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Review article

Women's experiences of birth trauma: A scoping review

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ABSTRACT

Background: A high number of Australian women report experiencing traumatic birth events. Despite high incidence and potential wide spread and long-lasting effects, birth trauma is poorly recognised and insufficiently treated. Birth trauma can trigger ongoing psychosocial symptoms for women, including anxiety, tokophobia, bonding difficulties, relationship issues and PTSD. Additionally, women's future fertility choices can be inhibited by birth trauma.
Aim: To summarize the existing literature to provide insight into women's experiences of birth trauma unrelated to a specific pre-existing obstetric or contextual factor.
Methods: The review follows 5 stages of Arksey and O'Malley's framework. 7 databases were searched using indexed terms and boolen operators. Data searching identified 1354 records, 5 studies met inclusion criteria.
Findings: Three key themes emerged; (1) health care providers and the maternity care system. (2) Women's sense of knowing and control. (3) Support.
Discussion: Continuity of carer creates the foundations for facilitative interactions between care provider and woman which increases the likelihood of a positive birth experience. Women are able to gain a sense of feeling informed and being in control when empowering and individualized care is offered. Functional social supports and forms of debriefing promotes psychological processing and can enable post traumatic growth.
Conclusion: Existing literature highlights how birth trauma is strongly influenced by negative health care provider interactions and dysfunctional operation of the maternity care system. A lack of education and support limited informed decision-making, resulting in feelings of losing control and powerlessness which contributes to women's trauma. Insufficient support further compounds women's experiences.

Statement of significance

Issue

A lack of recognition and understanding of birth trauma often results in a missed opportunity to offer women acknowledgment, ongoing support and the chance to recover and to reform practice.

What is already known

Women who are traumatized by birth face ongoing psychosocial difficulties, some even experience PTSD. Two key identifying risk factors for birth trauma are pregnancy complications and operative birth.

What this paper adds

This scoping review broadens understanding of women's traumatic birth experiences by identifying key contributing factors. This review also highlights the need for further Australian based research on women's experiences of birth trauma to aid in the recognition of birth trauma and acknowledgement for women.

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1. Introduction

In recent years, there is growing interest on the potential psychological impact of childbirth as a traumatic event. Greenfield et al. [1] define traumatic birth as "the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (p. 265) [1]. Most importantly, the perception of a traumatic birth experience lies within the 'eye of the beholder' and can ultimately only be defined by the woman experiencing it [2]. Research suggests that a significant number (45.5%) of Australian women report experiencing traumatic birth events [3].

Women who are traumatised by childbirth have an increased incidence of developing a number of psychosocial difficulties in the postpartum period. For instance, relationship break down, difficulty bonding with their baby, parenting stress and a loss of self-identity [4,5]. A traumatic birth experience can also leave women with symptoms such as flashbacks, nightmares, feelings of anger, anxiety and isolation [4,6]. In addition, some women report avoiding reminders of their traumatic birth experiences. This may begin with evading conversations about birth and sometimes avoiding a future pregnancy entirely [7].

Following a traumatic birth some women develop tokophobia, a fear of childbirth, with implications for future fertility decisions [8]. Conversely, women who experience tokophobia may pre-emptively perceive birth to be traumatic and thereby significantly increase the likelihood of actually experiencing trauma [9]. As a result, tokophobia itself has been identified as a contributing risk factor for traumatic birth [10].

A number of studies have investigated risk and protective factors for traumatic birth. These studies have found that tokophobia, operative birth and negative care provider interactions are common contributing factors [10–12]. Martinez et al. [13] reports that key protective factors include a respected birth plan, continuity of care and skin to skin contact immediately following birth [13]. Additionally, the level of postnatal support offered to women and families following a perceived traumatic birth can impact on whether a woman goes on to develop ongoing distressing reflections of her birthing experience [14]. Some women who report experiencing birth trauma may also have no predictable risk factors. A seemingly 'normal birth' may be interpreted by women as traumatic. This can lead to a new mother's psychological distress not being identified and necessary supports not being actioned in a timely manner. Thus, the potential for birth to be perceived as traumatic requires ongoing awareness and education for clinicians.

Following a traumatic birth, some women may experience subclinical distress with mild mood distortion or a form of anxiety disorder [15]. Others can develop symptoms meeting diagnostic criteria for post-traumatic stress disorder (PTSD) [4]. The World Health Organization's (2018) International classification of diseases for mortality and morbidity (ICD-11) characterizes PTSD as the re-experiencing and avoidance of thoughts of an event perceived to be threatening or horrific with the ongoing perception of threat. Symptoms of PTSD include: strong and overwhelming emotions of fear and horror, intrusive thoughts, flashbacks, sleep disturbances and hypervigilance, with symptoms lasting longer than several weeks and causing significant impairment in psychosocial functioning. A traumatic birth experience can also fall within the criteria of Complex post-traumatic stress disorder (CPTSD) as an event of "an extremely threatening or horrific nature . . . from which escape is difficult or impossible" [16]. For women who meet all diagnostic requirements for PTSD and in addition experience severe and persistent difficulties with affect regulation; perceptions of worthlessness, shame, guilt or failure related to her birth experience and difficulties in bonding, preserving relationships and feeling close to others, may develop the alternate diagnosis of CPTSD [16]. A recent meta-analysis of studies estimated the international prevalence of PTSD among new mothers to be 4% [17]. The incidence in Australia is slightly higher with an estimate of 5.8% of mothers reporting PTSD at six months postpartum [3]. Women diagnosed with postnatal PTSD may experience either an acute form with symptoms slowly resolving up to 2 years post birth, or a chronic form with symptoms persisting or even exacerbating for two years or more [3,18].

