

Birth Trauma in New Zealand

Some Major Concerns

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Be Heard. Begin Healing. Become Empowered.

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Introduction

The first time I witnessed birth trauma was as a midwifery student in the 1990s. Having just done a wonderful job of birthing her baby, Anna then needed to have a perineal tear sutured by the on-call obstetrician. He gruffly introduced himself then sat between Anna's splayed knees to begin his work. The obstetrician injected her with some local anaesthetic but clearly not enough as every time he drove his needle into her sensitive tissues she stifled a cry of pain and tensed her legs together. Rather than offering Anna some more pain relief, the obstetrician saw fit to slap Anna's inner thighs with his hands while demanding that she, "Relax! Relax! I can't do this if you tense up like that!" as though ridiculing Anna for being a disobedient child. The midwife said nothing. Anna's husband said nothing. I, too, watched on in silent horror. No justice was ever meted out to that abusive obstetrician. When a few days later I asked Anna if she wanted me to help her to write a complaint, she responded, "No, I just want to try and forget about it." Confronting her trauma was not high on Anna's list of priorities as a busy and exhausted new mother.

Throughout my years as a midwifery student and practitioner, and later as the author of a book on the birth stories of New Zealand families, I came to realise that insensitive and abusive practices were firmly embedded in our culture of birth. A profound amount of the trauma I was witnessing, or being told about, was being unnecessarily caused by the practitioners and institutions that served birthing women. In discussing their birth trauma with me, women felt a weight lifted. They didn't need much to begin their healing process. To be heard, have their experience validated, and to know that the trauma they experienced was through no fault of there's was often all it took to turn a positive corner in their journey. Over the past two years I have been voluntarily supporting numerous women in this manner. This work is what triggered my desire to start up a formal birth trauma support service.

In February 2015 I carried out an online survey in order to determine the support needs of New Zealand women who had had a traumatic birth. Three hundred and nineteen women voluntarily completed the anonymous survey. The survey was open to any New Zealand women who had experienced birth trauma. No definition of birth trauma was supplied as, given that birth trauma is a subjective experience, I was happy for women themselves to decide whether they fitted that criteria. Respondents were sought via Facebook networking channels with the survey link being organically shared amongst a wide variety of mothering-type groups.

The purpose of this research was to help guide the development of a primary care support service for women, and their partners, who had experienced a traumatic birth. The findings led to the establishment of a Waikato birth trauma support organisation called Voice For Parents (www.voiceforparents.co.nz), a not-for-profit social enterprise which is still in its infancy in terms of its development and the services offered. Although the initial intentions for this research were quite specific and localised, **the volume of compelling data I acquired urged me to broaden my intentions for how the survey findings may inform improved birth practices, policies, and perinatal support services within New Zealand.**

Rather than being an academic research report, this is a discussion paper that draws on the statistics and narratives derived from the survey data. Given that 319 women gave of their time and made the difficult emotional investment required to answer such a personal survey, I felt it was important to fairly represent a wide range of their unedited voices. Since the survey was anonymous, pseudonyms are used throughout this paper.

Perinatal mental health is, in part, a reflection of how women perceive their birth experiences (both past and present). Poor mental health outcomes can result from a birth that is experienced as traumatic. This is true for both the woman and her partner (or anyone else present at the birth), and may have detrimental impacts on infant mental health and family/whaanau relationships, too. Yet 'safe' birth outcomes have traditionally been measured by rates of maternal and infant mortality and morbidity, thus omitting the psychological aspects of 'safety' in birth. There is a need for mental health outcomes, including those for the woman, her baby, her partner and her family/whaanau, to be recognised as important considerations when we determine 'safety' and degree of 'risk' in birth (I use quotation marks around 'safety' and 'risk' because of their subjective nature and therefore the concerns I have with objective determinants of these two aspects of birth).

Birth trauma is caused by a range of factors. Some of these are unable to be prevented, for example the death and disability that are at times an inevitable part of birth and life. However, how practitioners and institutions treat families during these crises can exacerbate their trauma, or support them through it. Some birth trauma is caused needlessly by, for example, maternity

practitioner's poor emotional support of labouring women. Regardless of its cause, when a traumatic birth ensues it can potentially have a profound impact on:

- Maternal mental health
- Mother's ability to successfully breastfeed her child
- Bonding and attachment between mother and infant which may negatively impact infant mental health
- Paternal mental health
- Relationships within the family/whaanau

The issue of birth trauma appears to be poorly recognised within New Zealand. Consequently, maternity practitioners, primary postnatal care providers and maternity care consumers are at times unaware of the concept of birth trauma, its subjective nature and its potential implications. It is therefore difficult to know the number of families affected by birth trauma in New Zealand. What this survey does reveal is that the impacts can be very harrowing and that our current screening practices and perinatal mental health services fail to adequately meet the needs of a number of families affected by birth trauma. It also provides suggestions as to how we can decrease the incidence of birth trauma and support affected families in its aftermath.

The first sections of this report reveal factors that contributed to the respondent's traumatic birth experiences and the impacts of their birth trauma. Particular focus is paid to the ways in which maternity practitioners contributed to the trauma. The next section examines birth trauma support, including the respondent's experiences, or lack thereof, their readiness for accepting or seeking help, the types of support given and support options that the women regarded as potentially beneficial. Brief attention is paid to the trauma and support experiences of the respondent's partners, as described from the perspective of the women. This is followed by a report on the respondent's experiences of laying a formal complaint regarding treatment from a care provider that contributed to their trauma. The barriers, the positives and the negatives that were associated with laying the complaint are discussed. The last section of this report examines ways in which we can work towards lowering the incidence of birth trauma in New Zealand, and implementations are suggested for effectively addressing the needs of affected families.

I would like to acknowledge that while birth trauma is an issue for a number of New Zealanders, there are also many families experiencing very positive birth care and support. The care I received during the births of my three children was faultless. We are very fortunate in the birth choices and services we have available to us under the New Zealand maternity system. However, this should not discount the very real and difficult experiences of families whose perinatal care has been substandard, especially when there is awareness of ways in which we can better support vulnerable new families. I hope that in reading this report you feel compelled, as I did, to set the wheels in motion for positive changes to be made.



Chapter One
Causes of Birth Trauma

The following statistics indicate what the respondents believed to be the basis of their traumatic births (note, respondents could tick as many factors as were applicable), though the root causes weren't always easy to identify, as Abby reflects, "I'm still trying to work out why I found it so traumatic as my midwife was amazing."

- 62% Stress/fear related to an unexpected outcome eg. emergency caesarean
- 60% Feeling robbed of the birth experience you'd hoped for
- 53% Fearing for your own life and/or your baby's life
- 47% Poor care from a midwife and/or doctor
- 42% Poor pain management and/or other physical trauma
- 27% Baby in Neonatal Intensive Care Unit (NICU)
- 6% Baby death or disability
- 4% Triggering of a past abuse experience
- 26% Other (please describe)

Further discussion and analysis of these causes are provided under the subheadings, Unexpected Outcomes, Poor Care from a Maternity Practitioner, Poor Pain Management and Physical Damage Resulting from the Birth Process, and Triggering of a Past Abuse Experience, though as the above statistics reveal, **there were frequently multiple factors involved in the women's experiences of birth trauma.** Examples of descriptions that recounted a number of contributing factors include:

"I had involuntary pushing and my midwife told me I had to stop it otherwise I was going to have to have a caesarean (which I'd already told her I was terrified of) when I was 9cm dilated with a lip [of cervix]. I was then pushed into having an epidural which I didn't want and didn't understand why I needed it as I wasn't in pain, I just couldn't stop pushing. My baby ended up being born by ventouse and episiotomy as everything slowed down after the epidural. Then there was something wrong with how the cord was attached to the placenta, I think it came away, so they were hunting for some forceps and found some on a trolley in the hall and weren't sure if they were used. I was terrified they might use it so someone reached in and got my placenta out by hand. My episiotomy didn't heal properly and it had to be restitched and then scar tissue had to be removed months later."

"My daughter was 11lb 6oz was taken straight to surgery, [I was] 19 years old, nothing was explained to me. Recovery was horrific. Still suffer 8 years later."

"Bad SPD during pregnancy, birth - ventouse, episiotomy, shoulder dystocia, theatre/surgery manual placenta removal. Hospital for a week. Baby choking (mucus), catheter fail, bladder incontinence. Home - colicky baby, slow recovery from SPD, and stitches scar discomfort."

Unexpected Outcomes

There exists a broad array of occurrences in birth that may be considered 'unexpected outcomes'. While some could be argued as avoidable, such as an emergency caesarean that results from a failed medical induction, many troubling birth outcomes are not able to be prevented. We would do well to minimise the amount of unnecessary interventions in birth, however, poor outcomes, damage and death will always account for a fraction of the statistics no matter how good the care provided. Despite this being an uncontrollable aspect of birth, there is little acceptance of it within our society.

What we can work on improving are how we prepare families for a range of birth possibilities, how we support them through unexpected birth occurrences, and how we compassionately care for them when they are met with a tragic birth outcome. Births that involve unexpected outcomes do not necessarily entail trauma. For Kyra, the care she was given negated the traumatic effects of multiple medical interventions:

"I had three difficult births but it was my first that still hurts to remember to this day. In a lot of ways the second and third births were the more medically fraught but the difference was that in the last 2 births the staff were amazing. They had a plan for the births, they were caring and they believed me when I said there were problems occurring."

For Melissa too, good support from her midwife was what made all the difference:

"I had a traumatic experience with my first child and it wasn't really acknowledged by my midwife at the time. It was only when I was having my second child when my new midwife asked about my first birth that I felt able to talk about it. She was able to go through my birth notes and explain what happened. Things made so much more sense then and when my second birth ended with a caesarean I think it wasn't as scary as my first. I also felt more able to ask questions after my second experience."

Other examples of births that 'didn't go to plan' but were not experienced as traumatic are provided in *Where the Heart Is* (Sargent, 2013). In this book of New Zealand birth stories I included a chapter on unexpected outcomes to provide readers (consumers and birth workers alike) with insight into what was required for the women to achieve positive experiences despite needing various interventions. **Of utmost importance was that they were supported to maintain autonomy over choices regarding their births.**

For the women who answered this survey, the stress and fear related to an unexpected outcome during labour was the highest contributing factor towards their experiences of birth trauma, with 62% of respondents indicating so. A little over half of the respondents (53%) felt fear for their own life and/or that of their baby's during their births.

The following were amongst the unexpected outcomes that women shared about in their survey responses.

Emergency Caesarean Section

Maia's trauma was related to her emergency caesarean section, yet her surgery was not viewed as potentially traumatic by those involved in her care, *"Most of those around me including my midwife at the time did not see my emergency caesarean as a trauma."* Reflecting on New Zealand's 25% caesarean section rate (a rate much higher than the 10 to 15% target suggested by the World Health Organisation), Maia's experience is perhaps not surprising. When surgical birth becomes a commonplace part of a maternity practitioner's work, they may neglect to appreciate its impact on women.

Angela's trauma story involves a similar supposition. She reported, *"...everyone was so focused on saying (me included) baby arrived 'safely' despite the long labour and emergency c-section, that it's almost as though there was no acknowledgement that the birth was actually a very stressful experience in the end... there was no exploration by any professional of the emotional impact."* Like Angela's, many comments made by other respondents depicted the widely held belief that, so long as a birth results in a healthy baby, the way it was born and the impact this may have on the mother are not important considerations.

