Maternal mental health and birth trauma

Women's perceptions of birth trauma and adequacy of healthcare practices in labour-ward care: A narrative review

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"*Here's to strong women. May we know them, may we raise them, may we be them*." – Michelle Obama

To all the moms and maternal figures out there, especially my own.

Abstract

Background: It is thought that up to 45% of women globally report being mistreated by healthcare providers during childbirth. Research further suggests that an estimated 3-4% will go on to experience postpartum post-traumatic stress disorder. The negative effects of poor maternal mental health are many, for both mother and child. While there is an adequate amount of research on birth trauma, women's own perceptions of their traumatic birth experience are missing. There is therefore a need to better understand how women, as told by themselves, perceive healthcare practices, specifically the actions of healthcare providers, in relation to birth trauma. Not only would this promote more positive and fulfilling labour-ward experiences, but also better mental and physical health outcomes, making it a clinically significant area worth looking more at.

Aims: The aims of this study are to explore and synthesize existing raw qualitative data on women's (1) experiences of a traumatic birth and (2) perceptions of the adequacy of healthcare practices in addressing their needs.

Method: A narrative review was undertaken on two databases, PubMed and PsycInfo. 31 peer-reviewed qualitative studies met the eligibility criteria and were included in the review. The raw data from these were then analyzed using Braun & Clarke's thematic analysis.

Results: Three higher-level main themes were identified: (1) Over-medicalized, (2) Made to be a passive participant, and (3) Undermining the dignity of one's experience. These were then further organized into seven subthemes.

Conclusion: During pregnancy, childbirth, and postpartum, women are especially vulnerable and need to have healthcare providers that will both guide and support them. For the provision of truly woman-centered care, a means to protect against birth trauma, dedicated space has to be given to hear from women about how they themselves want to be cared for. Mothers deserve much more than the mistreatment and abuse many are currently faced with, and it is our responsibility as public health professionals to advocate for meaningful change.

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Content warning: While being sensitive is the most important thing to me, this thesis contains a discussion of topics some readers might find difficult or triggering, specifically the mistreatment and abuse of pregnant and birthing women. Please take this into consideration before deciding if and when to read it, and take care of your mental health. If needed, a list of resources is available below.

(1) The Birth Trauma Association: https://www.birthtraumaassociation.org

(2) Postpartum Support International: https://www.postpartum.net

(3) Swedish Health Services: https://www.1177.se

Language acknowledgment: Like other researchers in this field, I use the term "woman" to refer to persons who were assigned female at birth and have reproductive anatomy compatible with pregnancy and childbirth. That being said, I personally recognize gender as being much more inclusive and not just related to biological sex.

List of abbreviations

WHO	World Health Organization
HCP(s)	Healthcare provider(s)
PTSD	Post-traumatic stress disorder
ObGyn	Obstetrician-gynecologist
WCC	Woman-centered care
C-section	Caesarean section
TIC	Trauma-informed care

Justification for this thesis (i.e., the knowledge gap)

Maternal health, according to the World Health Organization (WHO), refers to the health of women during pregnancy, childbirth, and the postpartum period (meaning 6 weeks after birth) (WHO, n.d. -b). As rates of maternal mortality continue to decrease almost everywhere, research in maternal health has shifted to also look at morbidity, or the experience of illness and disease (WHO, 2022; WHO, 2024).

How a patient is made to feel when seeking care is just as important, although sometimes still neglected in favour of good physical health outcomes (Doyle et al., 2013). In their seminal study, however, Doyle et al. (2013) critically found that there does seem to be a positive association between patient experience and both self-reported and objectively measured health outcomes, making it a clinically significant area worth looking more at. In line with this, in their 2018 report, the WHO acknowledged, for the first time, women's experiences of maternity care as a public health issue (WHO, 2018). Given that the prevalence of mistreatment and abuse of women during childbirth (hereinafter referred to as birth trauma*) is thought to be up to 45%, it is a very pressing one at that (Alcorn et al., 2010). As the drivers of population growth and primary caregivers in many of our societies, mothers deserve much more than this. Although these issues have always been important, they are especially so now, during a time when the sexual and reproductive rights of girls and women are under increasing global threat (United Nations Human Rights Office of the Higher Commissioner, n.d.).

**This thesis focuses on psychological/emotional trauma resulting from the mistreatment and abuse of women during childbirth, and the term used to describe this will be "birth trauma." This is not to be confused with physical birth trauma, which results from the physicality of giving birth (e.g., perineal tearing, pelvic fracture, hemorrhaging, etc.).*

While there is an adequate amount of research on birth trauma, it was found that women's perceptions of their traumatic birth experience are largely neglected in favour of that written by researchers/healthcare providers (HCPs). This means that women's embodied knowledge, of knowing one's own experience best, is left out. There is also less research on the traumatic event itself, that being childbirth, compared to the aftermath/clinical outcomes, e.g., postpartum post-traumatic stress disorder (PTSD). From both a research and clinical standpoint, there is therefore a need to better understand how women, as told by themselves, perceive healthcare

practices, specifically the actions of HCPs, in relation to birth trauma. What do women want and need during pregnancy, childbirth, and postpartum, and how can HCPs support these to foster a positive experience? On the other hand, how do HCPs, intentionally or not, contribute to a perceived negative experience, such as in the provision of birth trauma?

On a personal note, last summer I volunteered at a birthing center in a rural Tanzanian village. Although the experience was very rewarding, both professionally and personally, it was my first-time seeing women being mistreated and abused by HCPs. Given that I have aspirations to become a doctor as a means to care for people, I found this juxtaposition both startling and unsettling. For my program internship, I worked at a non-governmental organization in Belgium called Make Mothers Matter. Based on my experience in Tanzania, I focused my research and advocacy on maternal mental health, and this thesis is a continuation of that important work.

Background

The healthcare provider-patient relationship; woman-centered care

During pregnancy, childbirth, and postpartum, women are especially vulnerable, both physically and emotionally, and need to have HCPs that will both guide and support them (Donate-Manzanares, 2021). It is well established that support can buffer (i.e., protect against) the effects of stress (Brown et al., 2022); Ford & Ayers (2011) found this to hold true even for women with a pre-determined higher risk of developing postpartum PTSD.

A birth attendant is any HCP specifically trained to provide care during childbirth, to both the mother and newborn (WHO, n.d. -a). This might be an obstetrician-gynecologist (ObGyn), nurse, midwife, or community health worker, although is not limited to just healthcare settings (some women, for various reasons, choose to give birth at home). Of note, in the studies included in the narrative review, HCPs were all grouped together. Still, it is important to acknowledge how the provision of care is defined and practiced for different HCP professions. Doctors and nurses, for example, tend to take a very biomedical (and historically paternalistic) approach; midwifery, on the other hand, is seen as being more holistic, with roots specifically in woman-centered care (WCC) (Eri et al., 2020). They also have different scopes of practice. In some places (and as is recommended by the WHO), midwives are the default HCP who attend to births, with ObGyns on stand-by in case there is a need for higher-level medical intervention

(Bradford et al., 2022). In others, ObGyns are the default, and a woman has to specifically request having a midwife instead.

All women, as per the WHO (n.d. -a), have the right to be cared for by skilled health persons during pregnancy, childbirth, and postpartum. Still, the delivery of competent medical care is not a means to an end. HCPs' professional and ethical responsibilities to treat patients with dignity and respect, therein protecting their fundamental human rights, are just as important in the provision of care. WCC does just that, by placing women at the center of their experiences (Fontein-Kuipers et al., 2018). In its provision, recognizing the limitations of a "one size fits all" model, care is adapted to meet each woman's wants and needs, based in her socio-cultural context (Public Health Agency of Canada, 2018). But first, a good working HCP-relationship needs to first be established, one built on mutual respect and trust. Principles of WCC also include choice, control, and empowerment (Fontein-Kuipers et al., 2018). That being said, these also require a conducive working environment, which is expanded on in the Discussion. According to Karlström et al. (2015), the practice of WCC is especially important for pregnancy and childbirth because it is so intimate and personally meaningful. When the HCP-patient relationship is not good, it makes way for the potential provision of birth trauma. These relationships, as will be seen, are instead characterized by unequal power, intimidation, manipulation, and fear.

Maternal mental health

Life-altering events like a newborn can understandably be stressful for new mothers, their partners, and caregivers. Globally, an estimated 10% of pregnant women and 13% who just gave birth experience poor mental health (WHO, n.d. -b). The most common of which is depression (referred to as postpartum depression) and is thought to affect 10-15% of new moms (Anokye et al., 2018). Of those suffering from poor maternal mental health, less than 15% are thought to receive treatment (Association of American Medical Colleges, n.d.). According to Ford et al. (2019), mothers often avoid talking openly about negative feelings relating to motherhood for fear they will be seen as "bad" or "incapable" mothers. Knowing this, one can assume that some statistics are underreported. The second barrier to help-seeking was found to be inaccessible and/or inadequate support from HCPs (Ford et al., 2019). Given these figures, it may not be surprising that mental health conditions are now the number one underlying cause of maternal

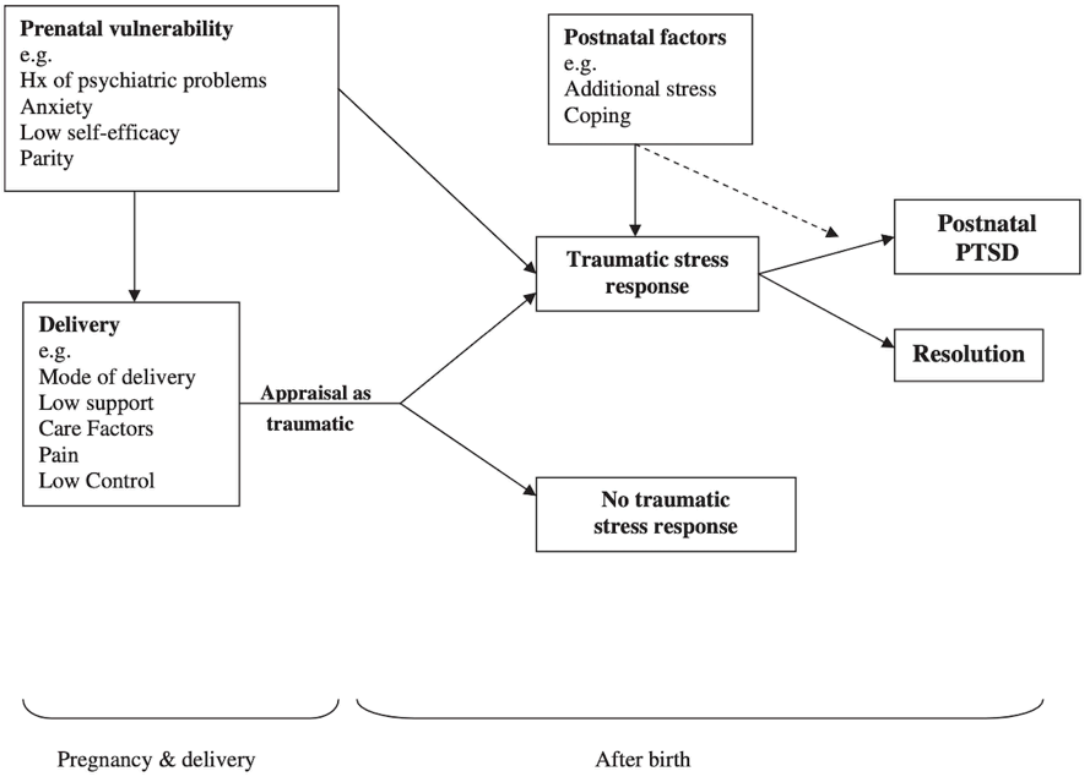
mortality worldwide (attributable to 22.7% of deaths), having surpassed hemorrhage (13.7%), cardiac conditions (12.8%), and infection (9.2%) (Wisner et al., 2024). The annual economic burden of this in the United States alone (which is, to my knowledge, the only country that has mathematically modelled this) is estimated to be $14.2 billion, or roughly $32,000 per mother-child (Wogan, 2022).

The negative effects of poor maternal mental health are many, for both mother and child. It is, for example, associated with poorer obstetric outcomes such as pre-term delivery, low birth weight, and prolonged labour (Voit et al., 2022). Babies born to these mothers are also more likely to have delays in physical growth and cognitive development as well as poorer mental health themselves (Satyanarayana et al., 2011).

Negative events during childbirth can possibly lead to the development of PTSD, referred to as postpartum PTSD (Perera et al., 2023). PTSD is a mental health condition triggered by experiencing or witnessing a traumatic event (American Psychiatric Association, 2013). People with PTSD often have intense and disturbing thoughts and feelings related to their experience, lasting long after the threat itself has ended (American Psychiatric Association, 2013). This may take the form of flashbacks, severe anxiety, nightmares, etc., and can also manifest as physical symptoms (American Psychiatric Association, 2013). In 1994, childbirth was added to the DSM's list of "potentially traumatic events," although postpartum PTSD is still not officially recognized as a diagnosis on its own (it is a subset of PTSD) (American Psychiatric Association, 2013; Beck, 2004b). Still, given how many women are affected, postpartum PTSD is undoubtedly clinically significant. Research suggests that an estimated 3-4% of women experience PTSD following childbirth, although this is, again, likely underreported (Radoš et al., 2020). This figure increases to 15-18% in high-risk samples (e.g., severe pregnancy complications, history of poor mental health, etc.) and up to 39% following infant death (Christiansen, 2017). According to Ayers (2004), the development of postpartum PTSD is thought to result from interactions between prenatal vulnerability, events that happen during childbirth, and if the woman perceives them as being traumatic. This is visually depicted in her model:

Figure 1

Diathesis-stress model for postpartum PTSD (Ayers, 2004)



Birth trauma

According to Watson et al. (2021), one of the most predictive risk factors for the development of postpartum PTSD is having had a perceived traumatic birth experience.

Beck, a leading scholar in this field, defined birth trauma in her 2004 paper as, "An event that occurs during the labour and delivery process involving actual or threatened serious injury or death to the mother or her baby, in which women experience intense feelings of fear, helplessness, loss of control, and horror" (Beck, 2004a). While trauma can, as aforementioned, be physical and/or emotional, this definition emphasizes both the psychological experience of birth and the negative effects it can have. It is important to note that while a standard definition of birth trauma like this exists, it can really only be meaningfully explained by the woman who has experienced it; researchers have called this being "in the eye of the beholder" (Beck, 2004a). This is, again, where the need for qualitative research comes in.

Bohren et al. (2015), seeing that there was no clear consensus on how birth trauma was to be defined and measured, were among the first to do so. Their study design was a

mixed-methods systematic review. The seven categories constituting birth trauma, according to them, are listed in Table 1 below. As can be seen, the provision of birth trauma exists at all levels of the micro-meso-macro model, making it a complex, multifaceted issue. That being said, it appears that most causes revolve, in some way, around the individual actions of HCPs (i.e., the micro level). van der Pijl et al. (2020) found poor rapport between women and providers to be the most commonly reported form of birth trauma, among their study sample.