In 2014, the National Institute of Care and Excellence UK (NICE) updated the antenatal and postnatal mental health clinical management and service guidelines. These guidelines were used in developing the 2016 National Perinatal Mental Health guidelines in Australia [19]. The guidelines recommend that women are offered support and advice following a traumatic birth, particularly women who develop PTSD. The guidelines also acknowledge that the prevalence of anxiety disorders, such as PTSD, are under recognised throughout pregnancy and the postnatal period [20].

With such a high incidence of women reporting trauma from childbirth, this scoping review aims to summarize the existing literature to provide insight into the birth trauma experienced by women unrelated to a specific pre-existing obstetric or contextual factor.

2. Methods

A scoping study is a research method that assists in identifying key concepts and sources of evidence on a particular topic, and identifies areas for further research to address gaps identified in the literature. A scoping study may contribute towards an ongoing process of reviewing, likely leading to a systematic review. For this study, a scoping review was deemed most appropriate for mapping the literature to identify key concepts into women's experiences of traumatic birth as well as gaps highlighting need for future research. The review follows 5 stages of the Arksey and O'Malley [21] framework. In addition, the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist [22] was also utilized for comprehensiveness.

2.1. Stage one: identifying the research question

The aim of this scoping review is to explore the experiences of women who describe their birth as psychologically traumatic and whose trauma was not reported to be primarily influenced by pre-existing high stress obstetric or contextual complicating factors as reported in the existing literature.

2.2. Stage two: identifying relevant studies

A three-step method, recommended by the Joanna Briggs Institute (JBI), guided the identification of relevant studies [23]. Initially, a limited search of 'birth trauma' was conducted in Ovid and CINAHL databases to identify relevant search terms. A PIO framework was used with text-words and index terms for woman, birth/postnatal and psychological trauma combined using Boolean operators (AND/OR) and truncation to perform each database search (see Table 1). To conduct a review of recent research only, databases were searched from March 2010 to March 2020 and included; Ovid Emcare, Ovid Medline, PsychINFO, Cochrane, Maternity and Infant Care database, Johanna Briggs Institute and CINAHL. Search limiters: adult female humans and studies written in English were also applied. Lastly, reference lists of included studies were checked to identify additional papers and a key author search was completed in the above databases. Grey

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Table 1
Search terms.

Population	Context	Outcome
Wome*	Birth	Psychological Trauma
Woman	Childbirth	Post traumatic stress
Mothe*	Postnatal	PTSD
Female	Perinatal	
Matern*	Postpartum	

literature was also searched using Google Scholar and via relevant organizations including NICE UK and COPE Australia.

2.3. Stage three: study selection

Inclusion and exclusion criteria, outlined in Table 2 below, were applied to literature sourced in stage 2. The criteria was used to examine the experiences of women who had not explicitly reported pre-existing psychosocial or obstetric factors that instigated their reported birth trauma. The primary focus of this review was women's experiences, therefore studies that included health care providers perspectives were excluded. Title screening was initially performed by the first author to exclude irrelevant studies. Abstract screening was then conducted by two authors, conflicts were resolved via discussion with a third author until consensus was reached. Next, full text screening was carried out by two authors, again a third author was utilized to clarify perspective and reach agreement on conflicts. Fig. 1 demonstrates the study selection process. Studies that explicitly stated, distinguished and/or highlighted a research focus on a known pre-existing primary contributing factor (as listed in exclusion criteria table), were excluded to identify studies on generally healthy and less vulnerable population.

2.4. Stage four: charting the data

See Table 3 for charting of included studies.

2.5. Stage five: collating, summarizing and reporting the results

The review includes five studies that met the inclusion criteria. Three were UK based [24–26], one in Ireland [6] and one international study conducted by Australian researchers [27]. Data collection included face to face interviews [6,24–26] and an online survey using psychological assessment tools and a single open ended question [27]. All of the studies used qualitative methods to examine and analyse women's experiences of birth trauma. These included grounded theory [24], interpretive phenomenological analysis [6], thematic analysis [25,27] and narrative analysis 26]. Three key themes related to women's experiences of birth trauma emerged; *Healthcare providers and the maternity care system*, *Women's sense of knowing and control*, and *Social support*. Table 3 provides a summary of the studies.