In my discussions with traumatised mothers I have noticed a tendency for women to blame themselves for 'failing at birth' when a caesarean delivery takes place. Practitioners' dismissive attitudes, such as those described by Maia and Angela, are likely to exacerbate a woman's sense of guilt for giving voice to her own feelings of trauma despite a positive outcome for her baby. Shelley's summation backs up this sentiment, *"Because my emergency caesar was successful, ie both of us are alive, I felt I should be grateful for that without acknowledging the grief feelings I was having."* This 'who am I (or, who is she) to be complaining?' belief system does nothing to heal a woman of her trauma, rather, it further devalues the mother's emotional response to her birth. **It is important that the woman's support network understand that she can be both grateful for her healthy baby (including the life-saving surgery that was available) and feel traumatised by her birth experience.** When a woman finds the courage to express her pain, her trauma deserves validation.

Baby Loss

Miscarriage and stillbirth were described as experiences where women's trauma was compounded by a lack of understanding or compassion amongst maternity practitioners and insensitive hospital policies. For Adrienne, a combination of these factors contributed to her trauma. She wrote, *"There needs to be more awareness made about baby loss. And when it does happen it'd be nice if the hospitals didn't try and rush us away."* Lack of awareness on the part of Rose's midwife may have added to Rose's birth trauma, too. She commented, *"My trauma was due to a previous loss which I hadn't processed... I needed someone to talk to about my loss. My midwife did not recognise the impact this could have on my [subsequent] pregnancy and birth."*

Supporting parents who experience a stillbirth requires timely responses by compassionate care-providers, and hospital policies that ensure simple but important omissions are not made, as expressed in this grieving mother's words, ***"I do wish there was a photographer or someone available with experience in infant loss that could've come and taken photos for us before we had his life support turned off. I never wanted my story in the media either so if there is ways to suppress the info from them. Also I still want to get someone to obtain the postmortem report so I know how big he was and his weight etc. Maybe that's something the hospital staff could've done for me and put in the box they sent out."***

Given the devastation felt around the loss of a newborn, birth workers could be forgiven for thinking that there is little that can be done to diminish the associated trauma for the parents. However, having talked with and supported families who experienced the loss of a baby, I have learnt that birth workers play a more vital role than ever under such circumstances. **Sensitively supporting couples to birth the way that feels right for them, to spend precious time with their dead or dying baby how ever they feel is most fitting, helping them to create tangible memories, and allowing them the space to grieve in whatever ways they need to, are all imperative to appropriately supporting parents to process such a tragedy.** To add a traumatic birth experience, one where parents were denied choices, or an insensitively managed post-birth and death experience to the grief and shock that baby loss entails would be a great shame.

Baby Requiring Intensive Care Support

Having their baby spend time in the Neonatal Intensive Care Unit (NICU) was cited as a cause of birth trauma by 27% of respondents. In their descriptions of the trauma involved, **the vast majority of women focused on the impact of being separated from their babies after birth and of the powerlessness they felt around supporting their baby's recovery.** The following are typical of these women's responses. Heidi said, *"[I felt] regret for not being more pushy with staff in NICU re holding my baby, staying with my baby, feeding etc."* Keira lamented, *"[I had] no freedom with baby, doctors took over, no skin to skin."*

Why is it that when a child has to spend time in hospital for treatment or observation, provisions are made for a parent to 'room in' with their child, yet when a child is a newborn baby, there is frequently minimal opportunity for the mother to be at her baby's side, except during attempts to breastfeed? Karen, in my sample, who was recovering from caesarean surgery, reported, *"The intensive care unit was on a different level to me so in order to see my child I had to go upstairs... the whole experience felt as though I was in unsafe hands."* It does not take a psychologist to appreciate what an emotionally harrowing time it would be for a new mother to have her baby in intensive care, yet **many of the respondents indicated that no emotional support was offered to them during their baby's time in NICU.** As one woman shared, *"Someone to come round neonatal to give me support or to talk to [would've been helpful]."*

Excessive Blood Loss

Antepartum haemorrhage, postpartum haemorrhage and postpartum haematoma were mentioned by numerous respondents as contributing to their trauma, or of being the primary cause. Descriptions included, *"80% blood loss for me", "placental abruption, huge blood loss, first ambulance had to wait for the second, crash csection under GA at 34wks"* and *"1.5L blood loss which led to me spending baby's birthday on a drip in no shape to even hold her or sit up."* Given the graphic nature of haemorrhage and the clear associations made between excessive blood loss and death, presumably such trauma would also take its toll on many of the partners bearing witness.

Poor Care From a Maternity Practitioner

Almost half (47%) of the respondents experienced treatment from a maternity practitioner that contributed to a traumatic birth. Presumably as a consequence, 45% of the respondents developed a mistrust of midwives and/or doctors and/or the maternity care system following their traumatic birth.

The following outlines the major ways women reported receiving poor care from maternity practitioners during their births.

Lack of Opportunity for Informed Decision Making and Consent

A number of respondents stated that poor information and/or a lack of opportunity for informed consent contributed to their trauma. A typical example was Elise who said that she was, ***“Stripped of all choices and no opportunity to consent or refuse.”***

It is clearly stated under the Health and Disability Commission (HDC) Code of Consumers’ Rights that every consumer has the ‘Right to be Fully Informed’ and the ‘Right to Make an Informed Choice and Give Informed Consent’ regarding any services being offered. Despite this, some practitioners appeared unwilling to invest the time and sensitivity required of them to ensure those rights were upheld throughout the birth process. For women like Daisy, such disregard for birthing autonomy equates to a disempowering experience. Daisy’s trauma resulted from ***“Feeling completely overruled in decisions relating to my body.”***

You need only listen to the conversations that take place amongst new mothers to appreciate that women are frequently unaware of their right to call the shots regarding any suggested pregnancy and labour interventions. Language such as, “I wasn’t allowed to...”, “I had to...” and “They wouldn’t let me...” reveals this misconception.

For parents of babies who are born in a very compromised state of health the consent lines seem to be somewhat blurred. This is an area of consumer rights that fell short of supporting the mother’s needs in Jo’s case. She stated, *“I had no choice in having my baby saved.”* Given that it was Jo who had to live with the ongoing consequences of such a decision, it seems unethical that she was given no choice regarding whether or not doctors were to try and save her baby’s life.

Bullying and Coercion

During their births some of the respondents felt bullied into agreeing to interventions that they did not wish to consent to. Lara recalled the following, *“Felt like doctors ganged up on me and pushed me into a birth I did not want.”* For others, such bullying was more overt and demonstrated outright abuse. Tina stated that she was, ***“Physically forced to do things against my wishes. Powerlessness.”***

Coercion, by way of guilt-tripping the mother into believing that she was putting her own needs ahead of those of her baby, was also alluded to by a number of respondents. For example, Ingrid wrote, ***“I was bullied into an elective c-section... My partner was extremely unsupportive and I feel like he didn’t really care what I went through, he just cared about the baby. This is what I felt like everyone around me did.”*** Again we see the mentality revealed that the mother’s emotional wellbeing was deemed unimportant during the birth of her baby.

Kerry’s birth trauma resulted from, *“Feeling bullied by protocol.”* This is an interesting statement as it highlights the potential conflict between hospital policies and informed decision making. **Are women who birth in hospital made aware that policies do not override their right to informed decision making? And are maternity practitioners supported within the hospital environment to uphold their clients’ right to such, or are there institutional pressures that hinder their ability to enact this obligation?**

Not Listening to the Mother

Having their voices fall on deaf ears was a key aspect of many respondents’ birth trauma. Bev made the following plea, *“Professionals need to listen to the mothers and their needs/wants... treat them with honour and trust the mothers instincts. Too many times trauma could have been prevented if they listened to the mum in the first place.”* The following response made by Laura implies that had she been listened to by her caregivers, her pregnancy may not have ended in a stillbirth. She implores, *“Still birth needs to be talked about/discussed more... someone needs to start acknowledging mothers feelings and what’s happening during pregnancy instead of brushing it off as normal. Please help.”* And for Alex, there were additional disrespectful behaviours on top of poor listening. She recounts:

“Second birth was an unplanned home birth because midwife came and said I wasn’t in enough pain yet to go to hospital but he started coming out twenty minutes later then she stitched me up with no pain relief (22 stitches!) and made jokes about playboy centrefolds.”

For Angela, there was a complete lack of awareness of her experience by her midwife. She recounted, ***“...I do remember thinking that [my baby] was dead because I heard the midwife say before she was born that it was too late, they had lost the heartbeat. The whole thing would have been better had the midwife listened to me, heard what I was saying...”*** But even when women felt heard and well supported by their midwife, they were sometimes let down by another maternity practitioner. For example Vera stated, *“The registrar at the hospital would not listen to myself or my midwife.”*

While technology clearly has its place in safe birth outcomes, it was also a contributing factor in the traumatic experiences of some of the respondents. At times maternity practitioners gave more weight to the information that a machine provided, than they did to the woman’s own understanding of what was happening to *her* body. This invalidating approach to labour support was commonly associated with CTG monitoring. Donna wrote, ***“Listen to the woman and what she feels, not what a machine tells you! I was told I had at least another 12hrs [of labour] left, have a milo, relax and sleep - If you won’t have pethidine there is nothing I can do to help you - and left alone. 30mins later I was holding my 4kg baby.”***

When a Lead Maternity Caregiver (LMC) fails to listen to what the birthing woman is saying, they undermine the woman's self-knowledge and break down the all-important element of mutual trust that is so vital to the woman-LMC partnership. Lydia highlighted this point in her statement, *"It was mainly the [midwife's] attitude of anger and uncaring that was the worst. If she had just said I will get help or I believe you it would have been so much better."* Furthermore, the LMC may miss key information (from the mother) that indicates that something is amiss and warrants further investigation. For example, Natasha recounted, *"...with the first birth my husband and I felt very nervous and when the labour went very wrong the midwife was flippant and appeared uninterested and left us in delivery suite alone while my baby went into distress, even though I had been very clear that there were issues and that more assessment was needed."*

Obstetric Violence

One of the insidious ways that respondents were abused during the births of their babies was via the maintenance of a 'patient-doctor' power differential. Physical invasion during labour and birth, including rough vaginal examinations or those done without consent, were a covert expression of the women's position of powerlessness at an incredibly vulnerable time in their lives. Amongst the reasons given by respondents for their birth trauma were, ***"Obstetric rape by obstetrician - painful violent internal after refusing CS without a trial of labour."*** Also, ***"Birth rape by doctor - restrained then forced painful vaginal examinations."*** Other such responses included, *"Feeling invaded and helpless"* and *"Feeling neglected, abused and alone."*

Insensitive, Disrespectful and Negligent Care

Women in the present study paint a dire picture of the callous and neglectful care birthing women, at times, receive in the hospital setting. Kylie and Deidre's experiences provide eye-opening examples of such poor care. They wrote:

"...labour stalled and baby was distressed. [I] was left in the room at Middlemore for five hours while they tried to find a midwife available. He had to be resuscitated but no-one offered to talk through it after."

"...the same midwife came to see me after labour and although she had not been present at the birth she insisted that I should get up and walk around. I was in too much pain and couldn't but she insisted that I was fine and forcibly pulled me out of bed. I couldn't stand (turns out that the birth had in fact fractured my pelvis which took over a year to heal to the point where I could walk satisfactorily) and I fell back into the bed screaming, at which point she looked disgusted and left."