Table 1

The seven categories of birth trauma (Bohren et al., 2015)

Third-order themes	Second-order themes	First-order themes
Physical abuse	- Use of force - Physical restraint	- Beaten, slapped, kicked, or pinched during delivery - Physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	- Harsh language - Threats and blaming	- Harsh or rude language - Judgemental or accusatory comments - Threats of withholding treatment or poor outcomes - Blaming for poor outcomes
Stigma and discrimination	- Discrimination based on sociodemographic characteristics - Discrimination based on medical conditions	- Discrimination based on ethnicity/race/religion - Discrimination based on age - Discrimination based on socioeconomic status - Discrimination based on HIV status
Failure to meet professional standards of care	- Lack of informed consent and confidentiality - Physical exams and procedures - Neglect and abandonment	- Lack of informed consent process - Breaches of confidentiality - Painful vaginal exams - Refusal to provide pain relief - Performance of unconsented surgical operations - Neglect, abandonment, or long delays - Skilled attendant absent at time of delivery
Poor rapport between women and providers	- Ineffective communication - Lack of supportive care - Loss of autonomy	- Poor communication - Dismissal of women's concerns - Language and interpretation issues - Poor staff attitudes - Lack of supportive care from health workers

		- Denial or lack of birth companions - Women treated as passive participants during childbirth - Denial of food, fluids, or mobility - Lack of respect for women's preferred birth positions - Denial of safe traditional practices - Objectification of women - Detainment in facilities
Health system conditions and constraints	- Lack of resources - Lack of policies - Facility culture	- Physical condition of facilities - Staffing constraints - Staffing shortages - Supply constraints - Lack of privacy - Lack of redress - Bribery and extortion - Unclear fee structures - Unreasonable requests of women by health workers

After experiencing birth trauma, women have reported several different consequences, both short- and long-term. For example, parenting stress, difficulty bonding with their baby, loss of self-identity, and breakdown of relationships (Watson et al., 2021). As exemplified by this, birth trauma not only affects the woman herself but also the mother-child bond and larger family dynamic (Taghizadeh et al., 2013). These women also have, on average, longer postpartum hospital stays, which is associated with increased mortality and other poor physical health outcomes (Sun et al., 2022). Moreover, a fear of childbirth (tokophobia) can develop, causing some women to avoid seeking necessary postpartum and neonatal care, or even not wanting to get pregnant again (Olsen et al., 2022). Luckily, there are thought to be possible protective factors, either to try to avoid birth trauma altogether or for it not to develop into postpartum PTSD. These include a respected birth plan, continuity of care, and skin-to-skin (i.e., kangaroo care) immediately after birth (Watson et al., 2021).

Aim and research questions

Aim: To explore and synthetize existing raw qualitative data on women's (1) experiences of a traumatic birth and (2) perceptions of the adequacy of healthcare practices in addressing their needs

Research questions:

(1) How do women perceive the experience of a traumatic birth?

(2) How do women perceive healthcare practices, specifically the actions of healthcare providers, in relation to birth trauma?

The PICO mnemonic (**p**opulation, **i**ntervention/exposure, **c**omparison, and **o**utcome) was used in coming up with these (Roever, 2018). This is one of the most commonly used frameworks, especially in health sciences research, to help in developing a well-built aim/research question (Roever, 2018). PICO can then also be used in literature search strategies. * is used to search for variable endings of a root word (e.g., woman vs. women, healthcare provider vs. professional).

Table 2

PICO mnemonic and literature search terms

P	I	C	O
- Wom* - Female - Mother - Maternal - Postpartum - Postnatal - Healthcare p*	- Birth trauma - Traumatic birth - Obstetric violence	- Experience - Perception - Perspective - Embodied knowledge - Interpretation	- Postpartum mental health - Psychological trauma - Emotional trauma - Postpartum PTSD - Postpartum stress

Methodology

A narrative review approach

All review methodologies are similar to each other in that they identify and synthesize what is currently known about a given topic (Sukhera, 2022). That being said, their uses have different intentions. Scoping and narrative reviews, unlike systematic reviews, are not exhaustive in trying to compile all possible research; they are instead exploratory in nature (Sukhera, 2022). The author's aim and research questions will define which specific area of the topic and help to narrow things down. Gaps can also be identified and inform future research (Sukhera, 2022).

A narrative review, specifically, is "an approach to the systematic review that relies on the use of text to summarize and explain the findings of the synthesis" (Popay et al., 2006). In analyzing what different people have to say about the topic, narrative reviews emphasize the idea that reality is both subjective and dynamic, best told by people with lived experience (Sukhera, 2022). With this paper's aim being to explore what is known about how women perceive, i.e., tell about, a traumatic birth experience, this type of review makes the most sense. In terms of methodology, while narrative reviews do sometimes involve "manipulation of statistical data," the decision was made to only take a qualitative approach because it is the social aspect that is of interest; it also honours birth trauma as being in the eye of the beholder (Popay et al., 2006). Grey literature is also allowed to be included. While this is important from a health equality standpoint (because participating in research is still inaccessible to many people and their voices deserve to also be included), it was not thought to be feasible within the timeframe, so only peer-reviewed scientific journal articles were searched. Of note, narrative reviews are limited in terms of subjectivity and bias (Sukhera, 2022). This is because they depend on the author's interpretation of the results, which is inherently based on their own background and knowledge of the topic. This is why transparency and reflexivity are so important for all qualitative research, but especially narrative reviews.

Search strategy

When first starting, Google Scholar was used to see what was out there, across a wide variety of databases, on the topic of birth trauma. Although the search term "birth trauma" yielded over two million results, after putting on a filter for just that which is psychological, there were significantly fewer results (in the hundreds).

After formulating several working research questions that addressed the aforementioned shortcomings (that being a lack of qualitative data on women's perceptions), an appointment was made with the school's librarians to help in developing a search strategy as a means to identify relevant studies. Eligibility criteria (see Table 3 below) first needed to be created, that which was specific enough but also not too limiting. While this paper's scope is admittedly quite broad, during the preliminary search, it was found that there were not enough articles to limit the search to, for example, a specific demographic of women. Based on both the PICO framework and the eligibility criteria, a list of search terms was then brainstormed (see Table 2 above), that were

thought to yield the most defined and relevant results. Synonyms of words (e.g., birth trauma = obstetric violence) and Boolean operators (AND, OR, NOT) were also used so as to create variety.

Table 3

Eligibility criteria

	Inclusion	**Exclusion**
Topic of interest	- Studies focusing on how women perceive the experience of a traumatic birth - Studies focusing on how women perceive healthcare practices, specifically the actions of HCPs, in relation to birth trauma	- Studies that do not consider women's perceptions of their experience - Studies that only focus on physical birth trauma
Methodology	Qualitative	Quantitative
Type of publication	- Peer-reviewed articles published in scholarly journals - Accessible through open access or the school's library	- Grey literature - Full text not available
Population	- Women aged 18+ - Mothers (primi- and multiparous) - The experience of birth trauma is subjective and can be self-reported	- Only including women who were told by their HCP that their birth was traumatic (i.e., not self-reported) - Only including women diagnosed with postpartum PTSD - Women with a pre-existing diagnosis of PTSD or other mental health condition - Fetal/newborn death or admitted to the neonatal intensive care unit - Only fathers interviewed
Setting	- Births in healthcare settings, attended to by an HCP - Any geographic setting	Home births
Language	English	
Date	Published in any year up to the present date	

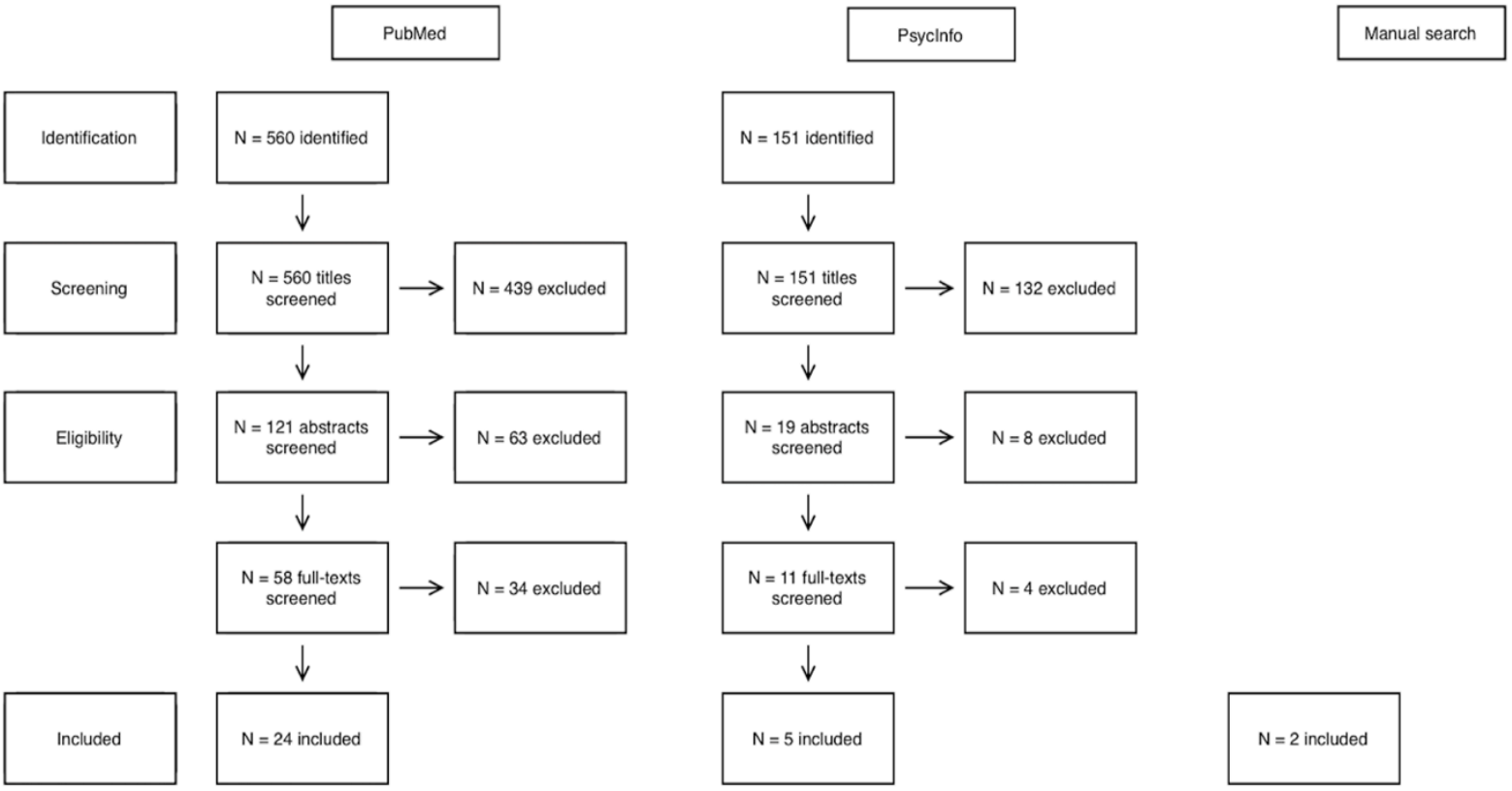
From February 8th to March 21st, 2024, two databases, PubMed and PsycInfo, were searched. PubMed is a database for biomedical and health sciences research; PsycInfo is for the social sciences, specifically psychology. These two were specifically chosen because they both frequently appeared during the preliminary search on Google Scholar. The topic of birth trauma also intersects with both fields, with each offering a unique analytical perspective.

PubMed originally yielded 560 articles and PsycInfo 151. The first step of screening was to read all these titles and exclude ones that clearly did not fit the eligibility criteria. If the title itself was not telling enough, then the abstract was read. If the abstract was not telling enough, then the full text was read. Ultimately, 24 studies to be included in the narrative review came from PubMed and five from PsycInfo. The two "manual search" articles (Beck, 2004a; Reed et al., 2017) were ones found during the preliminary search on Google Scholar. Although not a significant barrier, four articles were encountered that were not open access, leading to them being automatically excluded.

The following PRISMA-style flow chart is a visual depiction of this flow of information through the different phases of a literature review (Moher et al., 2019):

Figure 2

PRISMA flow chart (Moher et al., 2019)



Using Watson et al.'s (2021) chart as a template, the following is an organization of the 31 included study's characteristics:

Table 4

Characteristics of the studies included in the narrative review

Author(s), year	Study location	Study aim	Sampling	Methodology	Population	Main themes
Aksu & Serçekuş, 2023	Turkey	To determine the childbirth experiences perceived by women as traumatic, how they were affected by these experiences, and how they coped	Purposive, N = 16	Method: In-depth semi-structured interviews Analytical framework: Descriptive phenomenology and content analysis	Self-reported traumatic birth experience, 18+, not yet 6 months postpartum, no known mental health conditions, and no stillbirth/newborn death	(1) Reasons for traumatic childbirth (2) The effects of traumatic childbirth (3) Coping
Aktaş & Aydin, 2019	Northern Turkey	To analyze the factors associated with a negative childbirth experience from the perspective of the women who gave birth vaginally	Purposive, N = 11	M: In-depth semi-structured interviews A: Thematic analysis	Hospital delivery, single pregnancy, low-risk pregnancy, admitted to hospital in latent birth phase, delivered vaginally with a midwife, negative perceptions about birth, healthy newborn, and 18+	(1) Challenges/difficulties encountered (2) Embarrassment/privacy (3) Inadequate communication (4) Inadequate hospital facilities
Beck, 2004a	New Zealand, the US, Australia, and the UK	To describe the essence of mothers' experiences of post-traumatic stress disorder after childbirth	Purposive New Zealand (N = 22), the US (N = 7), Australia (N = 6), and the UK (N = 3)	M: Interviews A: Descriptive phenomenology	Self-reported traumatic birth experience and willing to articulate it, and diagnosis of postpartum PTSD	(1) Going to the movies: Please don't make me go! (2) A shadow of myself: Too numb to try and change (3) Seeking to have questions answered and wanting to talk, talk, talk (4) The dangerous trio of anger, anxiety, and depression: Spiraling downward (5) Isolation from the world of motherhood: Dreams shattered
Beck, 2004b	New Zealand, the US, Australia, and the UK	To describe the meaning of women's birth trauma experiences	Purposive New Zealand (N = 23), the US (N = 8), Australia (N = 6), and the UK (N = 3)	M: Written stories A: Descriptive phenomenology	Self-reported traumatic birth experience and willing to articulate it, and English language	(1) To care for me: Was that too much to ask? (2) To communicate with me: Why was this neglected? (3) To provide safe care: You betrayed my trust and I felt powerless