2.5.1. Healthcare providers and the maternity care system

All five studies highlighted that interactions with health care providers (HCP) has a significant impact on women's experiences of birth. Women often reported poor communication leaving them feeling left out and spoken 'at' rather than spoken 'with'. For example,

> One of my main negative feelings about that was I didn't feel anybody was actually talking to me directly. It was like I wasn't in the room everyone was talking about me or about the situation rather than talking to me saying this is what's happening and this is what we're going to do [26].

Byrne et al. [6] reported that individualised care that is accepting of all women, could play a significant role in positive psychological outcomes of birth. Participants in this study expressed feeling undermined and excluded from their care, which left them feeling dismissed, ignored and invisible. A disregard of women's own embodied knowledge, along with a woman's perceived need to defend her own body, contributed towards a failure to achieve partnership between women and her care providers [27]. Women experiencing birth trauma described how they had struggled to assert preferences and felt pressure to comply with the maternity system norms, leaving them with a sense of 'us against them' [6]. This common experience is illustrated by the following participant quote;

> I like at least feeling like I had enough information before I consent and she made me feel like I was kicking up a fuss and being a hassle and it was a bit of like . . . I feel like she was rolling her eyes at me like, ugh, another one of these kids . . . like I wasn't just agreeing blindly like, 'yes you do whatever you need to do', you know? [6].

Reed et al. [27] found that in addition to the difficulties of navigating the maternity system, women who experienced birth trauma also perceived care providers to, at times, prioritize their own agendas. For instance;

> . . . after an [Obstetrician] coming in and telling me that she would like me to deliver by 5 pm because she wanted to go home, I just burst in to tears . . . 20 people in theatre and half were sitting down on phones and chatting away while I had someone training with forceps on me . . . [27].

This sometimes resulted in unnecessary interventions or the presence of additional HCP attempting to utilize a learning opportunity. Some women also reported that they felt that pressure was used to coerce consent which could result in them feeling belittled, abused and violated [25,27]. One woman shared an example of advice she was given which left her traumatised;

> If you do not consent to syntocinon or a c-section then we can get our friend the psych registrar down here to section you – then we can do whatever we want to you but you may not be able to keep your baby [25].

Murphy and Strong [26] found that a care providers' interpretation of "just another ordinary bad birth" (p. 1) can be

Table 2
Inclusion and exclusion criteria.

	Inclusion criteria	Exclusion criteria
Participants	Women who report a traumatic birth experience.	Women who disclosed trauma experienced during birth that was reported to be instigated as a result of: socioeconomic status or region of birth; a pre-existing diagnosis of PTSD; a history of childhood trauma, sexual abuse or domestic violence; a high-risk pregnancy; birthing an infant requiring NICU admission; experiencing pregnancy loss; exposure to natural disasters or civil war during pregnancy.
Outcomes	Psychological trauma or distress.	Physical trauma.
Topicfocus	Women's experiences	Preventions, interventions, treatments, risk factors and prevalence.
Type ofstudy	Primary Qualitative studies.	Quantitative studies and other literature reviews.

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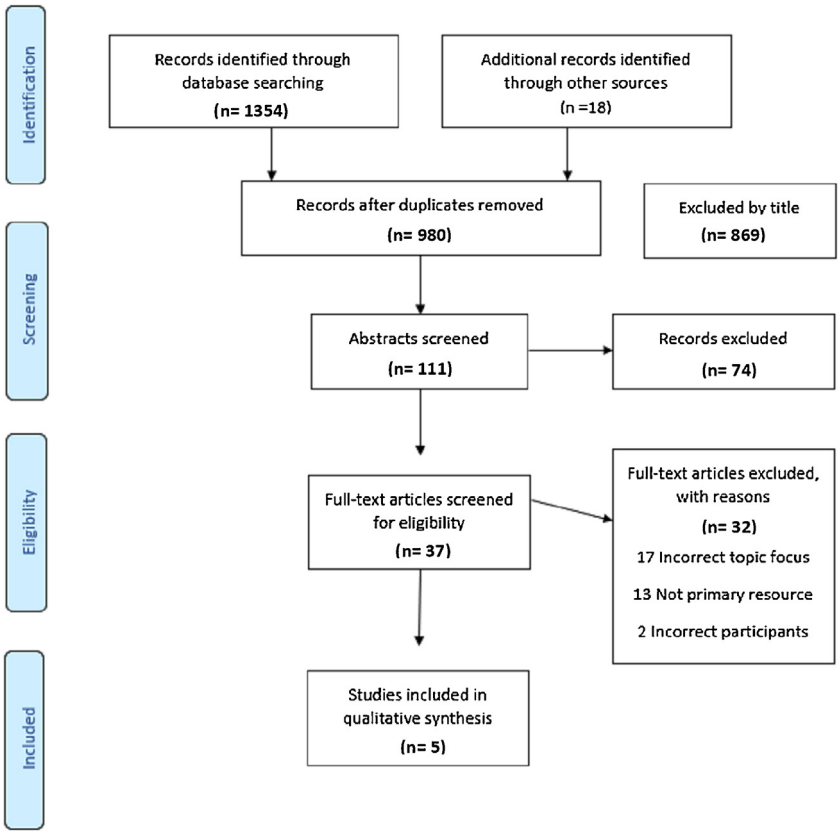