These quotes appear to indicate that the women were not attended by a known LMC. This highlights **the important emotional safety aspect of labour care being carried out by someone known to the woman**. When continuity of care takes place throughout the woman's pregnancy, birth and postpartum period, the LMC is much more familiar with the woman's needs and the two have likely developed a trusting rapport. This is consistent with the findings of a recent nationwide Maternity Consumer Survey which revealed that women who had a self-employed or independent midwife or group of midwives as their LMC were more likely to be 'very satisfied' with the birth care they received (Ministry of Health, 2012).

However, as individual maternity practitioners demonstrate wide variation in the ways they practice, not all known LMCs will provide women with the emotional support they require during labour. In a recent discussion I had with a DHB midwife, it was disappointing to hear that some midwives of women who are having their labours medically induced request that they not be contacted by staff to attend the woman until she is in advanced labour. Furthermore, the induction process and early stages of labour take place in a room that beds a handful of other women being induced, with a curtain being all that separates one woman from the next. **Such a scenario begs questions regarding a labouring woman's rights to privacy and to have present whoever she chooses as her support people** (the woman's partner is unable to remain with her until she is moved to delivery suite, later in her labour).

Given that 23% of New Zealand women begin their labours via medical induction (Ministry of Health, 2015), experiences like the one that follows may be traumatising more birthing women than is acknowledged. **Describing her traumatic labour induction experience, Katie revealed that she had, "No contact with my husband (hospital at fault) - left alone to labour, repeatedly told I was not in labour, that I should not be moving about or making noise, treated with disdain and patronised."** In fact, medical induction of labour was mentioned as a traumatic part of their birth by a number of respondents.

It is so disheartening that for some of the respondents even the most simple expressions of kindness and compassion were not carried out by their care providers. Avoidance of trauma for these women could have been so basic. Ava and Jane shared the simplicity of what was needed but was denied them:

"...all I needed for myself and my partner was kindness and reassurance and someone to sit with us and talk... I had a mental health birth plan already asking for empathy and reassurance but it was totally ignored. A kind face would have changed everything."

“If I could have just had some understanding, someone to talk to who didn’t tell me this was nothing, that everything was ok...that’s not what I needed to hear. I needed validation, help, resources, support and some general love and care.”

The following survey response reiterates the disrespectful and, indeed, unsafe manner in which some maternity practitioners have treated the women in their care. Disguised as a harmless quip, Helen’s obstetrician delivered a message which, in reality, was a covert abuse of the power differential that existed between ‘patient and doctor’ (further explored under the heading ‘Obstetric Violence’). Helen stated, ***“My obstetrician told me not to have the baby on Saturday as he was having a bbq (in a slightly joking way). In fact he was having a bbq and arrived so late that the baby was in distress and ended up being born unable to breathe properly.”*** In my practice as an independent midwife I recall similar interactions, though most were directed at me or another midwife rather than the women. Comments from on-call obstetricians such as, “Make sure I don’t miss the rugby tonight” were an intimidating attempt to ensure midwives would not request their presence at an inconvenient time.

Poor Pain Management and Physical Damage Resulting From the Birth Process

Poor pain management and/or other physical trauma was cited as a cause of their birth trauma by 42% of respondents. Amongst the descriptions of symptoms experienced as a result of birth trauma were, *“Physical problems which years later affect my quality of life and have never really been acknowledged by health professionals appropriately.”* Also, *“Serious physical injuries for which I’m still receiving treatment.”*

The consequences of such physical trauma sometimes lasted for years and multiple surgeries were unable to resolve it. Such is the ongoing experience of Tahlia who wrote, ***“I have had surgery 3 times to ‘fix’ what happened to me during child birth and after almost 6 long years I am still no better.”*** Their physical trauma clearly impacted on the mental wellbeing of these women, too. For example, Catherine recounts, *“I was in lots of pain for about 4 months so was constantly reminded of [my traumatic birth].”* For at least one respondent, ongoing birth-related physical trauma had serious social consequences. Kaitlyn shared, ***“I withdrew from friends as too many of them made awful assumptions - got to the point that I hid things - my faecal incontinence for one which meant not seeing people.”***

The surgical team who managed Esme’s birth injuries was not only negligent and inadequate in their repair work, they also treated her disrespectfully, something Esme appeared to attribute to the fact that she had attempted a home birth. Esme wrote, *“Sustained a couple of really nasty and rare injuries. On transfer from our calm, beautiful, peaceful homebirth I was met with judgment, disregard and awful treatment by a surgical team who also ignored one of the injuries. Requires additional surgery 11 months later as initial repair done inadequately, leaving me with faecal incontinence.”*

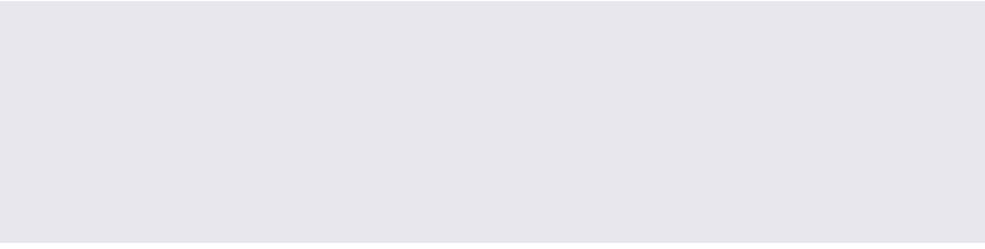
Poor pain management was not commonly discussed in the respondent’s descriptions of their birth trauma, though for Fiona the unbearable pain she felt was certainly a factor. Fiona’s trauma resulted from an *“Allergic reaction to Pethidine, believing my baby was dead, midwife saying labour had stopped and not listening to me that the pain was unbearable.”*

Also falling under this category were descriptions of trauma that related to poor anaesthesia administration or effect. One person stated *“Epidural puncture”* as the cause of their trauma, and two respondents told of experiencing caesarean surgery without being fully anaesthetised. They wrote, ***“...shock that I was to have an emergency c-section...I was not completely numb for the procedure.”*** And, *“Caesarean - anaesthesia was limited and I felt the procedure.”*

Triggering of a Past Abuse Experience

Routine hospital procedures, such as vaginal examinations to determine labour progress, may be extremely traumatising for women who have a history of sexual abuse. Teresa, who had experienced prior sexual abuse, found that having her waters artificially ruptured was consequently the most traumatic part of her complicated birth. She wrote, *“[More education is needed on] how past abuse affects birth etc. Past sexual assault or abuse is a big deal for a birthing woman. The most traumatic part of my complicated ordeal was one that would usually not be a big deal (AROM), it was only a big deal because of past trauma.”*

Although pregnant women are generally screened for sexual abuse by their LMC, it should not be assumed that all women will openly share such a history. A safe way to support all labouring women is to assume that they may have experienced sexual abuse. Thus any invasive procedures, such as vaginal examinations, should only be carried out when informed consent has been sought and should be performed in the gentlest manner possible. Of course such treatment should be the norm regardless of a woman’s history, but being mindful that a significant proportion of women have been sexually assaulted may prompt practitioners to be ultra compassionate and respectful in their care of birthing women.



Chapter Two
The Toll That Trauma Takes

Amongst the symptoms that respondents believed were attributed to their traumatic birth experience were (note, respondents could tick as many symptoms as were applicable):

58% Fear of becoming pregnant again

50% Depression

49% Difficulty establishing breastfeeding, or were unable to

45% Mistrust of midwives and/or doctors and/or the maternity care system

44% Difficulty bonding with baby, at least initially

Regarding the breastfeeding, bonding and depression issues that respondents associated with their birth trauma, we need to be asking questions about the longer term implications these may have on infant health. More and more information is coming to light about the importance of mother-infant attachment to the psychological wellbeing of the baby, with the first three years generally regarded as the most impressionable time. **Birth trauma has the potential for negative long-term consequences for both the mother and her baby.** In a report published by the Ministry of Health (2011) titled, *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*, it was stated that,

“Maternal mental illness in [the postnatal] period has a detrimental effect on the emerging mother-infant relationship and can result in delayed social and emotional development and/or significant behavioural problems for the infant, potentially leading to a range of negative outcomes that may persist into adulthood.” (p. V).

As well, **one third (33%) of respondents said that relationship issues with their partner was a symptom of their trauma.** Being provided with appropriate support may have been the difference between a resultant marriage saviour or marriage failure, as Libby and Anita noted:

“...having a physio and counsellor now at 4/5 months [postpartum] has probably been a marriage saviour.”

“I do feel the lack of information and support throughout for myself and my husband probably had a long term influence on our marriage and resulting divorce.”

Variations of the following comment showing that trauma can occur for the woman's partner too were made by numerous women. Linda wrote, *“My husband was distraught also. He went onto a different planet for 6 months+. We couldn't have sex to reconnect due to physical trauma. Whenever he touched me we reminded each other of it.”* More on traumatised partners is discussed in Chapter Four of this report.

Other common birth trauma symptoms included flashbacks, intrusive recollections of the traumatic event, and irritability or outbursts of anger. Each was experienced by about 40% of respondents.

Alarmingly, one in every five or six respondents (18%) indicated that, *Suicidal thoughts and/or thoughts of leaving their family, was a part of the devastating consequences of their birth trauma, and one respondent stated that she had, “Infanticidal thoughts.”* The latest PMMRC Report (MOH, 2015, p.111) revealed that, *“Suicide continues to be the leading ‘single’ cause of maternal death in New Zealand.”*

It is imperative that we take action to identify at risk women during their pregnancies and ensure that they are appropriately supported in their mental health needs. Part of this equation is minimising the amount of birth trauma taking place. The survey results here clearly demonstrate that a traumatic birth experience can have dire mental health consequences. The results also indicate that many of those women suffering mental illness in response to their trauma are not being given adequate postnatal support.

Serious consideration needs to be given to the suggestions made in this report for improved maternal support. Let's ensure that struggles like Jessica's no longer go unsupported. Following her traumatic birth, Jessica ***“... went on to suffer badly with post natal***

anxiety and OCD fears about my baby dying in their sleep. This went untreated for many months and developed into depression. There is no adequate screening for birth experience, nor for post natal illnesses in general unfortunately.

Where respondents had the opportunity to write any other symptoms that resulted from their trauma, a few answers showed up repeatedly. Panic attacks and anxiety were common, Post-Traumatic Stress Disorder (PTSD) or Post-Traumatic Stress Symptoms (PTSS) were mentioned numerous times, and anger came up often. Possibly the most prevalent responses though, were those that indicated a sense of guilt or failure surrounding the birth, as was the case for Zoe who described her birth trauma response as, *“Anger, Frustration, Feelings of disappointment in myself. Powerlessness.”*

Many of the women expressed a degree of self-blame for their traumatic experiences. For example, Laurel shared that, *“Looking back we should have been stronger and pushed more.”* Others believed that their bodies were flawed and that they had failed at giving birth, as is depicted in the following two responses:

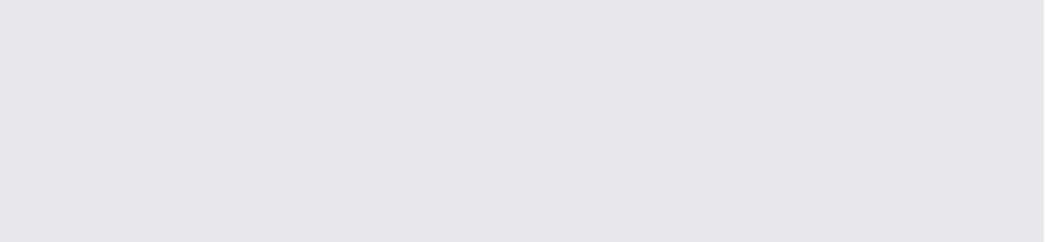
“I felt really let down by my body, and the fact that I couldn’t give birth naturally really affected my confidence in the first 6 months.”