						(4) The end justifies the means: At whose expense? At what price?
Beck & Watson, 2010	The US, the UK, New Zealand, Australia, and Canada	To describe the meaning of women's experiences of a subsequent childbirth after a previous traumatic birth	Not specified The US (N = 15), the UK (N = 8), New Zealand (N = 6), Australia (N = 5), and Canada (N = 1)	M: Written stories A: Descriptive phenomenology	Self-reported traumatic birth experience and willing to articulate it, and English language	(1) Riding the turbulent wave of panic during pregnancy (2) Strategizing: Attempts to reclaim their body and complete the journey to motherhood (3) Bringing reverence to the birthing process and empowering women (4) Still elusive: The longed-for healing birth experience
Brown et al., 2022	England	To understand the process of fostering resilience after a traumatic birth	Not specified, N = 8	M: Semi-structured interviews A: Constructivist grounded theory	18+ and self-reported having overcome a traumatic birth experience	(1) Am I worthy of care? (2) Who's accountable? (3) Do you have my consent? (4) Moving towards faith and spirituality (5) Supportive relationships (6) Motherhood becomes you (7) Self-care as a way of owning my journey
Buchanan et al., 2023	Perth, Australia	To explore women's experience of maternity care from an ethical perspective	Purposive, N = 19	M: In-depth semi-structured interviews A: Feminist participatory action research and reflexive thematic analysis	Chose a midwifery model of care and part of the community action group	(1) Midwife solidarity (2) Saving women from themselves (3) Uneasy alliance
Butterworth et al., 2023	The UK	To interview participants where one parent was help-seeking for the experience of birth trauma	Purposive, N = 8 (4 couples)	M: In-depth semi-structured interviews A: Multiperspectival interpretative phenomenology	Self-reported traumatic birth experience within 6 weeks-2 years, partner present at birth, couple is in a parenting relationship, English language, 16+, and living in/accessing care in study region, regardless of birth location	(1) From perfect plan to shattered reality (2) Trauma in the healthcare system (3) Trauma in the family system (4) The post-trauma family: Navigating the new normal
Byrne et al., 2017	Ireland	(1) To explore the subjective experience of birth trauma among	Random sampling (screening	M: Screening survey and semi-structured interviews	Primiparous, English language, and self-reported traumatic	(1) The "I" in childbirth (2) Dismissed, dehumanized, and passive

		first-time mothers in Ireland (2) To separate the potential effects of peripartum depression from this in limiting this qualitative investigation to women who reported birth trauma, without PPD	survey) and not specified (semi-structured interviews), N = 7	A: Interpretive phenomenology	birth experience within 2-12 months	(3) Detached self (4) Us against them
Chadwick et al., 2014	Cape Town, South Africa	To explore the factors associated with negative birth experiences in South African public maternity settings from the perspective of women's birth narratives	Not specified, N = 33	M: Unstructured interviews A: Thematic narrative analysis	Low-income women, aged 18-42, and recently gave birth in a public birth setting in Cape Town	(1) Negative interpersonal relations with caregivers (2) Lack of information (3) Neglect and abandonment (4) The absence of a labour companion
Donate-Manzanares et al., 2021	Spain	(1) To examine women's evaluations of quality of care from their perspectives (2) To explore individual and clinical factors related to women's level of satisfaction with the quality of care they receive (3) To examine themes associated with the experience of childbirth in a nationwide sample	Purposive sampling (national survey), N = 1,082 Purposive sampling (semi-structured interviews), N = 15	M: National survey and semi-structured interviews A: Phenomenology	Legal age (not specified) and Spanish language	(1) Expectations vs. reality (2) Relationship with professionals and their social skills (3) Newborn care at birth (4) Pain management (5) Continuity of care by specialists
Greenfield et al., 2019	The UK	To understand the choices women made in subsequent pregnancy(s) and birth(s) and explore the reasons behind them	Not specified, N = 9	M: In-depth semi-structured interviews A: Longitudinal grounded theory and constructivist grounded theory, underpinned by feminist research principles	Self-reported traumatic birth experience, baby born alive, 12-20 weeks pregnant at time of interview (subsequent birth), 18+, and English language	(1) Feelings about being pregnant and "the bump" (2) Gathering and analyzing information (3) Making plans for this time (4) Choice and control (5) Support (6) Postnatal decisions
Gregory & Maddern, 2023	Australia	To examine the lived experience and	Purposive, N = 8 (4 couples)	M: In-depth semi-structured interviews	Vaginal delivery within 2 months-5 years in the Australian public hospital	(1) Compassionless care (2) Violation and subjugation (3) Parenting after birth trauma

		psychosocial impact of traumatic birth in couples		A: Interpretive phenomenology	system, 18+, partner present at birth, pregnancy classified as "low risk" prior to labour onset, and couples in an intimate relationship involving shared parenting	
Koster et al., 2020	The Netherlands	To explore women's traumatic birth experiences in order to make maternity care professionals more aware of women's intrapartum care needs	Purposive and theoretical, N = 36	M: In-depth semi-structured interviews A: Constant comparison/grounded theory design	Self-reported traumatic birth experience, Dutch language, 18+, and gave birth in a Dutch birth setting no longer than 3 years ago at a minimum gestational age of 37 weeks	(1) Lack of information and consent: Maternity care professionals' unilateral decision-making during intrapartum care, lacking informed consent (2) Feeling excluded: Women's maladaptive response to the healthcare professionals' one-sided decision-making, leaving women feeling distant and estranged from the childbirth event and the experience (3) Discrepancies: Inconsistency between women's expectations and the reality of labour and birth, on an intrapersonal level
Mayra et al., 2022	Bihar, India	(1) To understand how women experience and attach meaning to respect, disrespect, and abuse during childbirth (2) To document women's expectations of respectful care	Purposive, N = 5	M: Body mapping (visual arts-based research method) and in-depth semi-structured interviews A: Feminist relational discourse analysis	Women aged 19-32 who gave birth in the last 3 years in different birth settings in Bihar	(1) "Good" birth, "bad" birth, and expected birth (2) Disrespectful and abusive birth (3) Respectful birth
Meaney et al., 2016	Ireland	To explore women's experiences of maternal morbidity	Purposive, N = 15	M: Semi-structured interviews A: Thematic analysis	Experienced a maternal morbidity during pregnancy or labour	(1) Powerlessness (2) Morbidity management (3) Morbidity treatment (4) Socio-behavioural responses to morbidities

Murphy & Strong, 2018	Southeast England	(1) To focus on the events during and after birth while also setting the births in their medical context (2) To provide an in-depth, focused, and subjective narrative accounts of self-defined traumatic births, acknowledging the multidimensional and medically complex aspects of the birth experience (3) To ask for recommendations for future peri- and postnatal care from this participant sample group	Purposive, N = 5	M: In-depth semi-structured interviews A: Narrative analysis	Self-reported traumatic birth experience and first child aged 3-8	(1) Experiencing birth trauma (2) Being invisible (3) "Just get on with it," (4) Making things better
Olsen et al., 2014	Norway	To describe expectant mothers' experiences of fear of childbirth after a previous traumatic birth	Purposive, N = 8	M: In-depth interviews A: Descriptive phenomenology	Expectant mothers with a previous self-reported traumatic birth experience and severe fear or anxiety of childbirth	(1) Suboptimal midwifery care, and loss of control and agency (2) Insufficient time and capacity to process a traumatic birth experience (3) "The baby has to be delivered" (4) The path to a new childbirth with the hope of mastering fears
Reed et al., 2017	Globally (although the majority of participants were from Australia, North America, and Europe)	To understand how interpersonal factors influence women's experience of trauma in order to inform the development of care that promotes optimal psychosocial outcomes	Not specified, N = 748	M: Online survey and in-depth interviews A: Inductive thematic analysis	18+ and self-reported traumatic birth experience	(1) Prioritizing the care provider's agenda (2) Disregarding embodied knowledge (3) Lies and threats (4) Violation
Rodríguez-Almagro et al., 2019	Spain	To investigate women's perceptions of living a traumatic childbirth experience and the factors related to it	Consecutive, N = 32	M: Semi-structured interviews A: Inductive thematic analysis	18+	(1) Birth plan compliance (2) Obstetric problems (3) Mother-infant bond (4) Emotional wounds (5) Perinatal experiences

Stankovic, 2017	Belgrade, Serbia	To explore how women, users of public maternity healthcare services in Serbia, experience birth and what the most problematic relational aspects of institutional context associated with negative or even traumatic aspects of birth experiences are, as described by the women themselves	Purposive, N = 15	M: In-depth semi-structured interviews A: Interpretive phenomenology	Primiparous women aged 26-49 and who had recently given birth in different public birth settings in Belgrade	(1) Feelings of isolation and abandonment (2) Lack of communication (3) Lack of a caring relationship (4) Lack of control and agency
Tafe et al., 2023	Australia	To explore women's experiences of midwifery continuity of care following a previous traumatic birth experience in Australia	Convenience (snowball), N = 8	M: In-depth semi-structured interviews A: Thematic analysis	Self-reported traumatic birth experience, received care from a midwife, 18+, and received care in Australia	(1) The nightmare lives on (2) Determination to find better care (3) A broken maternity system (4) The power of continuity
Taghizadeh et al., 2021	Ilam Province, Iran	To explore negative health consequences due to childbirth violence based on mothers' perceptions and experiences	Purposive, N = 26	M: In-depth semi-structured interviews A: Conventional content analysis	Reproductive age (18-49), hospital delivery (vaginal or C-section), within 1 week-3 years, self-reported traumatic birth experience, and Persian language	(1) Maternal and newborn injuries (2) Weakening of family ties (3) Sense of distrust and hatred
Taghizadeh et al., 2013	Iran	To explore the mothers' response to psychological birth trauma	Purposive, N = 23	M: Semi-structured interviews A: Content analysis	Traumatic birth experience assessed using the DSM-4 and Persian language	(1) Relationship gulf between mother and child (2) Demanding marital life (3) Social conflict (4) Uncertainty of decision-making
Taghizadeh et al., 2014	Tehran and Isfahan, Iran	To understand psychological birth trauma from the perceptions of Iranian mothers	Purposive, N = 23	M: In-depth semi-structured interviews A: Content analysis	Traumatic pregnancy/birth and Persian language	(1) Childbirth suffering (2) Childbirth sequel
Taheri et al., 2020	Iran	To identify perceived strategies of psychological birth trauma prevention	Purposive Mothers (N = 22), spouses	M: In-depth semi-structured interviews A: Content analysis	Given birth in the past 2 years and self-reported traumatic birth experience	(1) Skill-builder knowledge (2) Responsible caregiving (3) The alliance of prenatal and antenatal care

		among childbirth women in Iran	(N = 2), and health professionals (N = 8)			(4) Reconstruction of the structures
Thomson & Downe, 2008	England	To explore the lived experience of, and personal meanings attributed to, a traumatic birth	Purposive, N = 14	M: In-depth interviews A: Interpretive phenomenology	Phase 1: Self-reported traumatic birth experience and a positive one Phase 2: Self-traumatic traumatic birth experience and pregnant again Both: Accessed after-birth services as a result of their traumatic birth	(1) Being disconnected (2) Being helpless (3) Being isolated
Thomson & Downe, 2016	North-West England	To identify the emotional and support needs of pregnant multigravida women who have experienced adverse responses associated with a previous childbirth experience	Not specified, N = 112	M: Surveys A: Not specified	Multiparous, 18+, no known mental health conditions, and no known fetal anomalies identified via ultrasound scan	(1) The experience of trauma (2) Poor practices and mistrust (3) Health concerns for the infant (4) Adverse emotions and responses (5) Who provided/should provide support (6) Medicalization by staff (7) Tailoring professional support effectively (8) When support should be accessed (9) Identification of a specific time (10) Different needs at different times (11) Types of support that are or could be helpful
Tsakmakis et al., 2023	Australia	To explore socially-constructed realities and lived experiences of women and their partners who self-describe as experiencing birth trauma	Purposive, N = 28	M: In-depth semi-structured interviews A: Descriptive phenomenology, constructivism/interpretivism, and thematic analysis	Reproductive age (18-49), given birth in Australia in the past 5 years, and self-reported traumatic birth experience and willing to articulate it	(1) Individual (2) Interpersonal (3) Institutional (4) Community (5) Policy

van der Pijl et al., 2020	The Netherlands	(1) To determine what types of disrespect and abuse women reported in the #genoeggezwegen stories (2) To gain a more detailed understanding of the experiences reported by these women	Convenience, N = 438	M: Written stories shared on the Birth Movement's public Facebook page A: Social media content analysis	/	(1) Lack of informed consent (2) Not being taken seriously and not being listened to (3) Lack of compassion (4) Use of force (5) Short- and long-term consequences
Zhang et al., 2020	Wuhan, China	To explore Chinese women's lived experiences of psychological birth trauma during labour and birth	Purposive, N = 24	M: In-depth semi-structured interviews A: Descriptive phenomenology	Self-reported traumatic birth experience, 18+, and within the first week after delivery	(1) How am I supposed the relieve the endless pain? (2) Can't I be weak? (3) Am I not important? (4) What uncertainties are waiting for me?

Analytical framework: Thematic analysis

The framework used to guide the analysis of the results of the narrative review is Braun & Clarke's (2006) thematic analysis.

The purpose of both thematic and content analysis, in general, is to systematically find themes that are present in some qualitative data (Humble & Mozelius, 2022). While they are very similar to each other, there is one notable difference. With thematic analysis, codes are directly derived from the data itself; with content analysis, they are initially created based on theory or previous research and then searched for within the data (Humble & Mozelius, 2022). Narrative reviews also lend themselves more to thematic analysis because, similarly to scoping reviews, they do not have to start with a preconceived theoretical perspective (like systematic reviews do) (Munn et al., 2018). With the raw qualitative data of the 31 included studies, a plethora of data was available to amalgamate and find one's own self-defined recurring themes within; this is inductive reasoning and aligns with thematic analysis. As can be seen in Table 4 above, thematic analysis is also what was used by many of the authors.

Braun & Clarke's (2006) six steps of thematic analysis are: (1) Familiarize yourself with the data, (2) generate initial codes, (3) search for themes, (4) review potential themes, (5) define and name themes, and (6) produce the report.

