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Birth trauma and the anaesthetist

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Amy Dawes is the co-founder and CEO of the Australasian Birth Trauma Association (ABTA). Established in 2016, ABTA is a peer-led organisation helping to prevent, diagnose, and treat birth-related trauma. A firm believer in collaborative care, Amy has worked with parents and a wide range of health professionals involved in caring for birthing families to increase community understanding of birth-related trauma, provide support and education, conduct research, and advocate for change.

Edited by Professor Alicia Dennis

Consider the following fictional story that illustrates an example of psychological birth trauma:

Two weeks postpartum, Ms S remains impacted by her traumatic birth.

Hoping for some relief from the intense contractions that had been going on for hours, she requested an epidural. However, multiple insertion attempts were challenging, adding to her distress. As she struggled to remain still through contractions, the anaesthesia team worked to place it successfully. When it finally took effect, the initial relief was brief, soon replaced by sharp pain in her lower back and groin. She was reassured that this could be due to her baby's position and that the epidural was working as best as possible under the circumstances.

As hours passed, she heard the words: she was "failing to progress". The decision was made to proceed to an emergency caesarean section. Rushed to the operating theatre, she felt overwhelmed. Consent forms were presented, risks explained quickly in the urgency of the moment. Her partner held her hand tightly, his face pale with concern.

In the operating theatre, additional medication was administered through her epidural. She noticed she could still move her feet despite being told they would go weak. As the procedure began, she experienced intense pain. She cried out, panicked. The team acted quickly, placing a mask over her face to administer general anaesthesia. The last thing she saw was her partner's worried expression before everything faded to black.

She woke in the recovery room, groggy, with her baby and husband beside her. A brief explanation was given — she had been put under general anaesthesia. In the whirlwind of postpartum recovery, no further follow-up occurred of the events she experienced in labour and the operating theatre.

Now, the memories replay in her mind — the fear, the pain, the sudden general anaesthetic during her caesarean section and birth of her child. The experience weighs heavily on her, making it difficult to fully embrace these early days of motherhood. She longs for understanding, for closure, and for a way to heal.

INTRODUCTION

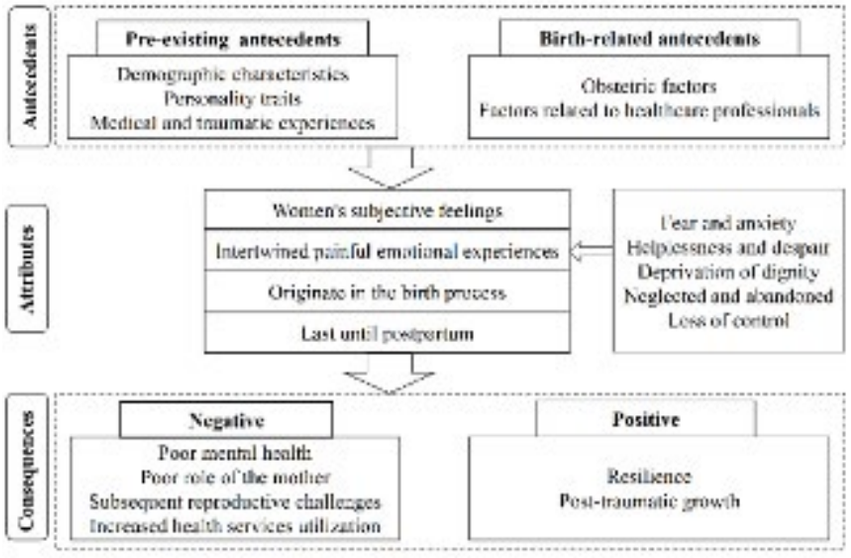
The birth of a baby is usually a memorable, emotionally charged and profoundly impactful moment in the lives of parents. Society perceives childbirth as an exciting and positive experience. However, research suggests that one in three pregnant people experience psychological trauma associated with birth.[1-6] Birth trauma has received increased recognition in Australia recently, particularly as a result of the NSW Parliament Legislative Council Select Committee on Birth Trauma Report released in May 2024.[7]

Prior to 2000, the terminology 'birth trauma' was exclusively used to refer to maternal or neonatal physical trauma after birth, such as pelvic floor dysfunction, neonatal cephalohaematoma, clavicular fracture or brachial plexus injury.[4] Since then, the concept has evolved significantly to include both physical and psychological components.[6,8] The Australasian Birth Trauma Association (ABTA) describes birth trauma as a person's experience of interactions and/or events related to childbirth that cause overwhelmingly distressing emotions or reactions, leading to short-and/or long-term negative impacts on a pregnant person's health and wellbeing.[2,8]