“To birth babies is something a woman is designed to do. To try that and feel that I’d failed created a body loathing that I’d not previously experienced and a complete loss of faith in my ability to do anything. In my case this was compounded by an extremely unsettled baby that screamed nonstop for months... the net effect was to make me feel like a complete failure as a mother and a woman.”

Perhaps having the opportunity to discuss their birth experience with someone compassionate, who could validate the woman’s concerns, might have made all the difference in their recovery from their trauma and restored their self-belief. Instead, women like those in this survey were left with phrases like “Failure To Progress” to dwell on, with no-one to clarify that such labels are falsely demeaning. It was not the woman who failed to progress in labour, rather, the ‘problem’ was typically an arbitrary time constraint placed upon her labour to ensure that the hospital ‘factory’ was running efficiently. **Her body didn’t fail her, the system did.**

When respondents were left holding the belief that they had ‘failed at birth’ there were sometimes ongoing repercussions. Debbie shared her postnatal experience of, *“Doubt of everything I did. Intense need to do everything The Right Way since I had stuffed up the birth so badly.”* That need to ‘control’ other aspects of her world was also a response that Kiriana had to her disempowering birth. She described the symptoms of her trauma as, ***“PTSD, anxiety, poor self esteem, self doubt, trying to gain ‘control’ over other aspects of life/household/relationship.”*** Such self-doubt would almost invariably have a negative impact on a woman’s subsequent birth too, especially if her LMC didn’t provide the opportunity to explore the reasons why her first birth eventuated as it did.

In my work with women traumatised by birth I have discovered that many of them felt resentment towards their child and/or their partner surrounding their difficult birth. Such was the case for survey respondent, Jill, who described her trauma response as, *“Grief of losing faith in my body, fear and resentment towards my son.”* While women who resented their partner for not rescuing them from a bad birth may have felt justified in their feelings, those whose resentment was directed at their child were left feeling particularly guilty. **They knew that blaming their little baby for causing their trauma was hardly fair, but it was their experience none-the-less and undoubtedly added to their sense of mothering failure.**



Chapter Three
Birth Trauma Support
- what helps and what
hinders healing?

Readiness (or Not) to Begin to Seek Help, and the Debriefing Process

The aim of a debriefing session is to provide an opportunity for women to talk freely about their emotions and reactions to their trauma, to clear up misconceptions regarding what took place, and to determine what further support and treatment may be beneficial for them. Women's readiness for, experiences of, and opportunities regarding debriefing their births were highly varied. Since debriefing, or discussing, their birth experience was generally how support was initially sought by, or offered to, affected women it is worth exploring their debriefing experiences in some detail.

When are Women Ready to Discuss Their Traumatic Births?

Although only one third (33%) of respondents felt ready to discuss their traumatic birth with someone in the first six weeks postpartum (the time during which women are still under the care of their LMC), there were also many responses that spoke of the immediate post-birth need to have someone clarify 'what went wrong' with their birth and to have their difficult experience acknowledged. Suggestions from women about what would have been helpful included:

"After the birth, your midwife asking how it went and seeing how you are feeling."

"Anything at all that acknowledged what I had been through."

"Debrief with the surgeons and perhaps the anaesthetist."

Where an immediate opportunity to debrief was needed, women described ways in which they believed it could have helped them to heal, and ways it may have reduced the likelihood of being further traumatised. Some examples were:

"I wish I had discussed the events with the midwife afterwards as I feel that would have helped me heal."

"I felt like a failure and if one of the birth team had actually talked to me about it and told me what had gone wrong, I might have dealt with it better."

"I feel like if I'd had an opportunity to just talk about the experience in the first few days and let the emotion out then I would have bonded with my son better sooner and possibly not had not so much trouble with breastfeeding etc"

Women's Birth Debriefing Experiences

In the days, weeks, and months (sometimes later) following birth, a number of women felt that the opportunity to debrief would have made all the difference to their postnatal experience. They needed to understand what happened and why, and they needed to have their feelings and experiences validated. They were certainly entitled to have their trauma acknowledged, yet for many, this simply did not happen.

Regardless of whether or not they were ready to discuss their birth, **just 38% of respondents were given the opportunity to debrief their birth with their LMC.** Half of the respondents (49%) were not given this opportunity at all, and the remaining 13% couldn't recall whether they had this opportunity or not.

Of the 121 respondents who did debrief their birth with their LMC, 60% said it was a helpful process, while 40% said it was unhelpful. The reasons women found the debriefing process unhelpful fell into the following categories:

1) Feeling it was too soon after the event, and that they needed more time to process the birth before discussing it.

This was a very common response. Many women felt that an opportunity to debrief their birth some time afterwards would have been helpful. During the early days and weeks post-birth, women were frequently too busy coping with new motherhood - learning to breastfeed, dealing with physical trauma, muddling through exhausting days and nights - to have mental space to begin processing what happened around their birth. They felt the need to 'put that behind them' and get on with mothering, initially.

For many, immediate support was not as needed or as helpful as later support. While 60% of respondents felt ready to begin working on healing from their trauma within the first six months postpartum, for one quarter of respondents (25%) it was more than a year before they felt that same readiness. Women frequently stated that they were either not ready to 'deal with' their trauma in the early days and weeks post-birth, or that they weren't affected by their trauma until some time after the birth. A few stated that it was not until pregnant with their next baby that their trauma revealed itself. Melanie described, ***"I didn't realise just how traumatised I was until I was 26 weeks pregnant with my second child and started having panic attacks about the impending birth."*** Likewise, Gayle stated, *"I didn't fully understand my trauma until my following pregnancy 3 years later. I started to experience severe depression and anxiety regarding my upcoming birth."*

For those who needed to debrief their births some time after their LMC care had ceased, many expressed that they didn't know how to access such support. Such comments included:

"Birth trauma has morphed into a number of different issues over the past 18 months. PTSD initially followed by PND, anxiety, relationship issues and depression. It seems to get more difficult to have access to help as the time goes on."

"I found I had symptoms much later and had no idea how/where to get help."

"Following finishing with the midwife/obstetrician at 6-7 weeks, there was no follow up care provided for me which I found very difficult."

2) Having the discussion revolve around a timeline of events rather than discussing how the trauma impacted on the woman's emotional wellbeing.

Lily felt let down by her invalidating birth debriefing experience. She wrote, ***"[The debriefing] only involved reading through the birth notes of the surgeon. It would've been useful to talk to someone about how the birth had affected me."*** Clearly, debriefing is a skill that not all maternity practitioners have been sufficiently taught or know how to carry out. Responses like Lily's demonstrate that some maternity practitioners are failing to execute an effective and appropriate debriefing process.

3) Women feeling unable to be honest and open for fear of upsetting their LMC.

Effective debriefing requires that the woman feels comfortable to openly share her concerns and her feelings. Some women felt that their LMC may construe their negative feelings as a criticism of the birth care they received. Leah shared why she didn't feel able to be honest about her trauma experience, ***"My midwife was amazing and I didn't want to offend her."***

4) LMC being an inappropriate person to debrief the birth with when they contributed to the woman's birth trauma.

A woman needs to feel safe to explore her emotional response to her birth and to ask any questions she needs to, to seek clarification about her birth process. If the LMC was felt to be part of the problem, they are unlikely to be able to support the debriefing process in a helpful way, especially if they are unwilling to accept or acknowledge the role they played in the woman's trauma. Huia described how her midwife justified her inappropriate care when Huia tried to talk with her about the birth, ***"Midwife shut me down by saying that she only did what she did to keep us safe."***

5) A dismissive, uncaring, or invalidating approach to debriefing the woman's birth.

If, through debriefing the birth, the LMC is aiming to provide an opportunity for the woman to express her feelings and concerns, they undoubtedly need to *hear* the woman, *listen* to what she is saying without judgment, and *validate* her experience, whatever that experience is. Isla's midwife failed her on all these counts. Isla wrote that her midwife's attempt at debriefing her birth with her was, *"Informal and brief and almost an attitude of 'you'll be right'."* Holly's experience was similar. Describing her attempt to discuss her traumatic birth with her LMC, she wrote, ***"I was told 'yeah it happens.'"***

Finding Support

The respondent's experiences of support, or lack thereof, regarding their birth trauma indicated that the available support systems failed many. Reasons for this were multi-faceted. The various responses provided in this survey section echoed familiar sentiments that have been shared with me in the work I've done with women affected by birth trauma. **Our culture of birth is such that many women (and often their caregivers, too) are not aware that certain practices are inappropriate and that the resultant traumatic effects are a valid response.** In other words, birth trauma is poorly understood, recognised and acknowledged as a part of many women's childbirth experiences. Tina's experience reflects this lack of societal awareness regarding the issue of birth trauma. Of her postnatal

experience she wrote, *“[It was helpful] once I found out there was something called birth trauma (articles on the internet).”*

When women don't realise that what they are feeling is 'not okay' or they are led to believe that 'all that matters is a healthy baby', they do not seek out the care that they require in order to heal from their trauma. Or when such support is made available to them, they are sometimes not well placed to begin 'dealing with' their trauma. If, later on, they are ready to seek help, they often don't know where to turn, or are declined the support they require.

Perceptions and Experiences of Support, or Lack Thereof

Women who were able to access support services, usually commented that such support was very helpful. However, those responses were worryingly rare. Examples included:

“When pregnant with my second baby my new midwife sent me to the maternal mental health service to work through issues I had. It helped finally break down those issues for me but it was 2.5 years after the fact!”

“My doula has been a Godsend. She has talked me through the last 2yrs, as I've been healing.”

“...I knew I needed help and basically asked everyone I could! I got good help from my GP too who prescribed safe drugs for breastfeeding. Once I got into maternal mental health the psychologist was amazing. The plunket nurse got me into the family centre which was excellent for helping work out the best way to feed my baby... They also recognised the PND and invited me to join the PND group.”

“The group really helped. Talking to my midwife once I discovered I had post traumatic stress really helped. Having a social worker to talk to and seeing a psychologist helped.”

Of great concern is that many respondents commented that they received no support at all and were not made aware that any support was available to them. Such responses included:

“...I didn't understand MMH [Maternal Mental Health] could help with counselling, so I didn't go to my dr earlier because I thought medication was the only option.”

“I was in the grips of insomnia, anxiety and grief and there was no support offered to me.”

“...[I] wasn't offered any help or support whatsoever.”

“There was no support.”

If, in the weeks following her birth, the woman's trauma had been acknowledged by a health professional, then presumably offers of further support and/or guidance around how to access existing support systems would have followed. But **trauma was frequently not acknowledged, no support was offered and often women didn't feel able to seek support for themselves.** Kim and Jackie described their support struggles as follows:

“I needed someone to get help for me. I was not capable of doing it for myself.”

“I took myself off the medications from the doctor, I'm not into pill popping. I would have liked to have been offered some counselling or someone to go through the birth records with me and my husband.”

In Naomi's case, lack of forthcoming support led her to the extreme of harming herself. She felt that that was the only way anyone would realise how desperately she needed help. She also pointed out that she was not made aware of the existing support networks and believed that her postnatal experience would have been greatly improved had she known about them. She wrote, ***“I struggled to get help, my GP was unhelpful and family couldn't get help for me either as they didn't know what was wrong with me...I was getting desperate and it seemed like the only way to get help was to harm myself. I wasn't aware of Wellington PND or the maternal mental health team - to have had access to these people would have greatly affected my recovery.”***

When women did reach out for support following their traumatic birth, they were at times met with invalidating responses. **Denial of their concerns by health care professionals further contributed to the trauma of some of the women,** as is implied in the following quotes:

“...our osteopath was the one medical practitioner who listened and validated my concerns about a difficult baby (“collicky”) whereas doctors belittled and denied any struggles I had.”