To first become familiar with the data (step one), a long list of all the raw qualitative data from the included studies was made. These were quotes taken directly from women participants in the included studies, talking about their traumatic birth experience and the adequacy of healthcare practices. Ones were eliminated that were thought to be redundant or not relevant to the aim/research questions. Step two was then to assign initial codes (i.e., labels) to the quotes. For example:

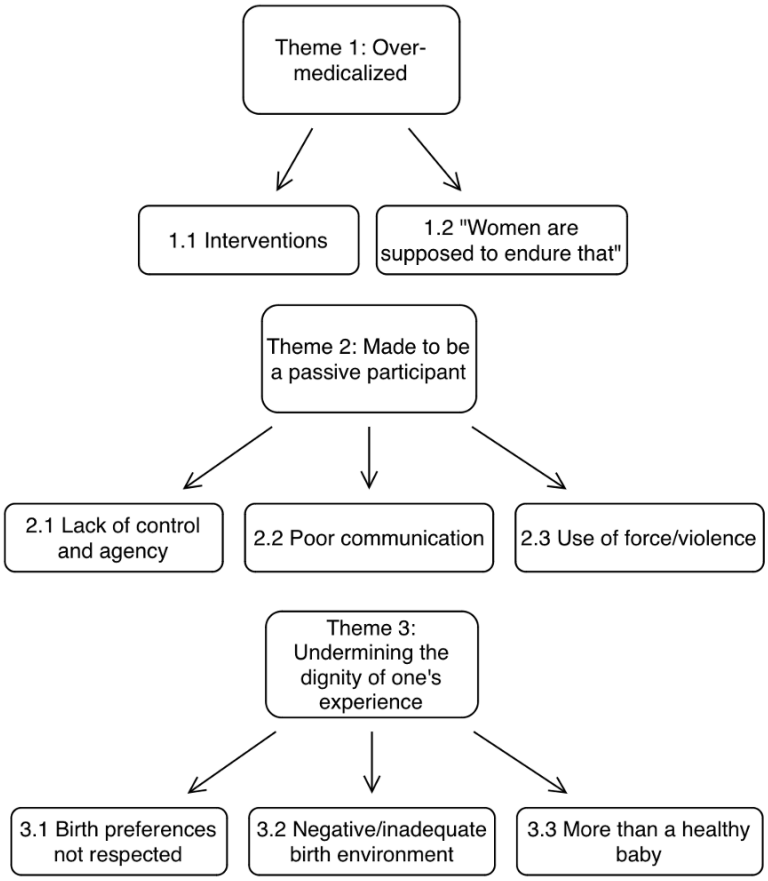
> *They did not tell me what and why they were doing it. I felt as though I was a thing at that moment because there is no one informing you. The only thing that they are thinking is to remove the baby from there.* (Aksu & Serçekuş, 2023)

Poor communication	Loss of autonomy	Lack of informed consent	Baby prioritized

For step three, the articles were all printed out and highlighters used to group together quotes that were thought to relate to each other in some way. A few sentences were written to generally describe the contents of each grouping and my first impressions (e.g., woman not kept in the loop, autonomy taken away; felt like thing and second to baby). In doing this, themes that were naturally emerging were recognized, as well as the relationships between them, in terms of both similarities and differences. According to Braun & Clarke (2006), "Data within themes should cohere together meaningfully, while there should (also) be clear and identifiable distinctions between (them)." Second-level coding was done as a means to make small differentiations and be even more specific. To clarify, these subthemes were generated first, and then grouped together into three higher-level main themes. A visual depiction of this and the relationships can be found below:

Figure 3

Flow chart of the three themes and seven subthemes



Braun and Clarke's (2006) fourth step is to review the themes, and define and name them (step five). This meant reading everything through again and making sure the assignments made sense and were appropriate. Step six, the last step, is the writing of this document.

Ethical considerations

Although the topic of birth trauma can be sensitive and potentially triggering, ethics approval was not required because of the nature of doing a literature review. Rather than collect primary data, secondary sources that were publicly available and would have themselves had ethical approval were used. Collecting primary data was not feasible within the timeframe because of how long it currently takes to get approved for this in Sweden. That being said, having women's stories be at the center of this research was what was most important and in using qualitative research, and especially doing a narrative review, this was still possible.

There is also a need to consider the effect that reading this thesis might have on others. When looking for studies specifically on birth trauma, the results are expected to be negative. That being said, this is of course not representative of all women's experiences and should not be taken to be. In line with this, it should not be assumed that all HCPs are uncaring or malicious. Moreover, there are always two sides to every story; only one side, the women's, is included here. It is also possible for there to be discrepancies between what was reported vs. what actually happened, so there is a need to read the results critically.

Results

The results from the narrative review are, again, organized into three main higher-level themes: (1) Over-medicalized, (2) Made to be a passive participant, and (3) Undermining the dignity of one's experience. These were then further broken up into seven subthemes. For a visual depiction of this, please see Figure 3 above. It is important to know that while the themes/subthemes were made categorically separate, they are all still interrelated, as is the nature of a complex, multifaceted issue such as this. Moreover, as was discussed before, a narrative review depends on the author's own interpretation of the results. This means that while the organization was done a certain way, others might feel it makes sense differently.

Table 5 below shows which studies the raw qualitative data used in the creation of each theme came from. In the List of References, the bolded ones are of the studies included in the review.

Table 5

Which studies the raw qualitative data for each theme came from

1.1 Interventions	(Beck & Watson, 2010), (Brown et al., 2022), (Buchanan et al., 2023), (Bryne et al., 2017), (Chadwick et al., 2014), (Greenfield et al., 2019), (Gregory & Maddern, 2023), (Reed et al., 2017), (Rodríguez-Almagro et al., 2019), (Stankovic, 2017), (Taghizadeh et al., 2021), & (van der Pijl et al., 2020)
1.2 "Women are supposed to endure that"	(Aktaş & Aydin, 2019), (Bryne et al., 2017), (Mayra et al., 2022), (Meaney et al., 2016), (Murphy & Strong, 2018), (Reed et al., 2017), (Rodríguez-Almagro et al., 2019), (Thomson & Downe, 2008), (van der Pijl et al., 2020), & (Zhang et al., 2020)
2.1 Lack of control and agency	(Aksu & Serçekuş, 2023), (Beck & Watson, 2010), (Brown et al., 2022), (Buchanan et al., 2023), (Butterworth et al., 2023) (Bryne et al., 2017), (Greenfield et al., 2019), (Gregory & Maddern, 2023), (Koster et al., 2020), (Mayra et al., 2022), (Meaney et al., 2016), (Olsen et al., 2022), (Reed et al., 2017), (Rodríguez-Almagro et al., 2019), (Stankovic, 2017), (Tafe et al., 2023), (Taghizadeh et al., 2021), (Taghizadeh et al., 2013), (Thomson & Downe, 2008), (Tsakmakis et al., 2023), & (van der Pijl et al., 2020)
2.2 Poor communication	(Aktaş & Aydin, 2019), (Beck, 2004a), (Brown et al., 2022), (Butterworth et al., 2023), (Donate-Manzanares et al., 2021), (Greenfield et al., 2019), (Gregory & Maddern, 2023), (Mayra et al., 2022), (Murphy & Strong, 2018), (Olsen et al., 2022), (Reed et al., 2017), (Rodríguez-Almagro et al., 2019), (Stankovic, 2017), (van der Pijl et al., 2020), & (Zhang et al., 2020)
2.3 Use of force/violence	(Aksu & Serçekuş, 2023), (Beck & Watson, 2010), (Butterworth et al., 2023), (Chadwick et al., 2014), (Mayra et al., 2022), (Meaney et al., 2016), (Reed et al., 2017), (Rodríguez-Almagro et al., 2019), (Tafe et al., 2023), (Taghizadeh et al., 2021), (Thomson & Downe, 2008), & (van der Pijl et al., 2020)
3.1 Birth preferences not respected	(Aktaş & Aydin, 2019), (Brown et al., 2022), (Buchanan et al., 2023), (Bryne et al., 2017), (Chadwick et al., 2014), (Greenfield et al., 2019), (Gregory & Maddern, 2023), (Koster et al., 2020), (Mayra et al., 2022), (Olsen et al., 2022),

	(Rodríguez-Almagro et al., 2019), (Stankovic, 2017), (Tafe et al., 2023), (Tsakmakis et al., 2023), (Thomson & Downe, 2008), & (van der Pijl et al., 2020)
3.2 Negative/inadequate birth environment	(Aktaş & Aydin, 2019), (Aksu & Serçekuş, 2023), (Beck, 2004a), (Mayra et al., 2022), (Murphy & Strong, 2018), (Olsen et al., 2022), (Rodríguez-Almagro et al., 2019), (Stankovic, 2017), (Tafe et al., 2023), (Taghizadeh et al., 2014), (Taghizadeh et al., 2021), (Taheri et al., 2020), (van der Pijl et al., 2020), & (Zhang et al., 2020)
3.2 More than a healthy baby	(Aksu & Serçekuş, 2023), (Beck, 2004a), (Beck 2004b), (Buchanan et al., 2023), (Bryne et al., 2017), (Donate-Manzanares et al., 2021), (Gregory & Maddern, 2023), (Koster et al., 2020), (Murphy & Strong, 2018), (Olsen et al., 2022), (Tafe et al., 2023), (Tsakmakis et al., 2023), & (van der Pijl et al., 2020)

Theme 1: Over-medicalized

Once thought of as a natural process, HCPs have now increasingly taken over responsibility for even normal births, making childbirth more and more medicalized. Women from the included studies, in this model, reported feeling like just an incubator of sorts and that there was too much unnecessary intervening. Their choices were also not taken at face value and there was the need to always justify themselves. That being said, this over-medicalization of childbirth did not extend to when women reported being in pain, which was often dismissed by HCPs and then went untreated.

1.1 Interventions

Many women in the included studies said they had wanted to try for a natural birth (i.e., without any medical intervention), but felt they were encouraged or forced into a medicalized one by their HCP. Their births were seemingly not allowed to progress naturally, and this was true even when the need for intervention was not medically indicated (i.e., mother/newborn not in distress).

> *At no point was I or my son in danger. Then why all these forced interventions?* (van der Pijl et al., 2020)

> *I did nothing by myself… I did nothing in the natural way, nothing was allowed to progress spontaneously. Doctor did everything, nothing happened by itself.* (Stankovic, 2017)

Women also felt they had to "negotiate every little thing" with their HCP, instead of "focusing on (their) baby and giving birth" (Rodríguez-Almagro et al., 2019). One woman from Greenfield et al.'s (2019) study said she felt like they, "(tried) anything to sway me" toward a more medicalized birth, including the use of intimidation tactics. According to Reed et al. (2017), the most common (and effective) threat was that relating to the wellbeing of the newborn: "Do you want a dead baby?" Moreover, Brown et al. (2022) found that HCPs seemingly straight-up lied to the women, even when she had proof to the contrary, making them question the lengths their HCP would go to get them to comply.

> *I said, "I'd rather you'd turn it (induction of labour hormone drip) off." And she said, "But I turned it off," and I said, "No you haven't, I can see you haven't!" And she said, "Yes, I have!" And there's nothing I could do about it.* (Brown et al., 2022)

Some women, too tired to continue arguing, ended up relinquishing what little control they did have and just letting the HCP take over completely. The HCP's own interests then seemingly became the number one priority (e.g., getting to go home early). Not only was the effect of this a total loss of control and agency for the woman, but it also sometimes caused unnecessary pain and suffering.

> *When my first was born, I was told "5 minutes or I get the forceps" by the doctor on call. I pushed so hard that I tore badly.* (Beck & Watson, 2019)

> *I begged not to have a C-section, neither I nor my baby were in distress or danger, but because the doctor was ready to go home, he did a terrible section that resulted in almost a year of recovery.* (Reed et al., 2017)

> *I found the comment, "Let's get this over and done with, I have a golf game to get to" traumatic.* (Reed et al., 2017)

1.2 "Women are supposed to endure that"

When talking to her HCP about her labour pains, one woman (from Zhang et al.'s (2017) study), expecting to be met with empathy, said she was instead gaslit and made to feel worse than she already did. While the experience of pain is subjective, HCPs still have a professional responsibility to reduce/manage it as much as possible. Validation of patient concerns is also important, even if the HCP might not necessarily agree. But for this to happen, HCPs have to trust women to know their bodies and limits best. Some women want to give birth without any pain medication and that is okay, too; whatever her choice, it should be respected.

> *I mean what happened to pain is what the patient says it is.* (Meaney et al., 2016)

> *The doctor emphasized it is impossible for women to give birth with no pain over and over again… Certainly, I did know childbirth came along with severe pain. I felt great pain already. Why did he still underscore the point? At least he should have given me some encouragement and confidence… I was fragile and didn't hope to hear the negative words.* (Zhang et al., 2020)

> *I felt like I was being told I was silly for thinking I was in labour and that this awful pain was nothing to be worried about. My opinion was dismissed and ignored.* (Reed et al., 2017)

> *(The) hospital staff did not listen to me, didn't trust me to know my body.* (Reed et al., 2017)

Another example is a woman from Murphy & Strong's (2018) study being told that her pain at that moment was nothing and that she needed to cope better, because there was a lot more to come. This is of course not reassuring and likely to cause even more distress.

> *At one point (the nurse) turned round and said to me, "You need to cope a lot better than this, you've got a lot more to come." ... She was shouting at me.* (Murphy & Strong, 2018)

One of the effects of this, besides not being taken seriously, is that women are sometimes made to undergo painful exams and procedures, including childbirth itself, without any pain relief (Rodríguez-Almagro et al., 2019). A common example of this is unanesthetized episiotomies (cutting of the perineum), which Mayra et al. (2022) say constitutes physical abuse. One woman from Murphy & Strong's (2018) study described how her HCP kept doing a vaginal exam, even after she had withdrawn consent, because the pain could not possibly be as bad as she was saying it was. Another stomach-turningly described how they started cutting for her C-section before the anaesthesia had set in (Rodríguez-Almagro et al., 2019).

> *She literally was holding her hand inside me trying to get them further up so she could feel it and I'm screaming at her, "This is hurting, you need to give me something."* (Murphy & Strong, 2018)

Theme 2: Made to be a passive participant

Within the context of the over-medicalization of childbirth, many women from the included studies reported feeling excluded from decisions made about their bodies and births; things were done to them, not with them. The women were not communicated clearly with, leaving them also feeling left out and confused as to what was happening. HCPs continued on without consent, and often used threats and even force/violence as a means to get women to comply.

2.1 Lack of control and agency

A lack of control and agency was identified in many of the included studies. One woman, from Koster et al.'s (2020) study, compared this to like being on an automated assembly line. Women as persons and what they wanted from the birth experience seemingly did not matter, it was just to, "*Lie down, shut up, and spread your legs*" (Stankovic, 2019).

> *I had rolled onto an assembly line… I was ignored. They carried on. I was only a number, a body, just a womb… Not a human being at all… Not a woman having a baby.* (Koster et al., 2020)

> *I had my eyes closed the whole time because I didn't want to register what was happening to me… I was a very passive person in the whole thing, you just tell me what to do, I'm not engaging in this at all.* (Byrne et al., 2017)

Women said their consent was blatantly not obtained and even if it was, it was oftentimes not informed. Because the process of giving birth is often long and tiresome, some felt their HCP was waiting for them to lose strength and effectively "tap out," so they could then take over total control (Thomson & Downe, 2008). One woman in Reed et al.'s (2017) study was told that even if she did not willingly consent to a Cesarian section (C-section), it would still be performed as soon as she went under.

> *They got my consent, but none of it was informed… Every person had a different opinion on what I should be doing and made it very well known that I should be doing only what they were saying.* (Tafe et al., 2023)

> *I had no option but to go with what was happening, because I didn't really know what was happening and I didn't have the strength to do anything about it.* (Thomson & Downe, 2008)

> *My daughter was breech… I was told that if I didn't consent to the cesarian before labor started then they would perform a cesarian without my consent under general anesthesia.* (Reed et al., 2017)

Some women in Rodríguez-Almagro et al.'s (2019) study also felt like a spectacle (particularly if their birth was especially "cool" or "abnormal") or a guinea pig for students to practice on. This was, again, not done with the permission of the woman.