Birth trauma has a widespread impact on the birthing person and their partner or support person. Physical birth trauma now includes birth injuries such as perineal tears, pelvic floor trauma or ongoing symptoms such as incontinence, nerve damage, infective complications and persistent pain.[9-11] These processes are often linked with psychological birth trauma — the focus of this article — particularly if there is a delay in diagnosis and treatment. Psychological birth trauma is harder to define but has been noted to have four key attributes in the psychology literature:[6,8,12]

1. Subjective feelings
   a) Noting that childbirth appearing normal and straightforward to health professionals can be perceived as traumatic by the parturient, and not all patients with complications have traumatic experiences.
2. Painful emotional experiences
   a) Such as fear and anxiety, helplessness and despair, deprivation of dignity, feeling neglected and abandoned, and loss of control.
3. Originate in the birth process.
4. Persists in the postpartum period.

Figure 1. The concept of psychological birth trauma[6]



The negative effects of psychological birth trauma can be short-lived or long-lasting. They can impact the parent-infant relationship, the confidence to cope with the challenges of parenting, breastfeeding behaviour, partner relationships and future reproductive decisions.[4,6,13] Experiencing birth trauma increases the probability of postnatal depression by four to five times.[14] In addition, evidence suggests that 4-6% of postpartum patients in the community meet diagnostic criteria for postpartum post-traumatic stress disorder (PTSD) following a traumatic birth experience.[15]

Psychological birth trauma is often preventable and treatable if anticipated and proactively managed.[7] Genuine, compassionate care and shared decision-making, coupled with heightened awareness, are instrumental to its prevention. Anaesthetists are well-placed to assist in preventing and decreasing the impact of psychological birth trauma. As Vogel and Homitsky suggest, "Our expertise in crisis management should also encompass acute emotional crisis management and the acceptance of our role as 'guardians of psychological safety'".[16]

STEP 1: AWARENESS OF FACTORS CONTRIBUTING TO PSYCHOLOGICAL BIRTH TRAUMA

Psychological birth trauma can be influenced by various risk factors, including unexpected events or complications during pregnancy, labour, and birth.[4,15,17,18] These may involve maternal, fetal or neonatal emergencies, as well as unplanned interventions that the patient does not fully understand. To mitigate such risks, early intervention and preventive measures should be integrated into pregnancy management, particularly for conditions like pre-eclampsia, haemorrhage, venous thromboembolism and sepsis.

A history of trauma, whether related to previous birth experiences or unrelated life events, can further increase vulnerability.[6] In such cases, a trauma-informed care approach is crucial, ensuring healthcare providers offer compassionate and patient-centred support that minimises re-traumatisation.[19] Additionally, pre-existing mental health conditions, including tokophobia — an intense fear of pregnancy and childbirth — can heighten psychological distress during the perinatal period. Socioeconomic disadvantage, social isolation, and limited health literacy further exacerbate the risk, making it essential for healthcare systems to provide targeted support to vulnerable populations.[1,11,20]

Physical pain and birth-related injuries are also key contributors to psychological trauma.[17,21] Ensuring effective pain management, along with strategies aimed at reducing physical trauma during birth, are both proactive and protective strategies. Furthermore, prolonged and precipitous labour have been associated with increased distress, as has the experience of being separated from one's baby immediately after birth.[17] Early recognition of these risk factors, combined with proactive education and support, can significantly improve outcomes.[11] Although some instances of birth trauma are inevitable, better recognition, preparation and support are paramount to help manage the impact.[7]

Importantly, psychological birth trauma is not solely the result of patient-related risk factors; external influences within the healthcare system also play a significant role. The structure of maternity models can either protect against or contribute to trauma, with patient survey data indicating a strong preference for continuity of care and trusted relationships with providers. Access to these models can be limited by socioeconomic factors, pregnancy-related factors and geographic location.[7] Regardless of the model, collaborative, compassionate and trauma-informed care is protective against birth trauma.[3]