“She told me I was starving my baby when I had no idea how to breastfeed.”

“We had our baby Christened at age 6 weeks, it was the first positive experience I had with the baby. The Priest was the first person to listen to me without judgement. My GP just told me ‘yes I understand you are unhappy, but you and your baby survived, you are lucky.’ I asked for counselling, but it was never arranged for me... Plunket did help a little, but only after I asked them how to go about having the baby adopted.”

“[I am] totally disheartened and depressed that my baby has endured unnecessary pain for 3 months due to my concerns falling on deaf ears.”

Birth Trauma Support Services: Referrals, Preferences, and Accessibility

When asked to briefly describe any professional support they had received, respondents (37% of total) mentioned a wide variety of services, everything from alternative therapies (for example, homeopathy, aromatherapy), to postnatal distress support services (for example, PND Wellington, CHAT, Waikato Family Centre, Parents Centre, Women’s Wellness), to qualified psychological support (for example, counselling, psychotherapy, psychology, psychiatry, MMH, Mothers and Babies Outpatient care), to social workers, GPs, lactation consultants, midwives, doulas and physiotherapists.

Referral to Maternal Mental Health services was offered to one quarter (26%) of the survey respondents. Those referrals were mostly offered by doctors (34%), midwives (32%) and Plunket nurses (23%). Of the women who were offered a referral, **half (50%) declined the opportunity. Reasons for this were varied, though the belief that such treatment was not warranted was a theme that ran through a number of the responses,** including the following:

“I didn’t think what had happened was Bad Enough. Didn’t realise how bad it really was until after I had been discharged by [my midwife]. I had physical problems that needed referrals and chose to focus on those and hope the emotional [problems] went away.”

“I thought what I was feeling was normal, didn’t realise how I had been affected.”

“I didn’t think it was needed. I didn’t want to ‘be in the system’ for future pregnancies.”

Such downplaying of their trauma experience may, perhaps, be a consequence of the culture of birth in New Zealand which normalises highly medicalised, interventionist births. Women who experience one of these ‘normal’ births may hold the belief that they have no reason to feel anything but grateful for their experience. Indeed, **numerous survey responses indicated that it is a pervasive belief within our society that a mother’s emotional wellbeing is unimportant when their birth results in a healthy baby, no matter how harrowing the birth may have been.** The normalising of what is, for many, a very traumatic event is not particularly surprising given the high rates of birth interventions. **The frequency of caesarean section surgery and induction of labour, for instance, are such that they have become a commonplace part of the day-to-day work of many maternity practitioners. Such practitioners unwittingly forget what traumatic experiences they can be for the women involved.**

Respondents were asked what sort of support they believed would have been beneficial in helping them to heal from their trauma. **Two thirds (66%) of the women said that, One-on-one support from someone understanding and empathetic (not necessarily a qualified counsellor), would have been helpful, yet just 46% felt that, One-on-one support from a qualified professional eg. psychologist, psychiatrist, psychotherapist, trauma counsellor, would have been beneficial in their recovery.** To speculate about why more women preferred the ‘unqualified’ support over support from a qualified professional, a few ideas come to mind based on responses to some of the other survey questions:

- Considering 45% of respondents developed a, *Mistrust of midwives and/or doctors and/or the maternity care system*, perhaps some women believed that the Maternal Mental Health system would similarly let them down. They may even have felt outright fear about visiting a healthcare professional if their trauma experience resulted from an abusive encounter with one.
- As discussed earlier, a number of women doubted the need for professional support or believed their trauma didn’t warrant it. Perhaps they felt more comfortable with, and justified in, accessing ‘unqualified’ support.
- Many women believed that if they had just had the opportunity to share their story with someone who would listen without judgement, thus validating their experience, that that would have made the greatest difference in their recovery. They didn’t need a qualified professional to achieve this.
- Some women stated that they wanted emotional support rather than being put on medication to assist with their healing. Perhaps those same women believed that they would have been pressured to take anti-depressant medication if they accessed support from a doctor or psychiatrist. As well, they may have wanted to avoid the ‘depressed, not-coping-with-motherhood, psychological disorder’ label that they may have feared would be assigned them through accessing Maternal Mental Health support.

Although a number of women found great support in attending community postnatal distress support groups, **just 38% of respondents said that, *Facilitated group support would have been beneficial in helping them to heal from their trauma.*** This is perhaps not surprising given the very sensitive nature of birth trauma, its lack of societal recognition, and the stigmatising nature of its impact on women (unable to breastfeed or bond with their babies, not coping with motherhood, feeling they had failed at birth and now at parenting, and so on). Group support may have felt a more appropriate option for those who had already accessed one-on-one support, but less of an option for women who had not had that opportunity. For many though, it may well be that the idea of discussing their personal experience, and hearing others' stories of trauma, felt too confronting, difficult, and potentially triggering.

Of interest is that **a large 79% of respondents said that, *Having a knowledgeable person go through your birth records with you, so you could make better sense of what happened and why, would have been beneficial for them in healing from their trauma.*** This may be a reflection of the lack, or poor quality, of debriefing which has previously been reported on. Clearly many women still felt confused about the circumstances surrounding their birth long after their LMC care had ended. **This result indicates that understanding why their births went the way they did is a very important aspect of a woman's path to healing following a traumatic birth experience.**

Although we have a robust and personalised system of support for many women who require secondary care related to their perinatal mental health, a lot of women were not referred to, or didn't know how to access, such support. What is more, some women's referrals were declined. And for women who did not require secondary mental health services, **there appears to be a gap in funded primary care options (personal ones as opposed to group ones) that specialise in birth trauma support, which is essentially what a lot of women are saying they needed.**

While some women found the support given by their GP and/or the free counselling sessions was helpful, a number indicated that the care provided was inappropriate or unsatisfactory. Birth trauma support is a specialised service that not all doctors, midwives and counsellors are adept at providing. **Their insensitive care implies that women who indulge their own suffering are selfish and ungrateful, and the mother-baby dyad is insignificant so long as physical wellbeing is achieved,** as the following responses attest to:

"There was no exploration by any professional of the emotional impact, and indeed this really only hit me after some time."

"My GP just told me 'yes I understand you are unhappy, but you and your baby survived, you are lucky.'"

"I went to the doctor and asked for help when my daughter was about 6 weeks old, I was suffering fear, thoughts and fear of death - hers and mine - was put on Antidepressants but suffered an allergic reaction to them which left me worse than before, doctor just told me to stop taking them and did not offer any additional support. Midwife just told me she didn't know what I was on about and I just had to deal with it."

There needs to be funded one-on-one specialised primary support options for women whose trauma response isn't, or for women who believe it isn't, severe enough to require secondary care. When asked, *Would you have been willing to pay for the support you needed?*, one third (31%) of survey respondents answered, *No, there is no way we could have afforded it.* There needs to be suitable support options made available that are free of charge.

Follow-Up Support

For those whose trauma was acknowledged in the early postnatal period, a number suggested that follow-up support some time down the track would have been very beneficial in their healing. Such responses included:

"...what else would of helped was maybe one or two follow up conversations 3 to 6 months down the track to check in and provide another opportunity to debrief as reflection and thoughts still occur for a time afterwards."

"Something helpful would've been having a system in place to follow up with women who experience traumatic birth and ensure they're receiving support - I felt even though the physical trauma of my birth was well-known, my mental health needs were barely addressed."

Many women needed time to process what had happened and to get through the initial exhausting phase of new parenthood that revolves around the baby's needs rather than theirs, before they felt ready to begin working through their trauma. A follow-up system would have allowed an opportunity for such women to access support at a more feasible time, and would avoid the situation of women not knowing where to turn for help. **There is not currently any requirement, or funding, for healthcare workers to provide this sort of follow-up support. These survey results suggest it is an area of perinatal mental health that needs consideration.**

Support for Mothers of Babies Who Require Intensive Care

Another aspect of poor support revealed itself in the experiences of mothers whose babies required lengthy NICU care. There were two main facets to this: **1) they lacked support for themselves at this incredibly difficult time, and 2) their LMC care often ended while the baby was still in the NICU**, therefore they were 'on their own' once the baby was discharged from hospital. The following quotes describe how daunting this transition was for the mothers involved:

"Because my baby was in NICU by the time I came home I had been discharged from my midwife and this was the time I really needed support. I had the outreach nurse visiting but she was there more for the baby than for me. Many of the women coming out of NICU suffered PND but during our time there, it was never spoken about. Maybe we should have had the opportunity to talk about it while we were still in the hospital."

"I felt I had help in scbu but looking after your baby at home after 3wks of having someone there is quite different."

"There was poor support for us when we were being discharged from hospital. My son had been in starship for 7 weeks, and there was no "Transition" or support to help us go home. He went from being on a 24 hour oxygen monitor to nothing!"

Practical and Financial Assistance

Trauma affected the ability of some women to return to work, including the work required of mothers who stay at home to care for their children and paid work. Practical and financial assistance were amongst the suggestions made by respondents, as to what they felt would have helped them in their postnatal recovery. Examples included:

"Financial help because I lost my job due to stress."

"Practical help (and company) at home as I had a baby and a young child, while recovering both emotionally and physically. Some days, just having someone there would've made it easier to cope."

"Cheap/volunteer doula or birth companion for future appointments and births."

As Rochelle expressed, having supportive family available to help out can be crucial when the mother is experiencing mental illness, but what about those who don't have any such support? **"I was unable to look after myself or my 2 children for 3 months, had to have family with me 24/7. I worry for people who do not have this support around them."**

Healing Experiences

Amongst the responses where women expressed some degree of healing after their birth trauma, a few really strong themes came through. Some found specialist support very helpful (see earlier quotes), though **many described informal support, provided through talking and writing, was what helped them most in their healing**. Here are a handful of the many responses that women gave regarding this type of support:

"I found a [Facebook] site 'NZ NICU Support' that had babies which also had problems and had traumatic birthing experiences. I found it helpful having others to talk to that had been in similar positions and feeling the same way."

"Sometimes just knowing that someone has been through similar is comforting - like safety/comfort in numbers."

"I just needed to talk about it with people who understood... 3 years on I am ready for counselling."

"I just needed to talk about it with someone who knew about it and then let it go. As in, I needed to let go that any of it was my fault as such."

"I have found it useful to read other peoples stories and support others."

"...it does feel better just to write [about my trauma] finally."

"Talking about it really helped and sharing my story with others."

Indeed, I commenced a 'closed group' on Facebook, titled *Birth Trauma Support NZ* in September 2014. By May 2015 it had accumulated 230 followers. Described as a '...safe space to share your birth and postnatal trauma experiences,' the group provides an opportunity for members to find, and give, support around the issue of birth trauma in New Zealand. There has been a wealth of

brave sharing and supportive responses within that online community. Many of its members have expressed their gratitude in having found such a group, and have written of the support they've experienced within that community.

Another way some women were able to experience healing was through a positive and empowering next birth experience. Such responses flooded this section of the survey. Examples included:

"I didn't fully understand my trauma until my following pregnancy... I was referred to a mental health nurse... Being able to tell my story to her, be understood and feel heard was an amazing step to being able to 1) acknowledge and understand my trauma [and] 2) leave it behind and put some strategies in place to manage and advocate my next birth which was an incredibly healing experience."

"...it wasn't until I was able to have a 'good' birth that I could fully make peace with my first birth."