> *The whole thing seemed like a showroom for groups of students, and I wasn't asked if I was OK with it. So it was not a great experience.* (Rodríguez-Almagro et al., 2019)

> *A lot of students… came to examine me… I saw at least 15 people and they all examined me, it was very uncomfortable, I felt like I was being continually violated.* (Rodríguez-Almagro et al., 2019)

Even knowing they were being mistreated, the women said they did not feel confident to speak up against their HCP or even know if they were allowed to. In addition to the inherent power imbalance that exists, there was also the thought that HCPs are supposed to have their patients' best interests in mind, so maybe it was okay to just leave things up to them (Thomson & Downe, 2008). One woman also explained this as being due to the stereotyped concept that women are just expected to be "good girls" who do what they are told without pushback (Buchanan et al., 2023).

> *(My wife) was really like I don't want this, it was that kind of helpless feeling, where I think she almost didn't have the courage or didn't know if she could say no I'm not having that.* (Butterworth et al., 2023)

> *Just letting them take over… I just kept agreeing to things because I was thinking well they should know, they're the midwives, they're the doctors and blah blah blah*. (Thomson & Downe, 2008)

> *And as a society and like the sisterhood, we're all in good girl mode like, we're going along with it (intervention) even though I don't agree*. (Buchanan et al., 2023)

2.2 Poor communication

Several of the studies also identified poor communication on the part of the HCP, e.g., that things were confusing to the women or not told to them altogether.

Because of the aforementioned sense of feeling excluded, women from Stankovic's (2019) study reported having difficulty recounting exactly what had happened and so were forced to fill in the missing gaps the best they could. They were saddened about not being able to fully remember their baby's birth, even if it was traumatic (again going back to the personal significance of the birth experience). According to Tsakmakis et al. (2023), this is why formal birth debriefs are so important and should be the standard practice.

> *They don't tell you anything and since you don't know and you are not informed, the only thing you can do is to guess and to try to reconstruct some kind of a story based on a few things you do know.* (Stankovic, 2019)

HCPs were also reported to have talked about patients in front of them as though they were not there, adding to women feeling as though their being in the room was not at all acknowledged. The HCPs of one woman, from Beck's (2004a) study, even talked openly about how her baby might be dying and with very little sensitivity.

> *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.* (Murphy & Strong, 2018)

> *They don't talk to you they talk over you and about you.* (Gregory & Maddern, 2023)

> *"We may have lost this bloody baby." The hospital staff discussed my baby's possible death in front of me and argued in front of me just as if I weren't there.* (Beck, 2004a)

Poor communication was also seen not only between HCPs and their patients but also among themselves (i.e., HCP-HCP). One woman in van der Pijl et al.'s (2020) study, for example, described how she was left alone for over two hours after giving birth. In addition to her feeling discarded, this could also be dangerous if something were to happen while no one had direct oversight.

> *After giving birth I was left alone with my feet up in stirrups. After two hours somebody said: "Oh, you're still here."* (van der Pijl et al., 2020)

> *The medical staff left me hanging. They changed shift at eight in the morning. The handover meeting took more than one hour. My call for them was met with ignorance. I felt like being abandoned.* (Zhang et al., 2020)

2.3 Use of force/violence

As referenced by Tsakmakis et al. (2023), in the literature, birth trauma is often synonymous with obstetric violence, with some even referring to it as birth rape. This is due to there being cases of HCPs using force and violence in the provision of birth trauma, including verbally, physically, and sexually (Tsakmakis et al., 2023).

The most common form of abuse, as reported by Mayra et al. (2022), is verbal. Some women said their HCP had raised their voices or screamed at them. Other times, HCPs used demeaning and shaming language, making the woman feel less than. One woman from Mayra et al.'s (2022) study would not even repeat what her HCP had said to her because it was so bad. An example of humiliating language can be seen in Chadwick et al.'s (2014) study, where the nurses "joked" about making the woman go clean up her own "mess," that being the aftermath (e.g., blood) from her birth. Women from the same study were also told it was gross to examine them because they smelled down there, making them feel shy and embarrassed.

> *It was very upsetting for me, especially the way they speak to the patients and scream at the patients when the patients are in labor.* (Chadwick et al., 2014)

> *Two sisters (nurses) were very bad because they were abusing me and shouting at me like anything, I can't even tell you the things they said to me.* (Mayra et al., 2022)

> *I messed on the floor, with the blood because I was pushing she (nurse) was there in the office, now I was messing and she told me um, um, "Go and get a mop there and make your mess clean."* (Chadwick et al., 2014)

> *And then when I get inside (maternal obstetric unit) some of them (nurses) was not, was not nice with me, they said I must just go and change my, change my, my gowns and that and start to wash again because I have a stinky smell.* (Chadwick et al., 2014)

A few of the studies had examples of women being or seeing others physically hurt. Although this was oftentimes done in the context of "care," the women felt it was completely out of proportion and unjustified. One woman from Meaney et al.'s (2016) study, for example, told how her nurse "pounded" on her as a means to try to get the uterus to start contracting. Still, another from Mayra et al.'s (2022) study reported that she had, for no apparent reason, seen others be "*slap(ped) across (their) face*."

> *She just started pounding on me. So more agony. I just didn't know exactly what she was doing. I read later on the internet that they can massage it to get it to contract but this wasn't massaging.* (Meaney et al., 2016)

> *After 15 minutes the placenta is still not here. The resident is leaning on his elbow, pushing his full bodyweight into my abdomen. I am crying. Then he pulls on the umbilical cord. He thinks he needs so much force that he has to put one foot on the bed for leverage.* (van der Pijl et al., 2020)

According to Mayra et al. (2022), being restrained (i.e., physically controlled) is also a form of physical abuse. A woman from Reed et al.'s (2017) study, not wanting to be examined, said her screams of "no" were muffled by an oxygen mask and that multiple people held her down, making her feel completely helpless. Another from Mayra et al.'s (2022) study described having a blindfold put on her, which is apparently not uncommon in that setting (India).

> *Being pinned down by 4 midwives (forcing an unnecessary oxygen mask on me just so my screams of "no" were muffled) and my husband so the consultant could examine me against my will.* (Reed et al., 2017)

> *No one told me anything… They just blindfolded me. (Mayra et al., 2022)*

Although not as common as that of verbal and physical abuse, a few women did say they felt as though they had been sexually violated by their HCP. One woman from Reed et al.'s (2017) study, for example, compared her experience of having her genitals touched without permission to being raped. She said how this would be rape "except when you are giving birth,"

when it is somehow made out to be okay. She furthered how this was more traumatic for her than the childbirth abuse she had experienced, demonstrating just how frightening and impactful birth trauma really can be. Sexual violation can also manifest as being made to be unnecessarily naked or denied covering.

> *The most terrifying part of (the) whole ordeal was being held down by 4 people and my genitals being touched and probed repeatedly without permission and no say in the matter, this is called rape, except when you are giving birth. My daughter's birth was more sexually traumatising than the childhood abuse I'd experienced.* (Reed et al., 2017)

> *My cervix was manually dilated forcefully after pleading for the Dr. to stop. This caused me to re-experience a previous rape… Images and fears from my past sexual abuse/assaults became constant in my mind after birth.* (Reed et al., 2017)

> *I could feel that they moved my clothes up to chest… There were 8 men in the room!* (Mayra et al., 2022)

Theme 3: Undermining the dignity of one's experience

Lastly, what women wanted from their birth experience did not seem to matter at all; it was just to get the baby out and be done. Even if they had communicated their wants and needs, these were, for the most part, not taken into consideration and were ignored. The women were also often made to give birth in environments they were not comfortable in, including having to do so all alone. This undermines both a woman's right to choose for herself and the personal significance that is often attributed to the birth experience.

3.1 Birth preferences not respected

Although some women have specific preferences for their birth, it is clear from the included studies that HCPs, despite being in the position to support what their patients want, often insist on doing things on their own terms or as per "protocol." A woman in Tsakmakis et al.'s (2023) study, for example, was specifically told not to make a plan because "you don't get to choose how birth goes." Although deviations do happen (and childbirth education is important in managing expectations), this still undermines a woman's right to choose for herself and also the personal significance that is often attributed to the birth experience.

> *I didn't want this, it was in my birth plan that I didn't want all of that… I let it happen… What else could I do? Protocols were thrown at me, so to speak.* (Koster et al., 2020)

Another in Olsen et al.'s (2022) study spoke about feeling "ignored" and "excluded" about decisions being made about how her birth would go.

> *I… felt like I wasn't allowed to be part of the things that were important to me, and it made me feel like I was watching myself in the room and was just an object that was going to deliver a baby… I felt like I was ignored and excluded from decisions made about my body. I felt I had lost myself.* (Olsen et al., 2022)

Having a birth partner of one's choosing (e.g., partner, family member, friend, patient advocate, etc.) has shown to have numerous benefits (Taghizadeh et al., 2021). Still, many facilities still do not allow for them, i.e., women are made to give birth all alone. This makes an already stressful situation even more so, affecting the mother's mental health and possibly labour outcomes (Chadwick et al., 2014). Chadwick et al. (2014) found this to be especially true for first-time mothers, who are left to navigate this overwhelming new experience on their own. A woman from Aktaş & Aydin's (2019) study talked about how this made her feel:

> *My husband could not enter the birth room. "It is forbidden" said the midwife… I really wanted my husband to be with me… As it was my first birth, I felt scared and needed his support. So I felt a little desperate and lonely at birth.* (Aktaş & Aydin, 2019)

Another from Stankovic's (2019) study compared her feelings of loneliness to that of an orphan:

> *You say goodbye to your husband… And then, with one bag in your hand, like an orphan, you go away.* (Stankovic, 2019)

After having had a traumatic birth experience, many women expressed that the most important thing to them in their next pregnancy was to be more in control. Through, for example, the insistence on having more "rigid" birth plans and finding an HCP who will work within this (Greenfield et al., 2019). This also aligns with the fact that a lack of say makes the birth experience more likely to be perceived as traumatic (Tsakmakis et al., 2023). The women also recognized that they would have benefited, both emotionally and physically, from having been allowed to have a support person with them. For example, while still recovering herself, having someone to help care for the baby,

> *I need to be in control next time, because they took all the control away from me and left me very vulnerable and I need to have that control this time and my wishes respected in order for it to be a good experience. So that's why there's gonna be quite rigid birth plans.* (Greenfield et al., 2019)

> *I would have benefited from my husband's presence for sure… I wanted him in the room with me… In this condition, husband is needed more!* (Mayra et al., 2022)

> *I felt so sick, I still had to look after this little baby, my husband couldn't stay with me.* (Gregory & Maddern, 2023)

3.2 Negative/inadequate birth environment

The physical birth environment is also important, yet how women are made to feel in spaces is often undermined (Aktaş & Aydin, 2019). Women from the studies, as indicated below, reported feeling that the environment they gave birth in, especially in big, impersonal hospitals, was not conducive to a good experience.

The first element of a negative/inadequate birth environment, as identified by Aktaş & Aydin (2019), was a lack of privacy. Many maternity wards, even in high-income countries, unfortunately do not have the capacity for each woman to have her own room and are thus forced to share, sometimes with multiple others. A woman from Aktaş & Aydin's (2019) further said that, even if you did get your own room, her walls were made of glass, making privacy impossible. In addition to their own experiences, the women were also affected by what they had to see others go through.

> *While the capacity of the room should be maximum 4 people… There were 6-7 people… I was influenced by the women who suffered at the delivery room.* (Aktaş & Aydin., 2019)

> *It's all in glass… So you can see every woman giving birth and they see you.* (Aktaş & Aydin., 2019)

> *I felt horrible when witnessing the childbirth process of other women… When I saw they had a rough time, I felt more scared.* (Zhang et al., 2020)

Furthermore, HCPs kept coming in and out of the women's rooms but never introduced themselves or their reason for being there. Even being in the physical presence of others, this made them feel alone. Something as simple as an introduction can immediately make a patient feel more comfortable, knowing who is caring for them. This is especially true given the intimate nature of gynecological exams and procedures.

> *There were loads of people in the delivery room, going in and out all the time. Nobody introduced themselves or explained what they were doing.* (Rodríguez-Almagro et al., 2019)

> *There were about nine people standing around me but I never felt so alone in my life.* (van der Pijl et al., 2020)

> *I was ashamed because there were many strangers and faces that I did not recognize, because it is your private region, and like it or not, it makes one ashamed for people you do not know to see you there.* (Aksu & Serçekuş, 2023)

Two of the studies (Taghizadeh et al., 2021; Taheri et al., 2020) identified that the aesthetics, or visual appeal, of the birth environment also mattered. For example, if it was uplifting or dulling. That being said, not a single woman from any of the included studies reported feeling completely comfortable with her hospital set-up; one even compared it to like being in prison (Taghizadeh et al., 2021).

> *A hospital is like a quarantine, it is like a prison, and women are treated like criminals.* (Taghizadeh et al., 2021)

> *Giving birth in such a place is damn horrible.* (Taghizadeh et al., 2021)

> *I prefer warm colors to be used… The current environment is not good for the birth room. Dumb colors are everywhere.* (Taheri et al., 2020)

> *I think nobody pays attention to that the childbirth environment should be charming, cozy, and warm*. (Taheri et al., 2020)

3.3 More than a healthy baby

Lastly, the women were told by their HCP that, despite having had a difficult delivery and it being traumatic for them, that they should just be happy they had a healthy baby. They were told to stop complaining because others had it worse off, which then made the women feel guilty for feeling the way they did.

> *Yes, I had a healthy baby… But at what cost emotionally, personally?* (Koster et al., 2020)

> *Feeling traumatized and devastated and disappointed and upset in some ways are so invalid because I should just be happy that I was saved and that my baby's safe and you've got a healthy baby. So, stop complaining kind of feeling.* (Buchanan et al., 2023)

> *I was so devastated at people's lack of empathy. I told myself what a bad person I was for needing to talk.* (Beck, 2004b)

> *(She said) "What are you crying for?" Not an arm round me or anything… Because she said what are you crying for, I thought, "Oh my God, should I not be crying then?"* (Murphy & Strong, 2018)

HCPs relied solely on clinical indicators to inform if a woman's birth would be classified on paper as traumatic or not. In all the included studies, women's perceptions (i.e., if they themselves found the experience traumatizing) were not taken into consideration in the

assessment of events. If there were discrepancies between the two (one found it traumatic and the other not), it was the HCP's say that was final. In some cases, women even initiated seeking out help after but were told they did not need it, i.e., that their birth was not "traumatic enough."