Mistreatment and neglect within healthcare settings further compound the issue. Reports indicate that one in ten birthing individuals have experienced dismissal, neglect or inappropriate treatment. At the same time, recent Centers for Disease Control and Prevention (CDC) data in the United States of America suggest that 20% of obstetric patients encounter some sort of mistreatment.[3,7,22] Violations of physical privacy, ignored requests for help, and verbal abuse are among reported concerns, with rates being disproportionately higher among minority and disadvantaged populations.[22] In addition, a lack of informed consent and choice, as well as misdiagnosis and delayed diagnosis, have all been identified as contributing to the incidence of birth trauma. When these issues are accompanied by a failure to provide open disclosure, the psychological impact is often worsened.[7]

Another significant factor is the denial of pain relief or the perception that one's pain is being dismissed. Inadequate pain management can greatly intensify distress.[23] Similarly, medical interventions that occur in an urgent or chaotic environment can be particularly distressing. According to the Centre for Women's Health Research and Maternity Choices Australia, the interventions in Table 1 are particularly triggering:[4,7,24-26]

Table 1. Interventions and their risk of emotional distress during labour

Intervention	Increases risk of emotional distress during labour by
Induction of labour	1.5x
Episiotomy	1.3 to 1.6x
Instrumental delivery	1.6 to 2.4x
Emergency caesarean birth	2.5 to 3.1x

PTSD is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) as exposure to a traumatic event perceived as a threat of death or serious injury to oneself or others and subsequent symptoms of reexperiencing, avoidance and hyperarousal. According to a pan-European multidisciplinary group of birth trauma researchers known as COST Action DEVOTION Ca18211, PTSD is estimated to occur overall in one in 11 patients with caesarean deliveries at two months postpartum and is predicted to occur more often in low or middle-income countries. However, research is limited in these settings.[4] Caesarean sections after induction of labour (odds ratio (OR) 1.8), postpartum haemorrhage (PPH) (OR 1.6) and high-intensity pain during the postpartum stay (OR 1.90) are also associated with increased risk.[4]

The complex interplay of patient, system and social risk factors, such as stigma around the 'right' way to birth and mental health in general, all contribute to the potential for developing birth trauma.[27] Workforce shortages and pressures on our health systems only compound this. Addressing psychological birth trauma requires a multifaceted approach that not only acknowledges individual patient risk but also recognises the broader systemic influences at play.

STEP 2: ANTENATAL PREPAREDNESS

The Joint RANZCOG/ANZCA/RACGP Position Statement on the provision of Obstetric Anaesthesia and Analgesia Services states "women should be informed prospectively of the obstetric anaesthesia and analgesia offered by a facility/institution. Where specific services (e.g. epidural analgesia) are unavailable, women and their partners should be informed and offered to transfer antenatally to a centre with more comprehensive services".[28] Antenatal access to obstetric patients by anaesthetists is variable and, if it occurs at all, is usually late in the antenatal journey. The mismatch of pre-birth expectations and actuality can lead to birth dissonance and disappointment.[23] Birth trauma could be prevented if parents were better prepared and were provided with well-balanced, evidence-based resources and education prior to delivery, as well as information about the resources available in their birthing environment as recommended by RANZCOG, ANZCA and RACGP.[7,23,28] Many primiparous patients in Australia aim for a birth that avoids pharmacological pain relief due to a widespread but unfounded belief that it is better for them and their baby. However, 75% of pregnant people in Australia ultimately request pharmacological pain relief.[23] Statistically, one in five patients will have an unplanned caesarean section and one in four first-time patients will have an instrumental delivery.[7] Many pregnant people reach the birth suite not having a sound understanding of these procedures. As a result of the inquiry into birth trauma, the NSW government has supported the recommendation to develop minimum standards for access to comprehensive, evidence-based antenatal education for birthing and non-birthing parents covering all aspects of birth.[29] This would include available models of care, potential interventions and a discussion of rights during the birth process

Access to antenatal resources is highly variable and depends on the model of care, marketing of what is available, affordability and palatability of various modalities. In-person attendance to classes often requires a highly motivated, health-literate patient cohort who is time-rich and may incur a cost. Time limitations and a fear of overwhelming new parents can lead to omissions during available education sessions. Overuse of jargon can compromise understanding. Engagement with written or online information requires direction and encouragement to avoid dilution with non-evidence-based opinions freely and easily accessible to parents online or via hearsay. Access for linguistically and culturally diverse populations can also be particularly challenging.