Fig. 1. Preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow diagram for the scoping review process (Moher et al., 2009).

far from the perceived experience of women themselves. As a result, women felt that they were left to just 'get on with it'. A lack of communication, compassion and understanding from care providers after the fact, caused women to feel they were expected to face the psychological challenges of trauma alone, having to just move on and accept it [6,24]. One woman described this scenario, stating:

> . . . so they kept going 'sure well he's fine, that's the main thing', but you're like well I'm the fully functioning adult who is having a mental breakdown and I need to look after him so telling me he's fine isn't really helping me [6].

Narratives such as this are highlighted in the studies and give insight into how women's birth expectations and experiences can be impacted by healthcare provider interactions.

2.5.2. Women's sense of knowing and control

Studies included in this review found that some women reflecting on their pregnancy can identify psychological factors that may have compounded their experiences of birth trauma [6,24–26]. Women identified fear of the unknown, nervousness, anxiety and apprehension surrounding the forthcoming labour often developed during pregnancy [6,24]. Some women reported that increasing their knowledge of labour promoted feelings of reassurance and a reduction in fear. Byrne et al. [6] identified that women found comfort in obtaining knowledge and information about the unfamiliar experience of childbirth which also allowed them to feel they could assert their personal preferences [6]. Some women, however, found that their levels of fear and anxiety peaked when actual events were not fitting with expectations of labour 24].

According to Byrne et al. [6], feelings of powerlessness, frustration, anger and self-blame arouse when the women's expectations were not acknowledged or met during labour [6]. For example, one participant expressed;

> "Yeah, I think was I too well informed going in? Well yes, because I was questioning everything and I think I was well informed for a first time mother and I think they just expect first time mothers to do what they say and not question and not have any idea what the options are and I don't think they expect you to have any critical thinking I suppose. I kind of feel like it's my own fault for kind of feeling empowered like I wouldn't have felt like all my power was taken away from me, if I hadn't felt empowered in the first place" [6].

Women described how, as their role in decision making and power diminished, their expectations faded, and a strong sense of vulnerability and distress surfaced throughout labour [26]. After birth, some women decided to take deliberate steps to regain control, strength and positivity while other women attempted to dismiss and downplay their own feelings in fear of being labelled [24]. For example, one participant stated:

> I guess it was a– the light switch goes on you think "oh gosh, I've got to really make a change here because otherwise, you know, I'm just going to go in to a darker hole –a deeper and darker hole [24].

Women's reactions differed to the mismatch between their birth expectations and reality experienced, often reported as traumatic. Some women took a strong focus to move forward and accept what had happened [24,25]. Putting negative experiences in the past and focusing on positives in the present helped women to move forward. Additionally, attempting to psychologically

Table 3
Results of review.

Author, year, title	Study location	Study aim	Sampling & sample size	Population	Methodology	Key findings
Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery, 51*, 1–11. doi:10.1016/j.midw.2017.04.017	Ireland	Explore subjective experience of birth trauma among first time mothers.	Convenience sampling. N = 7.	First time, English -speaking mothers who experienced a self- defined traumatic birth, 2–12months postpartum. Age: 27–35yrs. Residing in both urban and rural areas of Ireland.	Qualitative analysis guided by Interpretive phenomenology.	Superordinate theme: 'What about me? The loss of self through the experience of traumatic childbirth'. 4 subordinate themes: 1- "The 'I' in childbirth", lack of being active and informed in care. 2- "Dismissed, dehumanized and passive", non-individualised care with a struggle to assert personal preferences. 3- "Detached self", coping through detachment. 4- "Us against them", feelings of being seen as a problem, battle against the 'system'.
Iles, J., & Pote, H. (2015). Postnatal posttraumatic stress: A grounded theory model of first-time mothers' experiences. *Journal of Reproductive & Infant Psychology, 33*(3), 238–255. doi:10.1080/02646838.2015.1030732	UK	To develop a grounded theory model of first-time mothers' experiences of postnatal posttraumatic stress, with the aim of aiding understanding, formulation and treatment for new mothers.	Convenience sampling. N = 11.	First time mothers who had given birth in the previous 18months and perceived their birth as traumatic, reporting symptoms of post-traumatic stress. Age: 22–40yo, majority identified a white British ethnic origin.	Qualitative grounded theory design.	5 themes; Fear and anxiety, Coping and support processing, Choice and control, Me and my story (recollections, flashbacks) and the power of my experience (impacts on relationship with self and others).
Murphy, H., & Strong, J. (2018). Just another ordinary bad birth? A narrative analysis of first time mothers' traumatic birth experiences. *Health Care for Women International*, 39(6), 619–643. doi:10.1080/07399332.2018.1442838	UK	To explore subjective narrative accounts of self-defined traumatic birth.	Purposive sampling. N = 4.	Women' s retrospective reflections on traumatic birth experience of first child, 3–8years post-birth. White British women, 30–42years old.	Qualitative. Narrative analysis.	Themes: fear; care provider communication; feeling in control.
Peeler, S., Stedmon, J., Chung, M. C., & et al. (2018). Women's experiences of living with postnatal PTSD. *Midwifery*, 56, 70–78.	UK	To explore how women were affected by the memories of a birth that they perceived as traumatic.	Purposive sampling. N = 7.	Primiparous or multiparous, with no significant psychiatric history and were able to write in English, aged 21–49 years.	Qualitative methods with thematic analysis (this study was part of larger longitudinal quantitative study).	Key themes: Communication and support; Complicating or predicting factors; The maternity records and power, Perception of self, Women's desire to have an ideal birth.
Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy & Childbirth*, 17, 1–10. doi:10.1186/s12884–016-1197–0	Australia	To understand how care providers, influence women's perceptions of trauma.	Convenience sampling. N = 748	Women from all around the world, either primiparous or multiparous, aged 18–77years.	Mixed methods; Qualitative methods facilitated data collection of women's written experiences and quantitative methods facilitated demographic data and psychological assessments of participants.	Four themes identified: "prioritizing the care providers agenda"; "disregarding embodied knowledge"; "lies and threats"; and "violation".