> *Anyone reading a discharge summary would be like, oh, what an amazing birth on paper. But in terms of how I was made to feel, worse than a dog, I was treated so poorly.* (Tafe et al., 2023)

> *They didn't think it was that unusual for the delivery to last that long or for me to lose so much blood… I really didn't need to hear that. I needed to hear that this was a difficult experience, so that only made it worse.* (Olsen et al., 2022)

> *In your case, your birth was actually very normal." So, she basically was like, … "You shouldn't be feeling like that." And I suspect… she was doing her best to alleviate my concerns and to make me feel better. But… now knowing a little bit more about trauma, I can say that telling someone what they went through wasn't traumatic is not how you help someone*. (Tsakmakis et al., 2023)

One woman from Buchanan et al.'s (2023) study reflected on the idea that women are not made to be at the center in the medical model, even in the provision of labour-ward care (which is by definition supposed to be about women). She furthered that while having a healthy baby is of course very important, so is being "nourished as a woman and a new mother," and that you arguably cannot have one without the other.

> *This is not acknowledged at all in the medical model, it's all about the baby and you're not nourished as a woman and a new mother which is a part of the birth experience, I don't think you can separate it.* (Buchanan et al., 2023)

Discussion

Key findings and interpretations

This section offers key findings and interpretations compiled from the themes, backed-up by what is already known from the literature.

We know that most, if not all, women care deeply not only about the physical outcome of birth, that themselves and their newborn are okay, but also their experience, how they were made to feel. Most want a positive and fulfilling experience that can be looked back on fondly (Downe et al., 2018). For many women, pregnancy and childbirth are also highly anticipated and represent a transformative chapter in one's life, one into starting motherhood (Public Health Agency of Canada, 2018). In addition to promoting the mother-child bond, having a positive

birth experience also lends to the woman developing good postpartum self-esteem and easier adjustment easier to motherhood (Moniri et al., 2023; Karlström et al., 2015). A traumatic experience can, again, lead to poor maternal mental health, particularly postpartum PTSD, which has negative consequences. The most disappointment, according to a report by the Canadian Public Health Agency (2018), occurs when one's actual birth experience is not at all like they were expecting, i.e., there is a substantial disconnect between one's expectations vs. the reality. For most women in the included studies, it was their HCP that was the negative part of their experience; this supports what has been found by other studies (Reed et al., 2017).

Historically, HCPs only intervened in childbirth when necessary, believing it to otherwise be a natural process that women's bodies know how to do (Johanson et al., 2002). But alongside increases in technology, HCPs have increasingly taken over responsibility for even normal births, thought by Johanson et al. (2002) to be a means to have more control. For example, global C-section rates are higher than they ever have been, without evidence that this is called for (Angolile et al., 2023). This is also indicated by changing locations of delivery, from traditionally at home to now in hospitals, as well as which HCPs attend to the birth (midwives vs. doctors/nurses) (Johnson et al., 2002). According to Lothian (2014), unnecessary interventions make childbirth harder and less safe for mothers and newborns. Interestingly, one such "intervention" is a lack of pain relief. With this is an issue of credibility, where women are not trusted to know their bodies and limits best (Bever, 2022). The implication of this is that HCPs are more likely to underestimate women's pain and less likely to treat/manage it (Bever, 2022). When women do speak up, this often leads to gaslighting and dismissal by HCPs, with women then being left to deal with the fallout alone.

In this medicalized model, women are also not given a say in what they want from their birth experience, and are often made to feel like an after-thought to the newborn. Some women, for example, have specific preferences for their birth experience and expect these to be respected, to the extent possible (DeBaets, 2017). A birth plan, for example, is a means for women to communicate their wants and needs, and to be actively engaged in their care. It is also an opportunity for the HCP to educate the woman and realistically manage her expectations, knowing that deviations do happen. But in order for this co-design of care to happen, a good working HCP-patient relationship needs to first be established, one built on mutual respect and

trust. And we now know this to not always be the case. During such a turbulent time as childbirth, women need to have a group of trusted and reliable persons they can lean on for both emotional and practical support, and to put them first. In addition to generally making the birth more likely to be perceived as positive, a birth partner can also importantly serve as an advocate, helping to safeguard against birth trauma (Hoffmann et al., 2023).

Relating more to the physical birth environment, Kazemi et al. (2023) found for the women in their study, that the most important elements were a sense of physical security (including privacy) and calmness. Perceiving that the environment is a safe space also promotes the release of neurohoromones, thus encouraging natural labour progression (Goldkuhl et al., 2022). Although not within the scope of this review, those who give birth at home are generally reported to be more satisfied, likely due to the familiarity as well as having more control (Pidd et al., 2022). That being said, an interesting study out of Sahlgrenska University Hospital in Sweden tested a novel birth room that was completely customizable by the patient so as not to be as bland and impersonal; this was found to have positively contributed to the sample's birth experiences and is thus a promising application of a way to give women more control (Skogström et al., 2022).

On that note, although this paper focuses on the actions of individual HCPs, it is still important to consider how healthcare systems, on the macro level, are organized, i.e., the context in which HCPs work. If patient-centered care is the ideal, why is it not practiced by all HCPs everywhere? In other words, is it a matter of not wanting to, or not being able to? A study by Llyod et al. (2018) found four main barriers to this: (1) Staffing constraints, (2) high staff workloads and time pressures, (3) physical resource and environment constraints, and (4) unsupportive staff attitudes. Patients' ability to access high-quality care is also equally important, and will heavily depend on one's social determinants of health. In Europe, for example, an estimated 500,000 women do not have access to any care during the first months of pregnancy (European Institute of Women's Health, 2022). Mitenience et al. (2018) identified the following barriers specifically for accessing maternal care; the bolded ones are those thought to be most relevant. These would all need to also be addressed, in a multidisciplinary policy approach, when coming up with possible interventions, to make sure the working environment is also conducive to good patient experiences.

Table 6

Barriers to accessing adequate maternal care in the Georgian context (Mitenience et al., 2018)

Availability	Appropriateness	Affordability	Approachability	Acceptability
- Geographical location and distribution - Medical staff and services - Opening hours, time	**- Technical and professional adequacy** **- Environmental and facility adequacy**	- Ability to pay - Direct costs - Indirect costs - Opportunity costs	**- Awareness and information** **- HCP-patient communication** **- Provider's attitudes**	**- Culture, traditions** **- Personal values** **- Gender norms** **- Health literacy**

Relating to "culture, traditions," when reflecting on the provision of birth trauma, it is essential to be mindful of socio-cultural differences. Healthcare is not practiced the same everywhere: What is (un)acceptable in one culture will not be the same in another. In Mayra et al.'s (2022) study out of India, for example, it was not uncommon for women to be blindfolded, which I had never heard of happening before. Women's perceived worth in societies also differ, and will then dictate how much autonomy they are given as a patient. As was discussed before, it is important not to group all HCPs together, labelling them all as bad. As is the nature of a narrative review, the results are also not generalizable. That being said, birth trauma, according to Zhang et al. (2020), is itself a universal phenomenon. Being open in talking about poor mental health is also more normalized in some cultures or families than others. Remember too that Ford et al. (2019) found that mothers in particular often avoid talking openly about negative feelings relating to motherhood for fear they will be seen as "bad" or "incapable" mothers. Because of this, we can assume that there might be some selection bias in favour of places where stigma is not as prevalent, but that birth trauma is likely still happening.

According to Gupta et al. (2023), the provision of birth trauma can in fact be explained, at least in part, by the societal oppression of women. Women, for example, tend to be seen as the more fragile sex, in need of protection and someone to decide what is best for them (in this case, that being HCPs). This then manifests as taking full control of all aspects of their health, even if "the ultimate sanction to achieve this is a violation of basic human rights" (Gupta et al., 2023). That being said, patriarchal control over women's sexuality and reproduction is especially pronounced. Although there have been efforts to move away from this paternalistic ("doctor knows best") model, toward one that is more patient-centered, there is still clearly a lot more

work to be done (Bullock, 2018). In the Recommendations for Practice section, one such solution is proposed.

Strengths and limitations

This narrative review had many strengths, but also a few limitations. Firstly, a strength was that it synthesized information from 31 diverse studies. Although this was a large undertaking within the timeframe, including as many different women's perspectives as possible was what was most important. But at the same time, this is also a limitation. Because the studies came from a variety of different places, each one could not be contextualized in itself. Despite these differences, however, there was congruence (a strength) in the higher-level main themes of what most women reported to have experienced. Another limitation is the inevitability of some selection bias. That being said, an attempt was made to limit this as much as is possible by a single reviewer by closely following the study protocol and providing justification for why each study was or was not included. Moreover, because of timeframe limitations, only two databases (PubMed and PsycInfo) were searched. While these two were purposefully chosen because of covering different disciplines (the biomedical and social sciences) and a sufficient amount of data was found, the review likely missed some relevant studies published in other databases. Also for this reason, grey literature was not searched, so there is a bias toward women who have the means to participate in research. Lastly, because of only relying on secondary data, all the quotes used were decontextualized (full transcripts were not available). While Braun & Clarke (2006) say this is not ideal for thematic analysis, the effects of this can be lessened by fully explaining the phenomena being talked about and instead contextualizing it in the literature (Braun & Clarke, 2006). The following is a summary of these strengths and limitations:

Table 7

Strengths and limitations of this narrative review

Strengths	Limitations
- 31 included studies - Many different women's perspectives, from a variety of places (i.e., study locations) - Congruence in the higher-level main themes	- Lack of objectivity with doing a narrative review - Specific study locations not socially and culturally contextualized - Selection bias by single reviewer - 2 databases searched; not including grey literature - Quotes not contextualized because of using secondary data

Reflexivity

Qualitative research can never be completely objective, and is especially true for narrative reviews (Tsakmakis et al., 2023). It is important then that researchers explicitly state their positionality in relation to the research topic and address possible biases. So, a little bit about me: I identify as a White heterosexual woman (a majority population), was born in Canada (a high-income Western country), and am of childbearing age, although have not myself experienced pregnancy or childbirth. While I have worked on and off in clinical settings for many years, I am not a registered HCP. That being said, my research interests have always been in maternal and child health, specifically in low-resource settings and as it concerns minority women. Again, having witnessed the provision of birth trauma by HCPs in Tanzania and the disheartening effects this had on the women, I have a strong research interest in this topic, and this carries a risk of bias.

Recommendations for practice: Trauma-informed care

Rather than focus all on the bad, making suggested recommendations for practice can be a learning opportunity for HCPs to more intentionally align their actions with promoting positive birth experiences.

Together with woman-centered care, trauma-informed care (TIC) can, for the most part, address these concerns. An estimated 70% of the general population are said to have experienced some kind of trauma, although this disproportionately affects women (Kessler et al., 2017). In fact, one-third of pregnant women are thought to have this history (Cull et al., 2023). TIC is a care approach that recognizes the presence of trauma for many people and the ways it can manifest, especially when seeking healthcare (Tello, 2018). For someone who has had a traumatic experience (or really anyone), healthcare settings can be a scary, possibly re-traumatizing place. The following is The Substance Abuse and Mental Health Association's four assumptions (the four R's) and six principles of TIC (Ward 2020):

Table 8

Four assumptions and six principles of TIC (Ward, 2020)

Assumptions	Principles
(1) **Realize** the widespread nature of trauma and potential for recovery	(1) Safety (privacy, comfort) (2) Trustworthiness and transparency (3) Peer support

(2) **Recognize** the impact of trauma and how it manifests (3) **Respond** by integrating understanding into policy, practice, and procedures (4) Actively **resist** re-traumatization	(4) Collaboration and mutuality (5) Empowerment, voice, and choice (6) Cultural, historical, and gender considerations

Given that pregnancy and childbirth necessitate invasive gynecological exams and procedures, TIC is especially relevant when talking about birth trauma (e.g., for survivors of sexual abuse, etc.) (Ward, 2020). In his 2020 paper, Ward made the following TIC recommendations specifically for HCPs who care for pregnant and birthing women:

Table 9

Trauma-informed care recommendations for maternal care (Ward, 2020)

- Give the patient control and the "green light" and "red light" to start and stop all procedures - Whenever possible provide an option of a female provider - When entering a patient room, introduce yourself and the upcoming procedure at eye level - Invite patient to have support person in the room - Start with the least invasive methods of labor induction - Limit vaginal and breast exams - When possible, limit the number of people in a procedure room at any given time - Only ask the patient to remove clothing items necessary for a given procedure - Cover the patient between procedures - Avoid opening the patient's legs, and instead invite the patient to open when they are ready - Provide a full description of any procedures in advance, including potential discomfort and any alternative procedures

In creating physically and emotionally safe spaces, HCPs provide care that is both sensitive to and supportive of women's unique needs (linking to woman-centered care), thereby actively avoiding the provision of birth trauma. Not only does TIC promote a culture of safety, empowerment, and healing, but it also lends to better patient health outcomes (Tello, 2018; Trauma Informed Care Implementation Resource Setting, n.d.).

While TIC is evidence-based and seemingly the ideal, its practice depends on the individual healthcare facility, i.e., there are no professional regulations mandating it (Ayers et al., 2024). This means that the care a woman receives will depend on her accessibility (and relating social determinants of health), and that there will therefore inevitably be disparities. According to Ayers at al. (2024), a group made of international experts on birth trauma, there is a need to integrate trauma-informed respectful maternal care practices into international policy as well as to have sensitivity training for all HCPs.

Recommendations for future research

First, there is a long overdue need for more research, in general, on women's health. Despite significant advances in medicine, we still fundamentally misunderstand the nature and complexity of women's health (Jain & Bruzek, 2022). Globally, only 4% of healthcare research and delivery spending goes directly to women's health, half as much as what goes to male-prevalent diseases (even though we make up more than 50% of the population) (Haines & DaSilva). That being said, as has been discussed, there specifically needs to be more women-centered qualitative research, where instead of being reduced to statistics, their stories and voices are highlighted. In the words of Jain & Bruzek (2022): Without equal research, there cannot be equal care; without equal care, there cannot be equal outcomes.

In addition to doing more research in general on birth trauma, Salter et al. (2023) specifically identified the need the better understand how women's conceptualizations of birth trauma compare to and differ from that of HCPs. Their study, according to the authors, "Contributes new insight into maternity clinicians' conceptualization of patient trauma and how their descriptions of birth trauma overlap with mistreatment," and is the first to have looked at this. In having a better understanding of this, HCPs can purposefully align their actions with care that is, as defined by patients themselves, respectful and patient-centered, instead of being unintentionally part of the problem.

Lastly, from a health equity standpoint, I would have liked to see more research specifically on how different groups of women (e.g., by socioeconomic status, race and ethnicity, sexual orientation, etc.) experience birth trauma and (in)access to maternity care. The only examples of this I found were on race, specifically black women, in the United States. We know that in almost all settings, minority women have more difficulty accessing competent health services (Nair & Adetayo, 2019). They are also more likely to face stigma and discrimination by HCPs, making them less likely to seek care again (Hussein & Ferguson, 2019). Unfortunately, this means that minority women, in general, have poorer health outcomes than their counterparts (Nair & Adetayo, 2019).