Parents remark that they would have made more informed decisions or felt more comfortable if they had more awareness beforehand.[7,30] All care team members must acknowledge bias based on their own exposures and experiences around birth and be mindful not to project them onto patients. This includes anaesthetists. Ideally, all patients should receive evidence-based information on all options of analgesia and

anaesthesia for delivery. All members of the maternity health care team should be aware of the high-risk patients in which an early labour epidural would be additionally beneficial from a morbidity point of view, and this should be discussed, consented to and planned well before arriving at the birth suite.[31]

In the absence of standardised anaesthetic antenatal education throughout Australia and New Zealand, it is up to providers to know what is available at their centres and direct patients to these resources.[28] Anaesthetists must advocate for reliable anaesthesia-related patient education to be provided during antenatal care. This requires collaboration with other members of the maternity team who see the patient regularly in their antenatal journey and guidance on resources available in the absence of tailor-made programs for the health service (Table 2). Acknowledging that feasibility may be challenging, requests by patients of all risk profiles for anaesthesia review for specific questions about potential anaesthesia involvement in the birthing process should be welcomed, encouraged and funded appropriately.

Table 2. Freely available written antenatal anaesthesia resources

1. ANZCA Pain relief in labour fact sheets[32]
2. LabourPains: Information for expectant parents and healthcare professionals on pain relief choices during labour[33] – multilingual
3. ASA Epidural during childbirth, epidural & spinal anaesthesia and analgesia patient information pamphlets[34]

ANZCA: Australian and New Zealand College of Anaesthetists; ASA: Australian Society of Anaesthetists.

Armed with balanced, unbiased information about potential procedures involved in birth, patients can confidently share their well-thought-out birth preferences while remaining psychologically prepared for the unexpected.

STEP 3: LABOUR AND DELIVERY CONSIDERATIONS

Informed consent

Anaesthetists are legally obliged to obtain consent, including financial consent, where relevant. Consistent with all medical interventional care, it is vital that patients are aware of material risks prior to administering analgesia in labour or providing anaesthesia for deliveries in the operating room.[35] Consent should be individualised and not simply be a tick-box exercise or a standard script for all. Informed consent is an essential element of person-centred care and should be voluntary, free from coercion or pressure, with adequate discussions of alternatives, including the possibility of declining the intervention. Valid consent can be challenging and potentially compromised by a chaotic environment, a sense of urgency, the influence of pain, systemic analgesia and a lack of antenatal preparedness.[36] Although there are unique challenges in the maternity environment, the suggestion that labouring patients are not capable of giving informed consent, even when in pain or medicated, has been debunked in the literature and judiciary,[37,38] Despite this, a 2006 survey demonstrated that 70% of ANZCA anaesthetists believed active labour inhibits a patient's ability to give 'fully informed consent'.[35,39] Concerns included a pregnant person's capacity to consent while experiencing labour pain, the urgency with which some patients demand the procedure, as well as external pressures and stigma.[38,40] Failure to provide informed consent is associated with poorer birth outcomes and directly violates ethical and legal requirements.[41] According to the Birth Trauma Association (BTA) in the UK and ABTA, a lack of informed consent and a perception of coercion are reported by many patients who experience preventable psychological birth trauma.[17,29,42]

Key strategies to provide better-informed consent to labouring and pregnant patients include:

1. Empowering pregnant people with anaesthesia and birth-related information before labour and delivery via antenatal education and the use of written or visual aids.
2. Clear and tailored communication that is simple, jargon-free, calm, concise and structured to accommodate the patient's pain.
3. Use of teach-back methods or asking the patient to repeat key points to confirm understanding.

4. Demonstrate respect for individual preferences when discussing options and reaffirm consent as a continual process throughout the labour.
5. In emergency scenarios, when time is limited, the patient and support person should receive essential information in a structured manner.
6. Work collaboratively with the maternity care team to ensure a cohesive approach.

The ABTA provides helpful resources to patients to understand informed consent and frame it as an important empowering tool for advocacy and autonomy via the ThinkNatal Program.[42] The key areas of focus important to patients are:

1. Clear, evidence-based and comprehensive information before procedures (as much in advance as possible) that includes benefits, risks and alternatives.
2. Expectation setting and how the patient may participate to support self-advocacy.
3. Opportunity and encouragement to ask questions.
4. Voluntary decision-making without pressure or coercion, with respect for values and preferences, whenever possible. A mutual understanding that consent may change as the situation evolves and ensuring the patient knows they can refuse at any time is important to declare outright.
5. Clear and accurate documentation that can be accessed by the patient. Particularly in obstetrics, written information of the discussion provided to the patient and support person can be highly valuable reminders of the conversations had during stressful events.