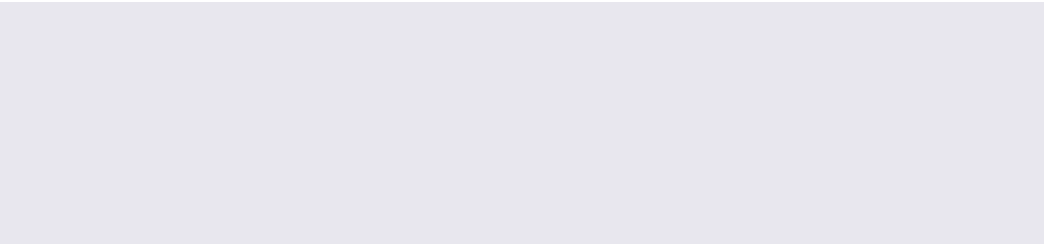
"...it was only after having a positive experience second time round that I truly got over the first experience."

For some of the women their healing birth experience enabled a restoration in faith in themselves and their bodies. The birth provided them with hard evidence that they were in fact capable of giving birth without it being a traumatic event, such was the case for Marie who wrote, *"I went on to have another child which was the final step in my healing, I proved I could do this and come through it fine."* For Crystal, too, *"Having a subsequent empowering birth that was entirely my own [was what helped me heal]."*

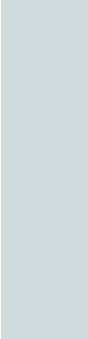
These responses are indicative of the long held self-doubt and self-blame women sometimes carry regarding their birthing abilities. For both Penny and Sarah, eighteen years went by before the positive birth of another child enabled them to be released from the trauma associated with their first births. They wrote, *"My vbac after 18 years gave me the peace and freedom."* And, *"My twins are now 18 years old and I've only recently truly healed. 8 months ago I had an amazing home birth with my daughter. And an awesome midwife that I'll never forget."*

For some women, the fact that their healing birth took place at home was significant. In their home the women were able to birth their way and had a full sense of ownership over their birth experience. **Given that much birth trauma revolves around a sense of powerlessness often related to hospital-based procedures and policies, it makes sense that the home environment could be a very healing space in which to birth a next baby.** That was certainly the case for Isobel, who shared, ***"The biggest healing thing for me was to birth my second child myself at home, catching her myself and feeling completely restored in my faith in myself."***

Isobel's positive home birth experience is compatible with the finding of the New Zealand Maternity Consumer Survey (Ministry of Health, 2011) that women who had a planned home birth were significantly more likely to express satisfaction with the way in which they were cared for during the birth. Of those who had a planned home birth, 90% were 'very satisfied' with their birth care, whereas only 68% of women who had a planned hospital birth gave the same response.



Chapter Four
**The Partners' Experiences of
Birth-Related Trauma
and Support**



This section will briefly summarise the responses to the section of the survey that questioned what the woman's partner experienced in relation to her birth trauma. It needs to be made clear that it was the woman and not her partner that filled out the survey responses. Answers may not therefore accurately depict the partner's experience.

Very few partners were present for a debriefing of the traumatic birth experience. This was predominantly due to the fact that there was no opportunity to debrief for many of the respondents. Where the woman did have this opportunity, less than half (45%) said that their partner was present during the debriefing.

In response to the question, *Did your partner feel traumatised/helpless/distressed by your birth experience?*, 68% said Yes, 14% said No and 17% said *I don't know*.

Despite a large number of partners being negatively impacted by the birth experience, just 6% were offered support for dealing with their trauma (88% said no support was offered). Most of the support offered to partners was via the midwife who created valuable opportunities to discuss the birth in the early postnatal weeks. Other support came through partners attending the woman's birth trauma counselling sessions.

When asked whether they thought their partner would have accessed professional support had it been offered, 55% of the respondents said they didn't know. The number of those who believed their partner would have taken up the offer of support was pretty much the same as the number who thought their partner would not have (22% and 23% respectively). Of those who did not think their partner would access support if it was available, most gave reasons that related to their partner not being open to discussing his feelings.

For those who did believe that their partner would access support if it was available, most (71%) believed that, *One-on-one support from someone understanding and empathetic (not necessarily a professional counsellor)*, was what their partner would likely have taken up. Fifty seven percent thought their partner would have been open to *One-on-one support from a qualified professional*, and one third (32%) thought their partner would have participated in *Facilitated group support* with other traumatised partners. A number of women also stated that their partner would have been most willing to get support if it had been done in partnership with the woman. For instance, **it was commonly stated that a type of couples therapy would have been the best way to get their partner 'on board'.**



Chapter Five
Laying a Formal Complaint

Just 13% of respondents laid a formal complaint regarding the birth care they received, yet only one third (34%) of respondents said they were satisfied with their birth care. Why did so few women choose to lay a complaint, and of those who did, what was their experience of the complaints process?

In response to the question, *Did you lay a formal complaint regarding the birth care you received?*, statistics were as follow (note, respondents could tick as many answers as were applicable):

34% No. I was satisfied with the care I received

18% No. Despite being mistreated, I didn't want to lay a complaint (Please explain why)

31% No, but I may have if I'd been supported through the process

19% No. I wasn't aware that I could

13% Yes (Please state whether you found it a helpful process, or not, and why)

Lack of awareness that laying a complaint was an option and not having someone to support them through the process likely played a significant role in many women not carrying out a formal complaint.

The Barriers

Of those who responded that, despite being mistreated they didn't want to lay a complaint, reasons given for this choice fell under the following categories.

Pointlessness

A number of women expressed pessimism about how the complaints procedure would unfold, including the belief that 'nothing would change' in response to it, as the following quotes revealed:

"I felt no one would listen to me as I was only young at the time."

"My daughter had already died, what could anyone do about it."

"Too busy caring for baby, complaint goes nowhere anyway."

"I was told to be appreciative that baby and I were healthy."

"I did not think it would make a difference as my midwife was not an NZCOM member."

Wanting to Put Their Trauma Behind Them

The complaints process meant confronting a difficult event that many traumatised women desperately wanted to try and forget about. For those women, the complaints process likely felt too daunting and potentially triggering to pursue. Examples of responses that fell under this category included:

"I just wanted to move on. We decided we wouldn't use that midwife again."

"I just wanted to move on from it. It was helpful to write it all down but I never sent the letter."

"I have too much to deal with and wanted to block it out not re-live it so I could try and support bubs."

"Dealing with a newborn I immediately put the trauma to the back of my mind."

"I was not emotionally able to go through that process and just wanted to move on and forget what happened."

Too Time Consuming or Too Late

Mothering a new baby, especially when dealing with the difficult aftermath of a traumatic birth, did not allow the extra time and energy required to carry out a complaint. And for those who didn't realise how traumatic their birth had been and how inappropriate their birth care was until quite some time after the birth, many thought it would be too late to make a complaint. This too was the belief of some women who needed time to recover from their trauma before feeling ready and able to carry out the complaints procedure. Amongst such responses were the following:

"My step son is high needs and my daughter has a mild disability. I didn't have time or the energy to lay a complaint."

"I'd just had a baby and was more concerned with getting on with [parenting]."

"I feel like it's too late to [make a complaint]."

"It took awhile to come to the realisation that my care was inadequate."

"My midwife almost excused her mistakes so it wasn't until after a few months I really found out how serious her mistake was."

"I believed that what happened to me was normal until I studied and became educated on the issue."

Mentally and Emotionally Incapable

Many women simply did not feel capable of carrying out the complaints process. Given the toll that birth trauma takes on a woman's state of wellbeing, this is hardly surprising. Here are what some women had to say regarding this:

"At the time, there was too much trauma going on, too much constant fear and the thought of laying a complaint just made me worse. I had to just focus on me, my baby and getting better for my other kids."

"Wasn't mentally physically able to do so initially."

"Didn't want to relive the pain again."

"Didn't want to revisit and by the time I felt able to it was much later (a year or so)."

"I did want to but thought that the midwife would have just been very angry and defensive and that would have just made me feel worse - I regret I didn't though as I have worried since that she likely went on to do the same things to other women in a vulnerable state."

"I wrote it all up, but never sent it. I just wanted to move on and try and bond with my baby that never stopped screaming. I never seemed to have time to do anything in the whole world and just couldn't summon the gumption to go through with it all."

"I didn't want to relive it, I just wanted to ignore it all."

"I couldn't handle anymore drama in my life."

"I had so much to deal with and my confidence took a huge knock. I was very scared."

Embarrassment

Some women felt that to complain would cause themselves embarrassment, and they didn't want to come across as being unreasonable. Examples included, *"I felt like I was 'whinging'"* and, ***"I feel like it's just another eye roll! I don't want to embarrass myself... I don't want to be treated or to feel like I'm being too sensitive."*** These experiences speak volumes about our societal expectations and cultural norms (more is written about this under the heading, 'Creation of a Birth Culture That Values Women's Experiences')

Not Wanting to Upset Her Midwife

Some women demonstrated a loyalty to their midwife that superseded their need to have her inappropriate care investigated. This feeling seemed to be exacerbated for those living in small town communities:

“Still thinking about [laying a complaint] - midwife is so lovely don’t want to upset her despite feeling like her treatment was the trigger for things going wrong... so confused still.”

“I did not want the midwife to feel bad.”

“Its a very small community [where I live] and didn’t want to rock any boats.”

“I didn’t want to point the finger and get anyone in trouble and my midwife made me feel like no-one was to blame and I was making a mountain out of a molehill.”

“I was encouraged to but as I live in a relatively small town and know my midwife I chose not to.”

The Positives

Of the 41 women who did lay a complaint, only eight (21%) stated that it was a helpful process. Half of the respondents (51%) indicated that it was an unhelpful process, and the remainder of responses didn’t state whether it was helpful or not (many were still going through the complaints process). Let us first take a look at the reasons why some women found laying a complaint a positive process.

Women felt positive about having laid a complaint when there was a consequence for the practitioner who they were complaining about. Even a simple apology or acknowledgement of wrongdoing was enough to help some women to accept and forgive what had happened, and/or to validate their trauma, as the following responses attest to:

*“My sister who is a nurse and was there at the time laid a complaint on my behalf. I received a letter from the DHB apologising to me and informing me that the doctor in question had been transferred and was being monitored. I also received an apology from the doctor. **This was helpful in giving justice and closure, and also hearing the apologies validated my feelings and helped me to heal emotionally.**”*

“Yes, I found it helpful, as hearing the nurses apologise and admit that they got caught up in their routines and policies helped me accept and forgive them.”

“Helpful response and apology and full acceptance there had been gaps in my care.”

“It took 18 months which is too long, but the outcome was helpful in healing and moving on.”

“...found it a good process. Got a letter of apology.”

“It validated my experience and the midwife’s inappropriate behaviour.”

A couple of women noted that the complaints process was helpful because they were doing something proactive and empowering, a positive contrast from their disempowering birth experience. Here are their responses, *“...The midwifery council was fantastic in fact they phoned me as soon as they had read my complaint. It made me feel better that I had done something proactive about the situation.”* And, ***“It was good to feel as though I had taken back some power I lost during the birth.”***

The Negatives

There were three main reasons women felt negatively about laying a complaint. The first was the result of an **invalidating response to their complaint, one where they felt their complaint was ‘fobbed off’, dismissed, or where an insincere apology was made:**

“No [it was not helpful]. I received a letter basically fobbing me off.”

“Had a mediation process, midwife fobbed it off.”

“No [it was not helpful] - hospital fobbed me off and HDC, HRC and Comm for Children were useless.”