Conclusion

Prior to starting this research, the need to better understand how women, as told by themselves, perceive healthcare practices, specifically the actions of HCPs, in relation to birth trauma, was identified as a current knowledge gap. What do women want and need during pregnancy, childbirth, and postpartum, and how can HCPs support these to foster a positive experience? On the other hand, how do HCPs, intentionally or not, contribute to a perceived negative experience, such as in the provision of birth trauma? This narrative review thus explored and synthesized raw data from 31 qualitative studies on women's experiences of a traumatic birth and their perceptions of the adequacy of healthcare practices in addressing their needs. For most women in the included studies, it was their HCP that was the negative part of their experience. What was anticipated to be a positive and fulfilling experience was instead made to be traumatic by the provision of birth trauma, possibly leading to the development of postpartum PTSD, a debilitating maternal mental health condition. For the provision of truly woman-centered care, a means to protect against birth trauma, dedicated space has to be given to hear from women about how they themselves want to be cared for. As the drivers of population growth and primary caregivers in many of our societies, mothers deserve much more than the mistreatment and abuse many are currently faced with, and it is our responsibility as public health professionals to advocate for meaningful change.

Highlighting the public health relevance

In summary, the public health relevance of this topic is as follows:

(1) Globally, an estimated 10% of pregnant women and 13% who just gave birth experience poor mental health (WHO, n.d. -b) Negative events during childbirth can possibly lead to the development of PTSD, referred to as postpartum PTSD (Perera et al., 2023). The negative effects of poor maternal mental health are many, for both mother and child, and we know the two to be inextricably linked.

(2) In their 2018 report, the WHO acknowledged, for the first time, women's experiences of maternity care as a public health issue (WHO, 2018)

(3) All women, as per the WHO (n.d. – a), have the right to be cared for by skilled health persons during pregnancy, childbirth, and postpartum. Still, the delivery of competent medical care is not

a means to an end. HCPs' professional and ethical responsibilities to treat patients with dignity and respect, therein protecting their fundamental human rights, are just as important in the provision of care. For the provision of truly woman-centered care, a means to protect against birth trauma, dedicated space has to be given to hear from women about how they themselves want to be cared for.

Declaration of artificial intelligence technologies

After writing a draft of my own original work, I used Grammarly, an AI writing assistance program, to check for spelling and grammar mistakes.

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Appendixes

Appendix A: All extracted supportive quotes

1.1 Interventions	**I was told "5 minutes or I get the forceps" by the doctor on call. I pushed so hard that I tore badly. (Beck & Watson, 2010)** **I said "I'd rather you'd turn it (induction of labour hormone drip) off." And she said, "But I turned it off," and I said, "No you haven't, I can see you haven't!" And she said, "Yes, I have!" And there's nothing I could do about it. (Brown et al., 2022)** What about me? … I'm not just an incubator like. (Bryne et al., 2017) Every baby's different, every mom is different, every body is different, you know? So they have to make allowances for that, but in hospital they don't. (Bryne et al., 2017) It's kind of like a production line and you just have to go down this line and do what you're told. (Bryne et al., 2017) They're the bad guys trying to force along something that we're made to do naturally, they shouldn't be forcing us to do it a certain amount of time. (Bryne et al., 2017) The midwife she was very um, very impatient… They shouted at you… They don't give you a chance to, to, to push the baby out, they, they, they just want everything to go quickly. (Chadwick et al., 2014) **They'll try anything they can to sway me the other way… (Toward a) more medicalised birth I guess. (Greenfield et al., 2019)** He's still in that mindframe that if a professional said that sort of thing, they're right, they know best, they're the experts. (Greenfield et al., 2019) He owes his son's life to doctors, whereas… In my head, they're kind of interfering with what has caused the problems that I had… Our experiences of childbirth are very different, um, and I was really scared

	that the choices that I make in this pregnancy would scare him. (Greenfield et al., 2019) It's just a body and they're fixing it. (Gregory & Maddern, 2023) **I found the comment, "Let's get this over and done with, I have a golf game to get to" traumatic. (Reed et al., 2017)** After an OB coming in and telling me that she would like me to deliver by 5pm because she wanted to go home, I just burst into tears. (Reed et al., 2017) **I begged not to have a c section, neither I nor my baby were in distress or danger, but because the doctor was ready to go home, he did a terrible section that resulted in almost a year of recovery. (Reed et al., 2017)** **Being bullied into interventions with such wording the following: "Do you want a dead baby?" (Reed et al., 2017)** I was basically told that if I didn't have a c-section on their timetable I would kill my baby, even though they couldn't tell me what exactly was "wrong" as to why I was not delivering vaginally… They broke me down gradually until they declared my baby was "in distress" (She wasn't… I could see the screens). (Reed et al., 2017) I felt violated, and angry that I should have to defend myself and my body while I was trying to push my baby out. (Reed et al., 2017) My pregnancy was amazing, but my daughter was in a breech position. I asked the hospital if I could still give birth naturally and they told me that it would be no problem. But it was all a lie, because when I arrived at hospital to give birth, they only gave me 7 h to dilate before taking me for a C-section for no reason, because we were both in perfect condition. Throughout the dilation period I had to put up with comments from midwives, some gynaecologists and other personnel criticizing and judging my decision to give birth to my daughter naturally. (Rodríguez-Almagro et al., 2019)

	Normal vaginal birth, not very respected. Unfortunately, my birth experience was like a lot of births: Unnecessary procedures and having to negotiate every little thing rather than focusing on my baby and giving birth. (Rodríguez-Almagro et al., 2019) The fact that they didn't want to "waste time," my daughter was born using a ventouse. (Rodríguez-Almagro et al., 2019) The fact I was not able to give birth naturally affected me emotionally. I think I will only get over it if I get pregnant again and manage to have a natural birth. (Rodríguez-Almagro et al., 2019) My childbirths were quite traumatic because I wanted them to be natural and they didn't fit in the birth canal. After many hours and being fully dilated they decided on a Caesarean. I feel like they robbed me of my childbirths. (Rodríguez-Almagro et al., 2019) **I did nothing by myself. Nothing… I did nothing in the natural way, nothing was allowed to progress spontaneously. Doctor did everything, nothing happened by itself. (Stankovic, 2017)** For no reason, they augmented my labor pains by medication so that I could give birth earlier. (Taghizadeh et al., 2021) They told me that, "If you don't cooperate, if you don't try, your baby will die and you will no longer hear the sound of his heart!" … It might be normal for them to say this, but it was very annoying for me, it was horrible, horrible. (Taghizadeh et al., 2021) **At no point was I or my son in danger. Then why all these forced interventions? (van der Pijl et al., 2020)** "I don't understand that you don't want this. You don't want the baby to die in your belly, do you?" After I refused a scalp electrode. (van der Pijl et al., 2020)
1.2 "Women are supposed to endure that"	I had great difficulty due to the pressure on my abdomen. The doctor puts his fist down so hard that I did not even breathe… That the midwives and

	doctor tried to get the head of the baby out of the vagina hurt me a lot. (Aktaş & Aydin, 2019) And they are cutting you. I thought that they were killing me, I felt like dying. (Aktaş & Aydin, 2019) She said, "Why are you yelling? Don't you know how it feels? This is your fourth birth. There was another woman who gave her first birth, but she did not yell." … I felt my self so bad and embarrassed. (Aktaş & Aydin, 2019) When you get to that point of, there's a certain pain threshold, I don't know like you're not even in your own body anymore like I'm not really here, it's like it's happening in a dream or something. (Bryne et al., 2017) "Women are supposed to endure that." (Mayra et al., 2022) **I mean what happened to pain is what the patient says it is. (Meaney et al., 2016)** I felt the midwife on duty was looking down her nose at me kind of going you've only had a Caesarean just get your ass out of bed. (Meaney et al., 2016) **The woman wanted to do an inspection to check my cervix. I was screaming because I was in so much pain and she's trying to check the cervix and I'm like it's hurting too much, you need to give me something, you can't just go down there. She literally was holding her hand inside me trying to get further up so she could feel it and I'm screaming at her, "This is hurting, you need to give me something!" (Murphy & Strong, 2018)** The process of the baby coming out with the Venteuse and the events that followed from that, being stitched up with no anesthetic then having placenta taken out (which my understanding is that this should not have happened in that order). (Murphy & Strong, 2018)

	A consultant came in and she was very blunt and said, “Take some Paracetamol and go home.” I was like, “Whoa, go home?” and she was like, “Yeah. Stay here for a little while but really there’s no point in you being here.” But they kept coming in and saying, “Are you ready to go now?” (Murphy & Strong, 2018) **At one point (the nurse) turned round and said to me, “You need to cope a lot better than this, you’ve got a lot more to come.” … She was shouting at me. (Murphy & Strong, 2018)** A different midwife walked back in, plonked him on me and said, “You decided to have this baby, you need to deal with him.” I was crying my eyes out and she offered me nothing, no support whatsoever. (Murphy & Strong, 2018). **I felt like I was being told I was silly for thinking I was in labour and that this awful pain was nothing to be worried about. My opinion was dismissed and ignored. (Reed et al., 2017)** She proceeded to dig out my uterus without any numbing medication. It was horrifying. (Reed et al., 2017) **(The) hospital staff did not listen to me, didn’t trust me to know my body (Reed et al., 2017)** **I had a C-section and they began cutting before the anaesthesia had taken effect (I told them that I could feel the wet cloth they rubbed over my belly, but they still began cutting) so I felt the pain of them cutting me and I could feel their hands opening my belly. (Rodríguez-Almagro et al., 2019)** They had to administer the epidural more than four times because my doctor had difficulty doing it. (Rodríguez-Almagro et al., 2019) It was a natural vaginal birth with no analgesia. It was very quick but very, very painful, the pain from the episiotomy was horrible, and even though they gave me a local anesthetic for the stitches, it hurt. (Rodríguez-Almagro et al., 2019)

	I actually thought that the only thing I can do to get out of this is die. (Thomson & Downe, 2008) Unbearable pain; I was panicking. Every request for an epidural was ignored. “Your body will never give you more pain than you can handle.” (van der Pijl et al., 2020) Lying on my back there was nothing I could to cope with the suddenly intense contractions – I wanted an epidural. “Madam, please stop whining.” (van der Pijl et al., 2020) At 08:15 I was being sutured. Every prick in my battered vagina, I felt. When I asked for pain relief, she said: “I could also leave it as it is, if you prefer.” I felt so small! (van der Pijl et al., 2020) I chose this hospital because I had known it could provide the service of painless childbirth. But when I was moved to the birth room, the doctor told me that the hospital had only one anesthetist who had the expertise of labor analgesia, and the very one was not available at the moment due to a business trip. I could not believe my ears when I heard it. The pain was so excruciating that I wanted to knock my head against the wall. Nobody had informed me that only one doctor could practice the technique in such a general hospital and that he was not on duty. (Zhang et al., 2020) Every pregnant woman had to endure the same pain to become a mother. You must bear severe pain on the body and mind throughout labor and birth. Such a saying may go well with others, but definitely not me… They all get me wrong, and nobody could understand my suffering. The birthing process was utterly physical and mental torture. (Zhang et al., 2020) **The doctor emphasized it is impossible for women to give birth with no pain over and over again. I was more disappointed when I heard that. Certainly, I did know childbirth came along with severe pain. I felt great pain already. Why did he still underscore the point? At least he should have given me some encouragement and confidence… I was**

	fragile and didn't hope to hear the negative words. (Zhang et al., 2020)
2.1 Lack of control and agency	They did not tell me what and why they were doing it. I felt as though I was a thing at that moment because there is no one informing you. The only thing that they are thinking is to remove the baby from there. (Aksu & Serçekuş, 2023) I closed my eyes when giving birth. I did not want to see. I did not want to see anything at that moment. I did not want to see the things there. (Aksu & Serçekuş, 2023) I need to bring a reverence to the process so I won't feel like a piece of meat lost in the system. (Beck & Watson, 2010) We (my partner and I) became assertive people, and no longer take it for granted. We no longer see a professional and think because they are a professional they're next to God. (Brown et al., 2022) This is my baby. This is my birth. This is my journey. Only I know how to look after myself. (Brown et al., 2022) **And as a society and like the sisterhood, we're all in good girl mode like, we're going along with it (intervention) even though I don't agree. (Buchanan et al., 2023)** You can feel a bit side-lined as a father, because there are all these experts, all these very, very clever people in a room. (Butterworth et al., 2023) **(Wife) was really like I really don't want this, it was that kind of helpless feeling, where I think she almost didn't have the courage or didn't know if she could say no I'm not having that, it was like oh my god I really don't want that, it was almost like the child and parent; the parents saying you will have that on the child say no I really don't want it, you know. (Butterworth et al., 2023)** 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 felt 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? (Bryne et al., 2017) Sort of feeling cut off was part of the trauma (Bryne et al., 2017) I think I had to push to discuss it with anyone and even when someone discusses the choices with you it's not really a discussion; it's more like this is how it happens. So I didn't really, like there wasn't much choice. (Bryne et al., 2017) I'm still upset by it and I feel kind of violated, that was wrong, that happened to me, it wasn't something that I was doing, it was something that happened to me, like I didn't get to take part in it, it was enforced on me or inflicted on me. (Bryne et al., 2017) **I had my eyes closed the whole time because I didn't want to register what was happening to me and I think the whole thing, I had resigned kind of like, do what you have to do, I was a very passive person in the whole thing, you just tell me what to do, I'm not engaging in this at all. (Bryne et al., 2017)** I was just being a problem to them questioning everything and that just did not sit with them at all. I just wasn't playing ball for them and it wasn't how they wanted it to go. (Bryne et al., 2017) 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 from me, if I hadn't felt empowered in the first place. (Bryne et al., 2017) (The midwife said) they (the obstetric team) assume you should go and give birth in that hospital, because you've seen the consultant there. Which was… I'm thinking well that's not true either because, I, I, I'm

	entitled to get a (second) medical opinion and could go elsewhere anyway. (Greenfield et al., 2019) And I just don't want to get in that state again… So I just think I need control over the situation. (Greenfield et al., 2019) You just gave to go with how it, goes along. (Greenfield et al., 2019) I need to be in control next time, because they took all the control away from me and left me very vulnerable and I need to have that control this time and my wishes respected in order for it to be a good experience. So that's why there's gonna be quite rigid birth plans. (Greenfield et al., 2019) The first time round I'd have done what I was told. I'd have just done what I was told and the impact of that is I'm saying do you know what, no. This, everything is my choice. It's my choice. It's my baby my birth. I don't want to do that, that's not going to happen this time. (Greenfield et al., 2019) I'd like more, control… I put a lot of trust in the team (last time)… And a few of them let me down… Making some distance a bit, this time. (Greenfield et al., 2019) The nurse in the clinic, kind of did a bit of a sneaky thing what, which was, we would like to do, erm, er, an Hba1C. And I know you're not keen, but, can we do it anyway? And I sort of went, *sign,* you know what? I just want to go home, just take my damn blood and do it. And of course, it all came back fine, thank god. But, I did feel pushed into that. (Greenfield et al., 2019) They were… asking my consent, but not really waiting for my consent, expecting that I would give it, and… Sort of asking for it while they were doing a procedure. (Gregory & Maddern, 2023) She (midwife) just did her thing, decided what to do and did it. It was shocking. I had no control. I did not consent. I had no power, no say in the

	matter. It felt as if somebody else controlled the birth and it sure wasn't me… There was no room for me. (Koster et al., 2020) **I had rolled onto an assembly line… I was ignored. They carried on. I was only a number, a body, just a womb… Not a human being at all… Not a woman having a baby. (Koster et al., 2020)** They were treating me like I'm a doll! Doing whatever with me without my permission. They did not care about me. (Mayra et al., 2022) Husband told me I did sign a consent form, I have no recollection of signing that consent form… I'd no sense of an understanding of what I was going through. (Meaney et al., 2016) That's what's so scary in a way – as long as you have control, you know what's happening, but when you lose control, you lose the ground beneath your feet and no longer have that foundation, sort of, and instinctively I had to focus on surviving. (Olsen et al., 2022) Told to stop pushing and… Being told what to do when my body was telling me differently. (Reed et al., 2017) **My daughter was breech… I was told that if I didn't consent to the cesarian before labor started then they would perform a cesarian without my consent under general anesthesia when I arrived. (Reed et al., 2017)** The gynaecologist ruptured my membranes without my permission, ignoring my requests and my agreement with the midwife. This caused a conflict between the two (midwife and gynaecologist). At no time did they give me any medical justification. (Rodríguez-Almagro et al., 2019) My birth was not respected at all. The midwife told me that I didn't know how to push, and it was my fault that the baby wasn't coming out. He tried to apply fundal pressure without explaining what he was doing. When I refused, he ignored me and tried to do it again. When I refused for the second time, he lost interest in me. It was the most brutal thing I have ever experienced. (Rodríguez-Almagro et al., 2019)