Compassionate care and communication

Sussan Stanford provides an impactful recount of her psychosocially traumatic but technically "mundane" elective caesarean section, where a lack of warmth, an unequal patient-doctor relationship and failure of communication were key contributors to her poor experience.[27,43] In 2024, the ABTA surveyed 100 members and asked how their anaesthetic or the anaesthetist affected their birth experience, positively or negatively.[44] Patients commented that when an anaesthetist was protective against or decreased the impact of birth trauma, it was because they treated them with kindness, reassured them that they genuinely cared and would do everything possible to provide the patient with a safe delivery. They explained procedures simply and honestly and empathised with the feelings of fear and excitement in a way that felt genuine. The use of "teach-back", where the patient can relay their understanding of the information they are provided in their own words, was empowering.[22,45] Feeling unrushed was paramount to respectful maternity care.[22] Patients vividly remember their interactions with anaesthetists and are positively impacted by those who ask about patient preferences and make attempts to facilitate them. This includes ensuring skin-to-skin contact can be facilitated as soon as possible after birth and limiting parent-baby separation, which are known to be protective against birth trauma.[29] In addition, if appropriate, creating a less intimidating medical environment by slightly altering lighting or including music is a low-effort intervention with a significant impact for anxious parents entering often foreign and overwhelming operative environments. Finally, role modelling and advocating for the whole theatre team to maintain a shared focus on the patient, their support person and their baby and avoid irrelevant background discussions was reported on positively.[3] This data demonstrates that our demeanour and communication style are two of the most powerful influences we have.

The anaesthetist's interpersonal skills can greatly impact the patient experience. Mindful language, particularly avoidance of negative suggestions and nocebos that can enhance pain and anxiety, should be implemented by all anaesthetists with all patients.[46] Adequate introductions, a friendly demeanour, eye contact and avoiding looking panicked even in the most time-critical scenarios can improve connection and help build the necessary trust required for successful psychological safety.[22,43] When the patient understands the rationale for clinical decision-making, they can be powerful allies in their own positive care experience. Poor communication is often at the heart of patient complaints, litigation and adverse incidents.[4]

Preventing and managing pain

The perception of pain despite anaesthesia during labour or delivery is a high risk for psychological morbidity, especially if combined with delays to management or a perception of being dismissed or

ignored.[27,43,47,48] Up to 23% of patients experience pain during caesarean delivery.[48] In her own case, Stanford recounts feeling pressured to agree that the block was sufficient despite her better judgement due to a power imbalance between the anaesthetist and the performance pressure of the theatre environment.[27,43] A rigorous test of the quality of the block with a focus on maternal satisfaction, in addition to objective evidence of the adequacy of neuraxial anaesthesia, is crucial.[49] The literature suggests the utilisation of multimodal testing, including fine touch (gold standard), cold and motor response (bilateral motor block in legs) prior to initiation of surgery.[47,50] Strict criteria for good quality neuraxial block, including a clear block to sensation (ideally two modes, including light touch) to T5 or higher and inability to straight leg raise against gravity bilaterally, should be achieved or mitigated with troubleshooting measures such as repeat neuraxial or offering general anaesthetic prior to commencement of surgery.[47]

We must disconnect ourselves from the feeling that objective assessment indicating adequate neuraxial block may still not meet adequate standards for patient comfort. Practitioners should confidently educate patients during consent that blocks do not always work effectively despite technical signs to the contrary.[27] Expectation setting and discussions of common breakthrough pulling, stretching, pressure and proprioceptive sensations is also crucial during the consent process.[47] However, so is the caveat that if these sensations cause distress, this will not be tolerated. Patients should be encouraged to speak up.[47] Regardless of why or when the patient experiences pain, the patient must be immediately believed, with reassurance given that a new plan will be implemented to address the situation. This is also true of the labour epidural, which should be made available when the patient asks for it and adequately tested for maternal satisfaction.[23] Dismissive language such as "it's just pressure" and "the spinal/epidural is working", despite being an attempt usually to reassure, can leave parents highly distressed.