“HDC complaint re NICU care - unhelpful as my concerns were not addressed.”

“Not helpful, they blew it off.”

“I wrote a complaint about the anaesthetist’s treatment towards me which was out of line... and she wrote a letter back pretty much saying she would never treat someone like that and I should be happy I got a healthy little boy out of it.”

Another common reason women felt let down by the complaints process was that nothing came of it. **Many of the women who sent a letter of complaint never even received a response**, including the following:

“No [it was not helpful]. Midwife Council didn’t even contact me.”

“CDHB said they lost my complaints.”

“Not helpful, no reply, nothing came of it.”

“Never heard back.”

“It was not taken further and I was unable to get a response.”

Also cause for negativity towards the complaints process was an apparent **sense of futility about having laid a complaint**. For many, the reason they went to the trouble of laying a complaint was in an effort to ensure that other women would not have to go through something similar. Women felt a responsibility to speak out against unjust maternity care and put the wheels in motion to affect change. However, rather than achieving a validating response through laying a complaint, **frequently no disciplinary action or consequence arose from the process**. Examples of such an experience included:

“I found the process harrowing and stressful and whilst my complaint was upheld I was distressed to find that there was no consequence. The whole process meant nothing in the end.”

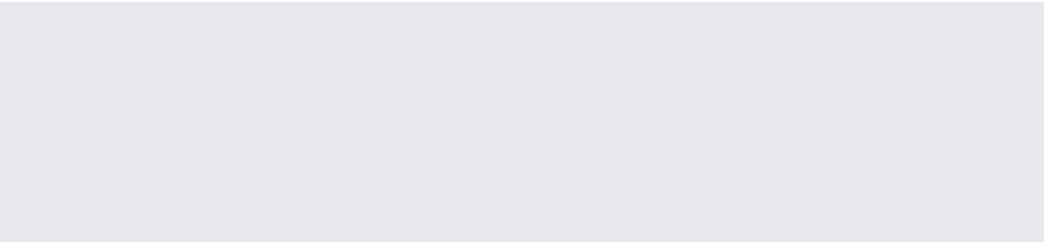
“It was a complete waste of time, received a carefully worded letter from the DHB which just made me more angry.”

“It was somewhat cathartic to write it out, but the responses received were ultimately more damaging - dismissive and no acceptance of wrong doing, no sense that anything would ever change.”

“...I got a reply, but does not give me confidence that it would not happen again. I don’t believe the maternity care system inside the hospitals treat birthing mothers as such, they treat them as patients that are expected to do what they are told, especially if you are there for an induction [of labour].”

“They told me it was standard practice.”

A couple of women stated how helpful an apology from those who had contributed to their traumatic experiences would have been. For example, Eliza advised that an, **“Acknowledgement of the issues from the staff involved [would have helped]. APOLOGIES - and not just the “we are sorry IF you were upset” kind.**” Perhaps, this type of validation and acknowledgement of wrongdoing would not only improve outcomes for affected women, it may also decrease the perceived need for laying a formal complaint.



Chapter Six
**Birth Trauma Prevention
and Preventing Repeat
Birth Trauma**

Given that 319 New Zealand women took the time and made the emotional investment of revisiting their trauma in order to answer this survey, it is imperative that their voices are heard, acknowledged and acted upon. Their voices can guide us to develop strategies which will see less women experiencing iatrogenic birth trauma, and more women receiving the support they need when trauma has been a part of their birthing journey.

Women and Their Partners

Parents-to-be need to understand their rights and responsibilities, and those of their maternity care providers, in order to be self-determining in their birthing and parenting roles. When women understand their entitlements within New Zealand's maternity system, they are better equipped to make the informed choices that are right for them.

Antenatal Education (first and subsequent births) and Action Plans

Generally speaking, many women expressed a need for more information prior to, during, and/or after birth. If 'knowledge is power' then the reverse rang true for these woman. They felt disempowered and, consequently, traumatised at least in part through lack of information. Suggestions from respondents included, *"More discussion about traumatic birth at antenatal classes."* And, *"One on one discussion and suggestions about bonding and attachment and potential long term effects of PND on relationships with partners."*

Women wanted to be informed about the potential for birth trauma, what the effects of such trauma may be, and what support is available for affected people. Other relevant responses included:

"There is no full open discussion at all before birth of the possible trauma, it was all glossed over. No list of services available."

"I feel that I needed more information through the whole process as things often were not explained to me... perhaps someone offering to come around and talk about it a couple of weeks after the fact may have helped, as well as some written information for me to read regarding traumatic births."

"Understanding impact of trauma and what helps/hinders healing [would have been beneficial]."

This is important information for LMCs and Childbirth Educators (CBEs) to know and to ensure that they incorporate into their teachings during the antenatal period. Since much of the ongoing effect of a traumatic birth is in response to having a lack of control over birth interventions and women blaming themselves for 'failing at birth', gaining an antenatal understanding of the causes of birth trauma may mitigate the long-term psychological impacts. As well, **LMCs and CBEs need to be giving parents a list of relevant support services lest trauma become a part of their birth experience.**

For women who have already experienced a traumatic birth, LMCs need to be aware that creating an 'action plan' for their next birth may play an important role in the mental wellbeing of those pregnant women. This need was expressed by Amanda, who wrote, *"Having an action plan in place for my second birth [would have helped]."* **Supporting women to choose the circumstances surrounding their next birth is an important step in women regaining autonomy over their bodies and their births,** as it was for April, *"Being told by maternal mental health that I can have an elective c section next time helped me begin to move on."*

Some midwives provide the support needed to help their clients prepare for the birth of their next baby after previous birth trauma. However, not all midwives have the time and/or skills to effectively achieve this. **It would be beneficial if specialised antenatal classes were an option for those who need them, an antenatal course specifically designed for couples who have experienced previous birth trauma and are pregnant again.** Hamilton-based birth trauma support organisation, Voice For Parents, offers such a course (our 'Planning For a Better Birth' antenatal series), but there are none like it elsewhere in the country, and the cost of attending is currently not subsidised.

Follow-Up Support

As was previously discussed in this report, **many women suggested that a birth trauma follow-up support system would have been beneficial.** This is particularly significant given the majority of traumatised women did not feel ready to discuss their trauma in the early postpartum weeks. Also, when women did feel ready to access support, many did not know what their options were or felt incapable of asking for help. A simple system of follow-up support could look like this: At their six week (postpartum) check-up women could routinely be given a list of local postnatal support services. At the bottom of the page there could be the following:

If your birth was traumatic (as defined by you), you can send an email to 'this' address to let it be known that you would like follow-up support by way of a phone call from a trauma support worker in three months time. In your email, state your full name, the town you live in, the date of your baby's birth and the phone number you would like to be contacted on. If at any stage you would like to be removed from the register, you can send another email to 'opt off'.

Of course, staffing and management of such a support system would require funding. However, the long-term mental health benefits for women and their families, and the mitigated social and financial costs, should ensure that such investment would be fiscally and socially advantageous, not to mention mandated from an ethical standpoint.

Perinatal Care Services and Professionals

Given that a significant proportion of women's traumatic birth experiences is the result of poor treatment by maternity practitioners, such service providers ought to be required to undergo training in the prevention of birth trauma. Also, those who are involved in women's postpartum healthcare - GPs, Well Child/Tamariki Ora service providers, Midwives - need to know how to sensitively support women affected by a traumatic birth.

Education

As has been made clear in this discussion report, much birth trauma is triggered or exacerbated through insensitive treatment by some maternity practitioners. Such dismissive and undermining 'care' speaks volumes about the attitudes of some midwives and doctors. Their unwillingness to listen to what women are telling them, to appreciate the important role that emotional support plays in their work, and to respect a woman's right to autonomy over her birth experience, is unacceptable. However, in our current patriarchal birth climate, perhaps a number of maternity practitioners are blind as to the impact they are having on the women they serve. **There needs to be some way to guide practitioners to a clearer understanding of the flow-on effects of their substandard maternity care. And those who continue to fail women in this manner need to be held accountable.**

Many women felt that maternity staff were poorly trained around birth trauma in general, and mention was made that there needs to be more awareness and education of how past trauma and abuse can affect a woman's birth experience. Without awareness and understanding, staff are less inclined to recognise the impact that their insensitive treatment of women may have. Suggestions made by survey respondents for improved maternity support included:

"Staff training with trauma."

"HCPs [Healthcare Providers] being more aware of potential for trauma and that some people will bury it (especially during focus on needs of new baby) but need help to talk and realise what happened to them."

"[More education is needed on] how past abuse affects birth etc. Past sexual assault or abuse is a big deal for a birthing woman."

"When my baby was 3 I got diagnosed with severe postnatal depression from my birthing experience. I believe there needs to be more awareness made for the health of the mothers too."

"More help and openness from the doctors at the time [of birth]."

Birth trauma prevention and ways to minimise repeat birth trauma need to be compulsory components of education for all trainee maternity practitioners, including specific training around how to competently and sensitively debrief births with women and their partners. Also, professional development programmes with birth trauma prevention as their focus, ought to be a part of all midwives' and obstetricians' ongoing education. Well Child/Tamariki Ora providers and GPs would also benefit from professional development that focuses on the impacts of birth trauma on women and their families, and ways to appropriately address the needs of affected families.

Reviewing Hospital Policies and Protocols

For hospitals to be experienced as safe places to give birth, it makes good sense that their policies and protocols are in line with 'best practice' based on current evidence. What is more, staff need to ensure that they are upholding the rights of birthing women to make informed decisions about their maternity care. But are these the reality in New Zealand's maternity wards? Survey responses indicated that for many women, giving birth in hospital was far from safe especially when mental health outcomes are included in the definition of safe birth.

On one hand women are led to believe that they are entitled to choose how they give birth, but in the labour ward they are manipulated and coerced into agreeing to interventions (frequently dictated by out-dated hospital policies or staff practices) that result in poor outcomes. It would be interesting to know how many women understand that hospital policies do not override a woman's right to choose whether or not she consents to any suggested intervention. Then again, understanding something and feeling supported to enact that right are two different matters entirely.

A number of women developed a mistrust of the hospital system as a consequence of their treatment there. And some made suggestions regarding hospital policies and procedures that contributed to their trauma, including:

"I think the hospitals need to look at their procedures and treatments of birthing mothers... Lack of care by the professionals who are meant to be looking after you and especially when they are "managing" your birth process by way of induction creates trauma that has no need to be there. The emergency C-section did not traumatise me so much as all that happened up to that point with the mismanagement of the induction they put me through."

"Would have loved [my partner] to stay, they kicked him out at 2am then told me to stop crying."

"It was a dark time, being isolated from family while trying to recover emotionally and physically from a traumatic birth which included a c-section under general anaesthetic. Having an outside agency involved in helping me through this time would have been gratefully received."

"A debrief of reasons behind 'protocol' would have been helpful as I am now very fearful of hospital and the medical profession in general."

Service Evaluation and the Complaints Process

Almost half of the survey respondents said that the poor treatment they received from a maternity practitioner contributed to their traumatic birth experience, yet only 17% laid a complaint. **If our maternity care service needs to change in order to better serve birthing women, then we need to be collecting feedback on women's birth care experiences.** LMC midwives are required to provide the women in their care with an evaluation form, but what of the hospital midwives and doctors that are a part of many women's birth care? **Why are new mothers not systematically given an evaluation form on discharge from the hospital?** Although there are currently avenues for providing such feedback, not all women are made aware of those opportunities, and many are not well-placed to write about their birth experience in the early postpartum weeks.