separate baby from the traumatic birth experience helped to release blame and negative associations with their newborn. For instance;

> . . . trying to find a way for me to recognise [baby] as a little baby and not just the product of something that had been painful and upsetting. And actually, try and start to separate [baby] from that, from those events [24].

Other reactions to birth trauma involved processes of avoidance, for some this involved distancing from people around them, including their baby. However, Peeler et al. [25] reported that efforts to deflect the sense of trauma were often invaded by reoccurring images, nightmares and reminders of birth [25]. For some women looking over their labour records and developing their own narratives helped them rationalise these reminders.

Peeler et al. [25] and Iles and Pote [24] each identified the significance of labour records as part of women attempting to process their birth trauma [24,25]. Participants in these studies discussed how memories of their birth experience were unclear or memory gaps became apparent. With missing information, women struggled to make sense of their birth experience, contributing further to their trauma. Revisiting labour records helped women to close memory gaps, providing a clearer narrative of their birth experience. Having an accurate birth narrative provided these women with a degree of reassurance and opportunity to regain power over their experience. One woman shared her view, stating:

> . . . just getting some clarity on my medical notes kind of helped a little bit 'cos obviously I didn't know why I'd gone down to theatre and even afterwards no one really like said anything [25].

The reflective process of developing a narrative also forced women to recognise how they had personally changed as a result of birth trauma. Peeler et al. [25] suggested that women's reflection and story-telling of their experience could re-structure memories to allow women to positively reassess their self-perception [25].

Altered perception of self and identity was an outcome of birth trauma identified across the literature. For example, women reported feeling abnormal, alone and confused and began to see themselves differently [6,25]. An ongoing sense of questioning, along with comparing experiences of other mothers, resulted in women viewing themselves as disconnected, absent and a 'bad parent'. Some women found that becoming a detached mother helped them cope with the distress by disassociation and distancing themselves from their birth experience [6]. Postnatally, some women discovered a lack of confidence and ability to cope as well as an increased awareness of personal limitations while for others a recognition of their strength also emerged [24,25]. Iles and Pote [24] also found the future self to be potentially altered with women reporting their birth trauma experience had impacted on their plans for future children. Women's fear of birth, secondary to birth trauma, caused them to question future pregnancies, with one woman commenting; "I am frightened to death of having another baby. Terrified. The whole- even the thought of getting pregnant makes me feel sick" [24]. These studies highlight the life altering significance of birth trauma and how it can strongly impact the lives of women and their families.

2.5.3. Support

A woman's support network was found to play a central role in their overall experience of birth trauma. Participants commonly reported that social expectations contributed to their concerns about being harshly judged and this could further compound their fear of admitting to negative feelings associated with birth [24]. For example, one participant stated;

> I'd spoken to one friend who'd had a baby a couple of months after me, erm, and she said "oh you should be over it by now" . . . and, erh, when I sort of said "oh, I still feel a bit in shock about it, you know, I feel a little bit– I'm just in shock about it all." And she was just like "well, you just should be over it by now." . . . And I felt like, I just very much felt like well perhaps I just haven't dealt with it well. Perhaps it wasn't such a bad experience, perhaps that's what everybody has and I just haven't for whatever reason coped with it [24].

Other women reported that the damaging psychological effects of birth trauma also had a significant impact on their social relationships. This resulted in difficulties forming a bond with their baby or stress felt within the marital relationship or with other family members and friends [26].