A positive childbirth experience is individually defined. Therefore, for optimum planning and shared decision-making, it is paramount to understand a patient's priorities, preferences and expectations. Knowing from the outset that a general anaesthetic is available at any time, although not preferred for a variety of valid safety reasons as the first-line option, can alleviate the perception of being trapped in a painful caesarean delivery and allow patients to be more open to the normal sensations of birth with neuraxial anaesthesia.[51]

There is evidence that patients who experience severe acute pain after childbirth, regardless of delivery mode, have a 2.5 times increased risk of persistent pain and a three times increased risk of postpartum depression.[52] Trauma-informed care and proactive consideration of post-delivery pain by all involved practitioners, along with the adoption of evidence-based guidelines such as the Procedure-Specific Postoperative Pain Management (PROSPECT) guidance for caesarean section, are highly recommended.[53] Patients should be given information prior to and at the time of delivery regarding expected discomfort after delivery and be encouraged to escalate their concerns early to their care teams to allow for proactive intervention. They should be reassured that their pain will be managed and that their management will be individualised.

STEP 4: POST-DELIVERY CONSIDERATIONS

Ideally, all patients cared for by an anaesthetist during their birthing experience should receive a post-delivery check-in by a member of the anaesthetic team. However, this can be practically challenging to achieve due to staffing, funding and workload pressures. In situations such as difficult epidural insertion, inadequate pain relief in labour, pain during operative delivery or major adverse events, it is highly recommended that the anaesthetist provides a dedicated post-delivery consult to address these events. We should also be highly responsive to postnatal referrals from concerned obstetric and midwifery staff. Whether the anaesthetist who performed the initial procedure is the most appropriate person to respond will depend on the relationship built with the patient and whether there were any interpersonal conflicts during the care. Unexpected emergencies should trigger a check-in to review the events and decision-making with the patient and ensure questions are answered. It is not the remit of the anaesthetist to provide formal psychological debriefing as additional training is required for this. We are also unable to provide the longevity of care that may be required. However, an early check-in with the patient to clarify questions, events, and decision-making during the anaesthesia episode can benefit patients and their partners, particularly when there is a lack of clarity. The early check-in also shows care and concern. As per the statutory duty of candour guidelines, patients should be offered a formal apology, and escalation through safety and quality channels should be followed whenever possible to promote process improvement.

Positive care immediately after birth trauma provides an opportunity for patients to process the experience and start to recover.[54] Drawing on trauma-informed care and psychological first aid principles, we propose

the PILAR Check-In to support initial care and provide a positive foundation for further psychological care in post-anaesthesia-related childbirth trauma.[55,56] The PILAR Check-In consists of five dynamic processes: Preparation (P), Introductions (I), Listening (L), Apology (A), and Reassurance (R). It aims to provide a safe space for patients to express their experience, provide reassurance, prevent re-traumatisation, and foster a positive foundation for further professional support. The PILAR Check-In should be employed at the first anaesthesia consultation that occurs after childbirth.

Preparation

The clinician should be prepared for possible behaviours associated with trauma responses.[57] Initial post-trauma responses include sadness, anxiety, agitation, confusion, detachment and withdrawal, distress, and dissociation.[58] Further preparation involves ensuring sufficient time is allocated for care. The PILAR Check-In should not be rushed and should not be interrupted unnecessarily. Allowing time for the patient to express the experience rebuilds respect and trust.[59,60] Consider an appropriate quiet location and ensure support people and staff are available to attend when possible.

Introductions and invitations

It is important to introduce yourself and any accompanying clinicians. Introductions also involve clearly stating the rationale for your visit to support transparency and trust in the relationship.[59,61] Having an awareness of demeanour is essential in these first few moments. Maintaining an open posture, making eye contact, and vocalising in a calm, clear, and thoughtful manner are vital to fostering a positive foundation for further communication.[60,62] Ideally, the clinician aims to establish a trusting, respectful, safe, and open dialogue for ongoing communication.[63]

A clinician inviting the patient to share the experience provides an opportunity to re-establish trust by re-empowering the patient to alter the power balance within the relationship.[62] If the patient declines the request to share their experience, reassure them that if/when they are ready to share, you will be open to listening. The clinician should be mindful that retelling events within the first 48-72 hours may cause further distress for some patients.[64] Thus, it is essential during recall that the clinician is supportive, not forceful, respectfully listens and provides reassurance where necessary.[60]

Listening

Listening is an art, and when performed well can support recovery after a distressing experience.[65,66] Often referred to as “attentive listening”, the aim is to demonstrate respect for the patient’s experience and build trust.[66] Listening should occur without interruption, and the clinician will need to use communication skills like eye contact, nodding and paraphrasing to acknowledge understanding.