Of those women who did lay a formal complaint about their birth care, it was alarming to note that at least half of them found it an unhelpful process. The fact that a number never heard back from the 'complaints team' is appalling, especially given the stress involved in writing a complaint. And the number of invalidating responses to women's complaints was also very disheartening. **We ought to look at ways we can better support women through this process and there needs to be more checks and balances in place to ensure that every complaint is responded to within a reasonable time frame.**

Some women felt hindered by a lack of advocacy through the complaints process. Amongst suggestions for improved support were, *"Having a knowledgeable person support me in writing a follow up letter to the DHB if there was grounds to do so from my notes."* And, *"An advocate to help make the complaints process less stressful."* Although the HDC offers such an advocacy support service, many new mothers are not made aware of it, and there is no such service for women wanting support with a non-HDC complaint.

The Bigger Picture

New Zealand's birth care system has some serious shortcomings for many women and their families. **Once we acknowledge the avoidable nature of much birth trauma and we gain clearer insight into the potential long-term impacts, we are compelled to look at ways to create a better system of care.** Why, when we are renowned for our world class maternity system, are so many

women experiencing avoidable birth trauma? How can we reduce its incidence? And how can we best support women and their families when birth trauma occurs? To answer these questions we need to look at the bigger picture surrounding the culture of birth in New Zealand.

Research, Recognition and Government Funding

This survey was carried out as a means of evaluating the needs of women and their partners in relation to traumatic birth experiences. What it revealed was that there are many people struggling with the consequences of birth trauma, and that there are large holes in the support services currently available to those people. **More in-depth research needs to be conducted in order to identify effective ways to minimise the amount of birth trauma taking place, and to ensure that appropriate support options are made freely available to those in need. Government funding is a must.**

Survey responses revealed that for many families affected by birth trauma there were no suitable primary care options available. Voice For Parents is one organisation that aims to fill that niche, offering a mix of one-on-one, couples, and group options that specialise in birth trauma support. However, such a service requires funding in order for it to be accessible to all those who need it. As well, services like those offered by Voice For Parents need to be set up in other regions around the country.

When we look at public health service evaluation regarding maternity care in New Zealand, we need to focus as much on the mental health consequences for mothers and babies (both short and long term) as we do on our statistical analyses of morbidity and mortality. **Whenever the term 'safety' is used in relation to birth intentions, interventions or outcomes, it ought to become a commonplace assumption that mental wellbeing is also factored in.** It should be very telling that suicide is the leading cause of maternal deaths, yet for far too many women the impact of a traumatic birth is down-played or altogether ignored. **When a survey like the one conducted here reveals an 18% rate of women having suicidal thoughts and/or thoughts of leaving their family following a traumatic birth, and one respondent having had infanticidal thoughts, we cannot ignore the very real toll that birth trauma takes on the health and wellbeing of New Zealand families.**

The Over-Shadowing of New Zealand's World Class Maternity Care System

One of the ways in which New Zealand's maternity care system is outstanding, is that women are able to experience continuity of care with an LMC of their choosing. Such care enables a partnership between a woman and her LMC that is based on mutual trust and respect. The LMC gets to know the woman - her history, her fears, her hopes, her 'norms' - so that by the time the woman is ready to birth her baby, the LMC has a full understanding of how best to support her.

LMCs though, like the women they serve, are influenced by the prevalent birth culture, one where medicalised birth is the norm and women are deemed incapable of making sensible decisions for themselves, their labours and their babies, and one where respect for a midwife's skills and knowledge falls short in the eyes of those who subscribe to the misogynistic paradigm of 'safe' birthing. So, despite our enviable maternity care system, and despite our HDC Code of Rights which entitles women to be shown dignity and respect in their labour care, including the right to make informed decisions (free from coercion) regarding all potential interventions, it seems that in many ways our patriarchal system manages to override much of it, nullifying that which is designed to protect and serve women in birth.

Mainstream media coverage of birth-related issues in New Zealand further damages the reputation of our midwives, and skews the public's view of safe birthing with a weighty bias towards medicalised birth. Midwives are scared to support women who choose birth options that fall outside of the mainstream. They fear that if something goes wrong the media will grab at the chance to vilify them. Yet, a baby who was aborted because a sonographer detected an abnormality that wasn't actually there isn't news-worthy, or a mother who experienced obstetric rape and went on to suffer PTSD for seven years, that's not news-worthy either. Media plays a vital role in shaping our birth culture. **We need more unbiased news articles that reflect on a range of women's experiences of birth, articles that responsibly encourage questioning and discussion of the issues as birthing women see them.**

Creation of a Birth Culture That Values Women's Experiences

New Zealand boasts a 78% rate of consumer satisfaction regarding their overall maternity care experiences (Ministry of Health, 2012). Our maternity care system is the envy of many midwives and birthing women across the globe. Here, midwives are autonomous practitioners who are viewed as the experts in normal birth. This is reflected in the number of women opting for a midwife LMC, with a rate of around 90% (Ministry of Health, 2015). Access to a care provider of their choice is free for women, and continuity of care is enabled. Furthermore, women are entitled to choose where and how they give birth, with such autonomy being reinforced via the HDC Code of Consumer Rights.

What does this say about the occurrence of birth trauma in New Zealand? Actually, very little. **While I believe New Zealand's model of maternity care probably results in a significantly lower incidence of birth trauma in comparison to other countries, I would caution the summation that since our rate of consumer satisfaction with maternity care is high, that our incidence of birth trauma must be low.** The Maternity Consumer Survey that our Ministry of Health conducts every few years does not specifically ask about the emotional and psychological impacts of women's births. A respondent may have felt satisfied with the care she received, yet be suffering symptoms of Post-traumatic Stress Disorder (PTSD) regarding birth interventions that took place. This may sound nonsensical but if we examine our current birth culture and societal values then maybe it would make more sense, and a greater appreciation for why I felt this survey was an important undertaking may be gleaned.

My observations have led me to believe that the average New Zealand woman has low expectations with regards to what constitutes a positive and safe birth experience. Although she longs for a quick and fairly painless birth, she expects birth to be scary, to be undignified, and to be excruciatingly painful. She anticipates needing some form of medical intervention, experiencing loss of control, and that birth will be a disempowering experience. And she is led to believe that so long as she has a healthy baby at the end of it all, she is fortunate and ought to be grateful. She learns that the ends justifies the means when it comes to childbirth and that her unmet desire for a natural, gentle birth experience was a selfish pipe dream anyway.

In other words, **when a woman has a medicalised birth that is hideously painful, frightening and disempowering, she is experiencing that what she expected of birth. Rather than registering her experience as unnecessarily traumatic, she concludes that it was disappointing but 'normal'.** When she struggles to bond with her baby, finds herself experiencing extreme anxiety as a new mother, and begins having nightmares and flashbacks about her birth, it doesn't register that these are reasonable responses to a traumatic experience. Instead, she feels a failure, she feels isolated, she feels helpless to know how to cope, and she has no idea why she feels the way she does.

As well, it doesn't help that she lives in a society where **cultural norms ostensibly discourage women from getting the support they deserve.** I refer to our 'number 8 wire mentality', the 'she'll be right' (notice not 'he'll') attitudes, the remnants of a pioneering nation that has learned to 'put up with things and stop whining'. The values embedded in these sayings reflect a materialistic culture that emphasises doing it yourself. It's about rugged individualism rather than cooperative endeavour; it's about manipulation rather than sharing and caring.

Corresponding with these social mores is the debilitating stigma we've attached to mental illness. This mind set is reflected in our atrocious national suicide rate which is at its highest since records began (McAllen, 2015). Of important significance to the proposed changes that this report suggests regarding birth trauma prevention and support, is that **more New Zealand women die due to suicide than any other single cause during the perinatal period** (PMMRC, 2015). Suicide is as much a sociological issue as it is a psychological one. **When we consider that mental health impacts are generally disregarded in our analyses of safe birthing, we see how the psychological burden of traumatic births and new motherhood experiences are undervalued in our society. To better support maternal mental health needs we need to reflect on the underpinning sociology that somehow deems such needs as unimportant.** When it comes to maternal mental health we lack even the ambulance at the bottom of the cliff at times. There is no support for many suffering mums.

Also a reflection of our dismissive social values regarding women's holistic experiences of birth, is that minimal national research has been conducted in relation to birth trauma. In my review of current literature the only directly related research I could find was a decade-old qualitative study that included the experiences of 24 New Zealand women (Beck, 2004). **The truth is that we simply do not know how many women are affected by a traumatic birth experience, the amount of birth trauma that is preventable, and the impacts such experiences have on the families/whaanau involved.** Given the anecdotal evidence I have acquired in my voluntary support of traumatised mothers over the past two years, I would suggest that birth trauma is a significant and very real issue for a large number of New Zealand families. The responses acquired through conducting this survey cemented this conviction for me.

Our current system is failing, terribly, many new mothers and their babies. We need to stop minimising the impact that traumatic birth has on women and their families, we need to find ways to sensitively support women during the perinatal period, and we need to hold accountable the healthcare practitioners and their employers who needlessly contribute to the trauma experiences of birthing women. We can only do this if we acknowledge that birth involves more than 'getting a baby out of a mother's womb'. Birth is a precious aspect of family life, rich in emotion and spirituality, a period of transition that can set a family up to thrive, or to struggle down a lonely and frightening road of mental ill health.

When we acknowledge the importance of the mother-baby dyad that is, in many regards, reliant on a healthy bonding and attachment process that starts at birth, we consequently place more value on supporting positive birth experiences. Safety in childbirth is then recognised as more than just low mortality and morbidity figures, it involves consideration of the mental, emotional and spiritual safety of the experience too, including the potential long-term impacts. A positive start to motherhood for women, and a positive start to life for babies, can only serve to benefit the wellbeing of the entire community and future generations.

I would value being contacted by those of you who are interested in looking at ways that we can:

- address the lack of research on the incidence and experiences of birth trauma in New Zealand
- decrease the incidence of birth trauma in New Zealand
- educate maternity practitioners about birth trauma and how to appropriately carry out the debriefing process, and find ways to support them to uphold the right of women to make informed choices about their care
- educate GPs, midwives and Well Child/Tamariki Ora service providers on how best to support the mental health needs of families affected by birth trauma
- educate trainee maternity practitioners about birth trauma, its potential implications, and how practitioners can best support affected families
- ensure that hospital policies are regularly updated based on current evidence for 'best practice'
- lower the incidence of unnecessary labour and birth interventions
- improve the public profile of home birth in New Zealand, including validation of home birth as a positive option for healthy women
- challenge our current social values surrounding birth by ensuring unbiased media coverage that addresses the issues as birthing women see them
- develop nationwide, funded, specialised, one-on-one support options for families affected by birth trauma
- develop nationwide, funded, specialised antenatal classes that support the needs of couples who have experienced previous birth trauma
- decrease the stigma surrounding perinatal mental illness
- challenge the use of the word 'safety' in relation to birth outcomes where it does not take into consideration the mental, emotional and spiritual components of wellbeing
- support the mental health needs of fathers/partners (and other birth support people) who are affected by birth trauma
- improve the mental health outcomes for mothers and babies when the baby requires NICU care, including increased mother-baby contact, mental health support for mothers during their baby's time in NICU, and a support plan for when baby is discharged
- improve the opportunities for women to evaluate their birth care
- address the issues (as revealed in this report) regarding the laying of complaints for women who have received substandard birth care
- develop a system of follow-up support for women affected by birth trauma where women can choose to be contacted some months after their birth
- fund the work we do at Voice For Parents so that services are at a minimal cost to consumers

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