Interestingly, Peeler et al. [25] found that group supports, social media, family support and talking were valuable means for women coping with birth trauma [25]. For instance, one woman shared, "it's almost like every time you talk about it you come to terms with it that little tiny bit more, and you, you maybe heal a little tiny bit more" [24]. Women valued support from their partner particularly throughout labour and postnatally the support received from other mothers. Support was deemed to be more beneficial when observed to be empathetic, honest and non-dismissive [24]. This highlights how postnatal support appeared to be the final opportunity to potentially offer a degree of relief for women recovering from birth trauma. If supports, however, were not available or inadequately offered than the negative consequences of birth trauma may have been further fortified.

3. Discussion

This review identified a number of elements that contributed to women's experiences of traumatic birth. A woman's expectations or apprehensions of birth can be damagingly impacted by negative Interactions with health care providers which can leave women feeling dismissed and disregarded and poor social supports can further facilitate ongoing feelings of stress and upset in women's lives following a traumatic birth.

Contributors to birth trauma can begin during pregnancy, some women are apprehensive about childbirth and this may build to tokophobia. Anxiety related to birth can have a negative impact on obstetric outcomes which can in turn increase the likelihood of psychological birth trauma [28]. According to Størksen et al. [29] HCP's can help facilitate a positive birth experience by providing women with information and security throughout pregnancy, birth and beyond which may ultimately prevent women from also developing secondary tokophobia [29]. Additionally, childbirth education during pregnancy can offer women awareness and preparedness of potential deviations of the normal birth process which can promote a sense of control and a more accepting and reassuring response to pain or difficulties during labour [30].

Continuity of carer can also help facilitate partnerships between HCP's and women, offering a sense of security and reassurance, increasing the likelihood of a positive birth experience [31]. According to Patterson et al. [32] positive relationships between women and midwives incited a joyous and satisfying experience for both the midwife and the woman [32]. In a meta-ethnography examining women's experiences of traumatic birth, Elmir et al. [4] found that women highlighted continuity of carer during pregnancy, labour and birth as a vital contributing factor towards possibly preventing a traumatic birth experience [4]. Women felt that continuity of carer was linked to an increased sense of control and choice. Compared to women who received 'standard' maternity care during pregnancy, women who had received continuity of carer reported to have had more opportunity to ask questions, felt more informed and active in decision making, found that their anxieties or concerns were validated and felt more reassured and emotionally supported [33]. This scoping study found that lack of information and control, poor support and inadequate care provider interactions were strongly associated with traumatic birth, the research of Forster et al. [33] would suggest that moving towards more standardized continuity of carer for all women may help negate these contributors [33].

During labour, expectations, individualised care and sense of control can all impact a women's overall birth experiences. In a study examining how midwives can promote a positive birth experience, Dahlberg et al. [34] found that those who exhibited an individualised and motivated approach to care enhanced women's strength and self-confidence in their birthing capability [34]. Furthermore, for women to feel safe they need dependable,

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truthful and unremitting care from their HCP's [32]. Karlstrom et al. [30] found that women speak of control in labour in two forms; firstly, related to managing pain and secondly to being actively involved in decision making during labour [30]. These two forms of control work hand in hand, women who feel empowered and validated during labour are more likely to develop a collaborative and trusting relationship with HCP's. A working relationship such as this, can allow women to feel, that in terms of pain, she can relinquish control and 'let go' and still feel safe and supported. Support was found to be a key factor in women's experiences of traumatic birth and was also often found to be a key component postnatally.

Social support is fundamental to assisting women to fulfil her new role of motherhood, which can be compounded by a traumatic birth experience. Women find the support of their partner and others in their lives, to be particularly important as they recover from and try to process their trauma [4]. Following trauma, sufficient functional social support can provide women with a sense of safety and stability, allowing processing and regulation of emotions [35]. Schroevers et al. [36] found that following a traumatic event, social support systems can promote disclosure, facilitate processing, help uncover alternate perspectives and find positive meaning, which can foster post traumatic growth [36]. Post traumatic growth describes personal positive changes that results in a positive shift in one's strength, beliefs and meaning following a traumatic experience [37]. In a study examining post traumatic growth after childbirth, Sawyer and Ayers [38] found that women were able to find enhanced relationships, increased resilience and maturity and a positive change in life philosophy and priorities, with social support seen as a vital mechanism to help achieve this. In addition to social support, a form of debriefing, or counselling intervention has been found to assist women in overcoming birth trauma [39].

Review of the literature found that women valued the process of going through birth records, allowing them to fill gaps of missing information and validate their experience. Existing research supports these findings [39,40]. While the evidence of effective debriefing intervention is unclear, Gamble and Creedy [39] suggest that a counselling intervention that involves women sharing their stories, with midwives helping them understand what has happened, can help offer women a positive way forward.

4. Recommendations for practice

Midwives must aim to optimise maternal and infant health outcomes which is inclusive psychological wellbeing of women.