Apology

An apology is an important step after healthcare-related adverse outcomes to rebuild trusting relationships.[67-69] The apology should be simple, in plain language, and authentic. It should emphasise that the experience was unplanned and not in keeping with the desired outcome. Dialogue box 1 provides some examples.

Dialog Box 1

I am sorry you had this experience; it was not our intention.
We appreciate that it was difficult to retell. Thank you.

I’m sorry. I can see how this experience would be upsetting. Thank you for sharing it with me.

I am sorry you had this experience. I believe we can do better. Thank you for sharing.

It is not always necessary to provide a rationale for the outcome, and it is challenging, especially if it is unknown at the time of the review. While the clinician might not have the answers, it is essential to emphasise that an explanation is important and will be fed back when available. In the aftermath of adverse outcomes, patients often wish to be provided with relevant information on how the issue will be addressed, and this has been shown to support recovery.[70,71]

Reassurance

Providing reassurance is centred on the patient’s needs. Ask the patient if they have any questions. Explore what can be done for them now. Encourage patient re-empowerment by offering formal feedback avenues. If acceptable within your departmental governance framework, ask the patient if they would like you to provide feedback on their behalf.

Another important aspect of reassurance is transparency about the investigative phases and offering the patient involvement in this process.[70,72] Outline the review process, which may include analysing the event history, interviewing participants, requesting and reviewing feedback from patients and families, root cause analysis, or alternative adverse event reporting.

After any traumatic events, it is essential to offer further support. Collaborative care with clinical psychology, midwife liaisons, psychiatry and social work has demonstrated positive outcomes for patients who have experienced psychological trauma and is essential to optimal recovery.[73-76] Promotion of freely available resources on discharge for both parents, such as their maternal child health nurse, the ABTA, Perinatal Anxiety & Depression Australia (PANDA), Mums Matter Psychology, the Gidget Foundation Australia, and other local online, phone or community services, can be highly beneficial to ensure the patient is as protected against severe psychological distress as possible. Before closing this episode of care, create a plan for re-connection if the patient desires to do so. This further supports trust and reassurance. Post-birth obstetric anaesthesia clinics can be highly valuable avenues for this.

Limitations

The PILAR Check-In has not been designed as a complete psychological care package. It considers that many healthcare professionals are not formally trained in trauma-informed care or psychological first aid and provides basic care guidance to promote a positive platform for future psychological care. It aims to prevent any negative consequence associated with care discussions. The PILAR Check-In is not designed to replace psychological or adverse incident medical debriefing. Often, such debriefing requires more extensive and collaborative care planning. While the PILAR Check-In process has foundations in trauma-informed care and psychological first aid, it has yet to undergo rigorous testing. Finally, the PILAR Check-In does not address issues of trauma in the partner or support person who may be suffering due to witnessing or learning of a traumatic birth event.

STEP 5: STAFF WELFARE AND TRAINING

According to Make Birth Better, vicarious birth trauma (also known as secondary traumatic stress) describes the indirect trauma that can occur when one is involved in a difficult birth, fatality in birth, mistreatment, inadequate care or a serious adverse event.[77] Signs include feeling detached from your patients, difficulty “shaking off” anger, sadness or mistrust after incidents, a sense of guilt and shame around the involvement in incidents, frequent thoughts of the incident which may be intrusive, pessimism, empathy fatigue, low mood, anxiety and burnout. Therefore, it is imperative to be aware that the emotionally charged maternity environment can have profound impacts on not only the patient and their support network but on the staff as well. Recognising the signs and proactive engagement with a trusted local doctor, psychologist, employee assistance program, mentor and mental health practitioner, as appropriate, is vital to maintaining good mental health and longevity in the industry.

Resources available to practitioners who want more training in birth trauma include:

- Make Birth Better course.
- ABTA professional resources, including the ThinkNatal Education and Training eLearning Hub.
- BTA professional resources.

CONCLUSION

Birth trauma is more common than most maternity providers realise. It is a significant and ongoing issue in Australia and New Zealand, and globally. It is often underdiagnosed and undertreated, which highlights the need for greater awareness and support in this area. Armed with an increased understanding of the issue, anaesthetists are well placed to decrease the impact of this potentially avoidable and detrimental complication, particularly through prevention and management of complications, early recognition and management of psychological triggers and utilisation of the PILAR Check-In.

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