and in subsequent pregnancy

• Development of mother-infant wellbeing programs where mothers can access 40 subsidised psychological services with a focus on maternal wellbeing AND the mother-infant relationship.

• Screening for CB-PTSD and depression in birth partners

• Legislation regarding informed consent for medical procedures

• Investment in antenatal birth classes

• Investment in maternal and infant mental health research to develop best-practice interventions for mothers and infants.

Finally, I would like to share my birth experience that led to my pursuit of research. In 2016, I fell pregnant with my first child in a planned pregnancy. I attended antenatal classes at my local hospital, consumed books and papers relating to active birth strategies and had a relatively uneventful pregnancy. I was not fearful of childbirth. My pregnancy was managed through a shared-care process with my GP. On the day of my son's birth, my local hospital birth ward was busy, and I was advised to stay at home for as long as possible. I laboured well at home and eventually went to hospital when my contractions were regular and intense. I was placed in a storage room that had a bathtub (due to limited labouring rooms) and midwives and staff entered the space regularly to get towels for other birthing people. I experienced kindness from the birth suite midwives, who were very stretched but warm and supportive. I laboured in the hospital from around 9am and gave birth just before 3pm. In the final, transition stages of labour, I was advised the midwife was having trouble picking up my sons heartbeat on the portable doppler.

She requested I sit on the bed and leave the shower (which I had been using for pain management along with nitrous oxide) and get on the bed to be hooked up to a CTG machine. I protested as I specifically had decided I did not want to birth on my back. The midwife insisted she needed to check on babies wellbeing. During this stage, I began pushing. I was told that my son's heartbeat had decelerated and accelerated and the midwives wanted to keep a close eye on him. I was advised I needed to lay on my back for the CTG machine to get a clear reading. I was on all fours, and recall hospital staff placing hands on my wrists and guiding me onto my back. This act felt invasive, and against my natural instincts. I was then guided into pushing my baby. After a significant pushing stage, an obstetrician entered the room. I was not addressed by name by this clinician.

The obstetrician stated to the midwife words to the effect "what is wrong with this woman, she is not pushing properly. Has she had an epi(dural)". I recall thinking (possibly saying) "something is wrong" and having a strong urge to move to all fours. The obstetrician directed the midwife to give me an episiotomy. I was not consulted and did not provide consent. A statement was made with words to the effect "I am going to cut you now to help baby come out". An incision was made in my genitals, and I witness a slash of blood hit the midwife and attending obstetrician. The obstetrician chastised the midwife and said she had performed it in the wrong position (straight down). I was then advised to push on my next contraction. I responded that I had ignored contractions as something was wrong. The obstetrician then stated words to the effect "I am going to give you one more chance to get this baby out, then I will vacuum him out". I was not given an explanation of this procedure and did not provide consent. The obstetrician used the ventouse, and my son's head emerged. It was quickly realised that my son was not able to emerge from the birth canal due to shoulder dystocia and an emergency button was hit.

Staff entered; a procedure called the McRoberts manoeuvre was performed. This was invasive (my legs were pushed up; a staff member was pushing my stomach and the energy was frantic). My son emerged. He was unharmed (other than a misshapen skull) and his Apgar score was excellent (9 and 9). He was rushed away fpr examination after a staff member screamed at my husband "cut the cord" but handed him surgical clamps instead of scissors. My husband was distressed during this period. My son required no support and was fine. I dissociated during this period and vividly recall the treatment by the obstetricians in the room. By this point a senior obstetrician entered. The first attending obstetrician stated that he would stitch me up, and the senior obstetrician stated, "don't you think you have done enough". I was informed I had a second-degree episiotomy/tear and required stitches. Pain relief was inserted in my anus without my knowledge or consent and stitching began which took some time (approx. 40 minutes).

At one point I winced and stated it hurt and was met with "how can you even feel that". A local anaesthetic was administered. I recall feeling disconnected from my baby and in a daze. Hours later I was moved to the maternity ward and my husband had to leave. I felt overwhelmed and shocked. My son began choking on mucous and I felt paralysed. A midwife responded to him and was kind to me, however subsequent treatment on that ward was unhelpful. This included while trying to learn to breastfeed having a midwife state, "what is

wrong with you, isn't this your second baby?" and then proceeding to grab my breast and force it into the babies mouth (without my consent or understanding). I had another midwife look at my vulva and state "whoa". I was unaware of the level of damage. In the following weeks and months, I experienced urinary and faecal incontinence and a physiotherapist advised that the damage was more consistent with a third-degree tear as the perinium scarring indicated the area was nearly completely severed.

I experience symptoms of posttraumatic stress (hyperarousal, difficulty sleeping not related to babies sleep, difficulty bonding with my son, flashbacks and nightmares about the birth, excessive fear that my son would die). I tried to raise this with the community nurse three weeks after my sons birth and was dismissed as I did not meet criteria for postpartum depression according to the Edinburgh Postnatal Depression Scale. I had significant difficulties breastfeeding and received no support for this.

During my second pregnancy, I research shoulder dystocia. A primary risk factor is birthing on the back, as is induction. I was told in my second pregnancy I needed to be induced to prevent my baby from getting too big (my eldest son was 3.6kg, average) and to prevent the risk of dystocia. I was told if it happened again there was only seven minutes to get my son out or he could die. I was told that the risk was substantial. When I asked about active birth strategies to prevent reoccurrence I was dismissed and left feeling frightened. I attempted to advocate for myself to have an active, upright birth with a birth pool to manage pain. I was advised this would not be possible and found hospital staff to be dismissive and rude. I was in a privileged position to access a private midwife and opted for a homebirth. I birthed a larger infant, upright with no complications.

In my postnatal period I experienced joy, bonding with ease with my infant and none of the psychological symptoms I experienced in my first birth. My story is one of privilege. I have been privileged as a white, middle-class woman with a university education, and I have been privileged as a psychologist to have access to resources and support. I hope that this inquiry will shed light on the experiences of all birthing women and people, but particularly those who do not experience the same level of privilege that I have. Safe, informed births lead to stronger maternal and infant wellbeing. Investment in mothers and babies results a stronger community and birth trauma may represent one of the earliest adverse childhood experiences that could be avoided from a public health perspective.

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