Antenatal, intrapartum and postnatal factors can all play a role in contributing to birth trauma. The introduction of antenatal screening for tokophobia and birth related anxieties would aid in identifying women at risk and developing individualized care and education to reduce women's likelihood of experiencing birth trauma. Additionally, specific education and training of HCP's to improve their understanding of birth trauma would benefit women at risk. It is also vital that women's trauma is acknowledged appropriately. An open reflective dialogue between women and HCP, where a woman feels safe and supported to share her experience and clarify uncertainties, can offer women validation and initiate a step towards healing [39]. Finally, recent preliminary findings on the intervention of brief Eye Movement Desensitization and Reprocessing (EMDR) has found promising results as a feasible treatment for symptoms of post-traumatic stress following traumatic birth [41].

5. Limitations

The literature search was carried out by one reviewer only, in attempt to eliminate bias, abstract and full text screening was completed by two reviewers. Of the included studies, convenience and purposive sampling of participants may have increased selection bias. Majority of studies only include a small sample size. Exclusion of studies examining women's experiences of birth trauma related to obstetric or psychological risk factors may inhibit findings from being applicable to a wider range of new mothers.

6. Conclusion

A small number of studies have examined birth trauma for women with no pre-existing complicating factors. Existing literature highlights how women's experiences of traumatic birth are influenced by tokophobia, disempowering health care provider interactions, unmatched birth expectations, loss of control and decision-making power in labour and lack of acknowledgement of their birth experience and level of social support. In working towards improving the quality of maternity care in Australia, further research to build the understanding of traumatic birth experiences of Australian women with no key pre-existing risk factors is needed. To help inform midwifery practice, a research focus on the impact of continuity of carer as a protective factor against birth trauma may also support the expansion of midwifery continuity models of care for women.

Declaration of competing interests

There is no known conflict of interest to be declared.

References

[1] M. Greenfield, J. Jomeen, L. Glover, What is traumatic birth? A concept analysis and literature review, Br. J. Midwifery 24 (4) (2016) 254–267.
[2] C.T. Beck, Birth trauma: in the eye of the beholder, Nurs. Res. 53 (1) (2004) 28–35.
[3] K. Alcorn, A. O'Donovan, J. Patrick, D. Creedy, G. Devilly, A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events, Psychol. Med. 40 (11) (2010) 1849–1859.
[4] R. Elmir, V. Schmied, L. Wilkes, D. Jackson, Women's perceptions and experiences of a traumatic birth: a meta-ethnography, J. Adv. Nurs. 66 (10) (2010) 2142–2153.
[5] Y.M. Parfitt, S. Ayers, The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond, J. Reprod. Infant Psychol. 27 (2) (2009) 127–142.
[6] V. Byrne, J. Egan, P. Mac Neela, K. Sarma, What about me? The loss of self through the experience of traumatic childbirth, Midwifery 51 (2017) 1–11.
[7] R.J. Boorman, G.J. Devilly, J. Gamble, D.K. Creedy, J. Fenwick, Childbirth and criteria for traumatic events, Midwifery 30 (2) (2014) 255–261.
[8] N. Goutaudier, C. Bertoli, N. Séjourné, H. Chabrol, Childbirth as a forthcoming traumatic event: Pretraumatic stress disorder during pregnancy and its psychological correlates, J. Reprod. Infant Psychol. 37 (1) (2019) 44–55.
[9] J. Söderquist, K. Wijma, B. Wijma, Traumatic stress in late pregnancy, J. Anxiety Disord. 18 (2) (2004) 127–142.
[10] S. Ayers, R. Bond, S. Bertullies, K. Wijma, The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework, Psychol. Med. 46 (6) (2016) 1121–1134.
[11] M. Hollander, E. Hastenberg, J. Dillen, M. Pampus, E. Miranda, C. Stramrood, Preventing traumatic childbirth experiences: 2192 women's perceptions and views, Arch. Womens Ment. Health 20 (4) (2017) 515–523.
[12] J.E. Soet, G.A. Brack, C. DiIorio, Prevalence and predictors of women's experience of psychological trauma during childbirth, Birth 30 (1) (2003) 36–46.
[13] A.H. Martinez, J.R. Almagro, M.M. Alarcon, et al., Postpartum post-traumatic stress disorder: associated perinatal factors and quality of life, J. Affect. Disord. 249 (2019) 143–150.
[14] S. Ayers, S.N. Rados, S. Balouch, Narratives of traumatic birth: quality and changes over time, Psychol. Trauma Theory Res. Pract. Policy 7 (3) (2015) 234–242.
[15] C.T. Beck, Birth trauma and its sequelae, J. Trauma Dissoc. 10 (2) (2009) 189–203.
[16] World Health Organization, International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision), (2018) . (accessed 05/08/2020 2020) https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559.
[17] P.D. Yildiz, S. Ayers, L. Phillips, The prevalence of posttraumatic stress disorder in pregnancy and after birth: a systematic review and meta-analysis, J. Affect. Disord. 208 (2017) 634–645.

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[18] S. McDonald, P. Slade, H. Spiby, J. Iles, Post-traumatic stress symptoms, parenting stress and mother-child relationships following childbirth and at 2 years postpartum, J. Psychosom. Obstet. Gynecol. 32 (3) (2011) 141–146.
[19] Centre of Perinatal Excellence (COPE), Mental Health Care in the Perinatal Period, Australian Clinical Practice Guideline, 2017.
[20] The National Institute for Health and Care Excellence, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance April 2018, (2014). (accessed May 10 2019) https://www.nice.org.uk/guidance/cg192/chapter/Introduction.
[21] H. Arksey, L. O'Malley, Scoping studies: towards a methodological framework, Int. J. Soc. Res. Methodol. 8 (1) (2005) 19–32.
[22] A.C. Tricco, E. Lillie, W. Zarin, et al., PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation, Ann. Intern. Med. 169 (7) (2018) 467–473.
[23] M.D. Peters, C.M. Godfrey, H. Khalil, P. McInerney, D. Parker, C.B. Soares, Guidance for conducting systematic scoping reviews, Int. J. Evid. Healthc. 13 (3) (2015) 141–146.
[24] J. Iles, H. Pote, Postnatal posttraumatic stress: a grounded theory model of first-time mothers' experiences, J. Reprod. Infant Psychol. 33 (3) (2015) 238–255.
[25] S. Peeler, J. Stedmon, M.C. Chung, et al., Women's experiences of living with postnatal PTSD, Midwifery 56 (2018) 70–78.
[26] H. Murphy, J. Strong, Just another ordinary bad birth? A narrative analysis of first time mothers' traumatic birth experiences, Health Care Women Int. 39 (6) (2018) 619–643.
[27] R. Reed, R. Sharman, C. Inglis, Women's descriptions of childbirth trauma relating to care provider actions and interactions, BMC Pregnancy Childbirth 17 (2017) 1–10.
[28] M. Laursen, M. Hedegaard, C. Johansen, Fear of childbirth: predictors and temporal changes among nulliparous women in the Danish National Birth Cohort, BJOG Int. J. Obstet. Gynaecol. 115 (3) (2008) 354–360.
[29] H.T. Størksen, S. Garthus-Niegel, S. Vangen, M. Eberhard-Gran, The impact of previous birth experiences on maternal fear of childbirth, Acta Obstet. Gynecol. Scand. 92 (3) (2013) 318–324.
[30] A. Karlstrom, A. Nystedt, I. Hildingsson, The meaning of a very positive birth experience: focus groups discussions with women, BMC Pregnancy Childbirth 15 (1) (2016).
[31] U. Dahlberg, I. Aune, The woman's birth experience – "the effect of interpersonal relationships and continuity of care", Midwifery 29 (4) (2013) 407–415.
[32] J. Patterson, C.J. Hollins Martin, T. Karatzias, Disempowered midwives and traumatised women: exploring the parallel processes of care provider interaction that contribute to women developing Post Traumatic Stress Disorder (PTSD) post childbirth, Midwifery 76 (2019) 21–35.
[33] D.A. Forster, H.L. McLachlan, M.-A. Davey, et al., Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial, BMC Pregnancy Childbirth 16 (1) (2016) 28–29.
[34] U. Dahlberg, J. Persen, A.K. Skogas, S.T. Selboe, H.M. Torvik, I. Aune, How can midwives promote a normal birth and a positive birth experience? The experience of first-time Norwegian mothers, Sex. Reprod. Healthc. 7 (2016) 2–7.
[35] A. Charuvastra, M. Cloitre, Social bonds and posttraumatic stress disorder, Annu. Rev. Psychol. 59 (1) (2008) 301–328.
[36] M.J. Schroevers, V.S. Helgeson, R. Sanderman, A.V. Ranchor, Type of social support matters for prediction of posttraumatic growth among cancer survivors, Psycho-Oncology 19 (1) (2010) 46–53.
[37] R.G. Tedeschi, L.G. Calhoun, Posttraumatic growth: conceptual foundations and empirical evidence, Psychol. Inq. 15 (1) (2004) 1–18.
[38] A. Sawyer, S. Ayers, Post-traumatic growth in women after childbirth, Psychol. Health 24 (4) (2009) 457–471.
[39] J. Gamble, D.K. Creedy, A counselling model for postpartum women after distressing birth experiences, Midwifery 25 (2) (2009) e21–e30.
[40] J.D. Baxter, C. McCourt, P.M. Jarrett, What is current practice in offering debriefing services to post partum women and what are the perceptions of women in accessing these services: a critical review of the literature, Midwifery 30 (2) (2014) 194–219.
[41] V. Chiorino, M.C. Cattaneo, E.A. Macchi, et al., The EMDR Recent Birth Trauma Protocol: a pilot randomised clinical trial after traumatic childbirth, Psychol. Health 35 (7) (2020) 795–810.

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