	The whole thing seemed like a showroom for groups of students, and I wasn't asked if I was OK with it. So it was not a great experience. (Rodríguez-Almagro et al., 2019) **A lot of students… came to examine me… I saw at least 15 people and they all examined me, it was very uncomfortable, I felt like I was being continually violated. (Rodríguez-Almagro et al., 2019)** And he (the doctor) gave me something for the pain… But I'm not sure… They just come and put something. I have no idea… And you are afraid of what happens next, what they will do to you next, what they will do to you next? (Stankovic, 2017) You see you don't have any control over anything that is happening, just forget about it. Literarily anything. Everything is just happening to you and the only thing you can do is to wait for it to end. (Stankovic, 2017) **You just have to lie down, shut up and spread your legs. (Stankovic, 2017)** I refused induction. But I see that I say this, "I had to" go in for monitoring and that makes me angry because it goes into my psyche, that "I had" to do these things, that I didn't have a choice. If I wanted to be treated respectfully I had certain things that I couldn't do. (Tafe et al., 2023) **They got my consent, but none of it was informed. It was all very, "Do it or your baby's going to die." And every person had a different opinion on what I should be doing and made it very well known that I should be doing only what they were saying. (Tafe et al., 2023)** The thing that I found not supportive was the constant intervening, the forceful behaviour and not accepting no as an answer, not respecting my rights or accepting me saying no, like my consent didn't matter. (Tafe et al., 2023)

	Do you know when you're in a traumatic situation and people say it was like having an out of body experience? That's what I felt like at the end, I felt like I was looking down at myself, like not myself, this was just happening to someone else. (Tafe et al., 2023) That is, they treated me in such a way that I felt I was of no value to them. It was as if I were a non-living thing. (Taghizadeh et al., 2021) I felt as if I was a little lamb, when I went to the delivery ward, it seemed to me that I had handed everything over to them so that they could make any decision they wanted. (Taghizadeh et al., 2013) **Just letting them take over… I just kept agreeing to things because I was thinking well they should know, they're the midwives, they're the doctors and blah blah blah. (Thomson & Downe, 2008)** **I had no option but to go with what was happening, because I didn't really know what was happening and I didn't have the strength to do anything about it. (Thomson & Downe, 2008)** Having a form shoved under my nose and being told to sign this… And I was like, well, I don't even know what this is… And I just scribbled my name. (Tsakmakis et al., 2023) She brought up the stretch and sweep (of the cervix). And I'd said, "Look, I've spoken to (the obstetrician) last week about it. I'm not, I don't really want to do it." And then she goes, "Well I need to check the cervix." And I said, "Well, you can check the cervix only," and she did the stretch and sweep then. And I nearly flopped off the table. It was the worst experience of my life. I felt violated… At the end, she just holds up bloody fingers and goes, "Thanks for letting me do that." … I will never ever let anyone touch me again after that. (Tsakmakis et al., 2023) I was hooked onto the IV. I was opposed to this, but it was hospital protocol. The nurse said casually that if I were to refuse, perhaps I could try for a different hospital. (van der Pijl et al., 2020)

	Even though I had emphatically prohibited the doctor from breaking my waters without permission, she did it anyway. (van der Pijl et al., 2020)
2.2 Poor communication	When the midwife was doing something on me, she should have explained it to me. This would have increased my confidence in her. (Aktaş & Aydin, 2019) I did not know who would be my midwife at birth. I went to the birth room and I learned it there. I preferred to have been informed before. The midwife never introduced herself and made an explanation. I did not know whom to trust. (Aktaş & Aydin, 2019) They had me in all kinds of positions… And about 20 students came in the room without my permission. (Beck, 2004a) **"We may have lost this bloody baby." The hospital staff discussed by baby's possible death in front of me and argued in front of me as though I wasn't there. (Beck, 2004a)** You know, they could have been more careful. They could have checked, they could have not left me with a student nurse who didn't know what to do. Someone should have been there to take my hand and say, "You know what? You're losing too much blood." And I should have been seen before I lost that amount of blood. (Brown et al., 2022) I mean you're not supposed to say, "I'm going to break them anyway." You're supposed to say, "Right, we need to sit up and have a discussion about this." … At that point I think I just felt completely violated. Because somebody had just done something without asking me. (Brown et al., 2022) They were all speaking over each other and (wife) is screaming, saying can someone please tell me what is going on?! (Butterworth et al., 2023) I mean, I imagine that from the professional point of view it was very well, because they must have done their job… But emotionally, zero. (Donate-Manzanares et al., 2021)

	Well, if I tell you the truth, I think they were doctors. I don't know, but I think that they were doctors. (Donate-Manzanares et al., 2021) They just lie. (Greenfield et al., 2019) What I really wanted… Talking to me like a human not just like a, get her in, get the baby out, get her going. (Gregory & Maddern, 2023) They don't talk to you they talk over you and about you. (Gregory & Maddern, 2023) They should have explained (about vaginal examination) to me. Then I would have though, okay they will do this to me and it is required. So I would have convinced myself to have courage. I would have prepared myself. (Mayra et al., 2022) 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. (Murphy & Strong, 2018) There was a bit of discussion going on. Then (the doctor) saying, "We need to take this baby." They took him… No, I didn't know why. I actually had never really been told what the deal was… He'd obviously been taken round to neonatal. Again, that wasn't explained, I didn't really understand why. (Murphy & Strong, 2018) They didn't explain anything to me, they were just taking her to neonatal to get her checked out and that was about one o'clock in the morning. I woke up at seven and she still wasn't there and I was panicking, where's my baby… But that whole time, I kept waking up in the night thinking where is she? And I wasn't being told anything. (Murphy & Strong, 2018) I actually felt a bit like I was being ignored when they wouldn't tell me anything about what was going on, I was just kind of told that a gynaecologist was going to try suction and forceps. Then more of them

	just kept appearing. It was like all information was being withheld to the point when I was so in need of reassurance. (Olsen et al., 2022) I was a looking point for students and anyone who hoped to witness a twin vaginal birth and a breech birth. (Reed et al., 2017) The doctor asked a student nurse, first day on the job, if she wanted to suture my episiotomy incision. (Reed et al., 2017) It was horrible because I didn't feel respected by the healthcare personnel that treated me, they came in and touched me and didn't even introduce themselves. (Rodríguez-Almagro et al., 2019) A lot of strangers in the operating room, and my partner wasn't there. I didn't know who was who, the gynaecologist, the front desk personnel, the anaesthetist. (Rodríguez-Almagro et al., 2019) Giving birth was the worst day of my life. The midwife was very caring, but the trainee was anything but. The plan was not complied with. The person that sewed me up (episiotomy) was very rude, he told me to be quiet and complained that women always say that he doesn't sew them up properly. (Rodríguez-Almagro et al., 2019) As soon as I got to the hospital after my waters broke, about five people touched me without looking me in the eye, they didn't even introduce themselves, I felt violated. (Rodríguez-Almagro et al., 2019) A lot of students and doctors came to examine me, it was very uncomfortable and happened during the early morning, morning and night shifts. (Rodríguez-Almagro et al., 2019) All the time during birth their policy is to be quiet, they don't tell women anything and they have it their own way. (Stankovic, 2017) **It is like that you know, they don't tell you anything and since you don't know and you are not informed, the only thing you can do is to guess and to try to reconstruct some kind of a story based on a few things you do know. (Stankovic, 2017)**

	And I really can't understand why they are not telling us anything? I don't understand why it is so difficult for them to say it aloud, when they know how much you care, they know everything, and they still do not do it. (Stankovic, 2017) The placenta didn't want to come out. Rushed to the operating theatre; lost liters of blood… Suddenly somebody whips the blankets of my naked body, pushes my legs aside. Next I hear panicked deliberation: "if the bleeding continues like this, she might die." Hello! I can hear you!!! (van der Pijl et al., 2020) On the way to the operating theatre for a Christmas eve caesarean section. My baby was in danger. The staff were talking in detail about their presents and plans. (van der Pijl et al., 2020) **After giving birth I was left alone with my feet up in stirrups. After two hours somebody said: "Oh, you're still here." (van der Pijl et al., 2020)** **The medical staff left me hanging. They changed shift at eight in the morning. The handover meeting took more than one hour. My call for them was met with ignorance. I felt like being abandoned. (Zhang et al., 2020)**
2.3 Use of force/violence	They put pressure on my abdomen, and I tore. I was in pain. When the tearing occurred, I wanted to leave there as soon as possible. My bleeding was also a lot. (Aksu & Serçekuş, 2023) With my legs held in the air by 2 strangers while a third mopped the blood between my legs I felt raped all over again. I wanted to die. I had failed as a woman. My privacy had been invaded again. I felt sick. (Beck & Watson, 2010) When he started pulling on the baby's head – and I can't believe the amount of force that was applied to pulling the child out… I was like, Jesus, he's going to pull the baby's head off in a minute! (Butterworth et al., 2023)

	It was very upsetting for me, especially the way they speak to the patients and scream at the patients when the patients are in labor. (Chadwick et al., 2014) I saw, while this one girl was in labour she was also laying in her own vomit and they left her just like that. (Chadwick et al., 2014) **I messed on the floor, with the blood because I was pushing she (nurse) was there in the office, now I was messing and she told me um, um, "Go and get a mop there and make your mess clean." (Chadwick et al., 2014)** **And then when I get inside (maternal obstetric unit) some of them (nurses) was not, was not nice with me, they said I must just go and change my, change my, my gowns and that and start to wash again because I have a stinky smell. (Chadwick et al., 2014)** **Two sisters (nurses) were very bad because they were abusing me and shouting at me like anything, I can't even tell you the things they said to me. (Mayra et al., 2022)** The doctor inserted her fingers inside me and I screamed very loudly. She said, "(Name) has no pain threshold, she can never have a normal birth!" (Mayra et al., 2022) She said, "Shut up! Why are you screaming so much? Behave! Look how you are screaming!" (Mayra et al., 2022) **They do hit women in that condition… A woman had come, she was screaming so much from the pain that she could not stay in her bed. The sister (nurse) gave her two tight slaps across her face. (Mayra et al., 2022)** Some guardians can not pay as much as the doctors ask for. The nurses withhold the baby saying, "We want this much or we won't give the baby." Many people don't have enough money to free the baby from them. Sometimes it turns into conflicts. (Mayra et al., 2022)

	No one told anything… They just blindfolded me. (Mayra et al., 2022) **I could feel that they moved my clothes up to chest… There were 8 men in the room! (Mayra et al., 2022)** **She said that it was that the uterus wasn't contracting properly and that is why I was losing blood and then she just started pounding on me. So more agony. I just didn't know exactly what she was doing. I read later on the internet that they can massage it to get it to contract but this wasn't massaging. (Meaney et al., 2016)** **Being pinned down by 4 midwives (forcing an unnecessary oxygen mask on me just so my screams of "no" were muffled) and my husband so the consultant could examine me against my will. (Reed et al., 2017)** **My cervix was manually dilated forcefully after pleading for the Dr. to stop. This caused me to re-experience a previous rape… Images and fears from my past sexual abuse/assaults became constant in my mind after birth. (Reed et al., 2017)** **The most terrifying part of whole ordeal was being held down by 4 people and my genitals being touched and probed repeatedly without permission and no say in the matter; this is called rape, except when you are giving birth. My daughter's birth was more sexually traumatising than the childhood abuse I'd experienced. (Reed et al., 2017)** During the contractions I couldn't help but cry out, and they basically treated me like an animal, shouting at me and telling me to be quiet, saying that if everyone cried out like I did they would go deaf. (Rodríguez-Almagro et al., 2019) The gynaecologist and nurse held me down without my consent to examine me. I felt a lot of pain and fear. (Rodríguez-Almagro et al., 2019)

	My son was born with congenital torticollis and two injuries to his head and cheek from the spatulas used by the gynaecologist. I had an episiotomy, but the spatulas tore the entire perineum and anal area as well as part of my thigh. If it happened to me now, I would report the gynaecologist, but at the time all I wanted to do was cry. (Rodríguez-Almagro et al., 2019) The gynaecologist was barbaric, I don't think a woman that has just given birth should be examined like that, inserting a hand that roughly, I felt violated. (Rodríguez-Almagro et al., 2019) He asked me to take my clothes off, for a breast exam followed by a pelvic exam. And that was my first experience of rape. Obviously, as you know, it's unnecessary for a 24 year old to have either of those exams. And so I was completely taken advantage of with that pelvic exam and that breast exam. (Tafe et al., 2023) She actually physically grabbed my right leg and rolled me over onto my back, forcing me to be on my back and putting my legs in the stirrups. And I just felt hopeless at that time and helpless. And like, I didn't have anyone there to advocate. (Tafe et al., 2023) During childbirth, they pressed my abdomen hard, forcing the baby to be born. After the delivery, I started bleeding profusely… I had a severe rupture, so I had a lot of sutures. (Taghizadeh et al., 2021) There was a woman next to me. They shouted at her. She was very agitated and terrified, the door was open and she ran away. (Taghizadeh et al., 2021) Don't feel I gave birth and had a baby on that day I just felt I went into a room and was just assaulted. (Thomson & Downe, 2008) I was involuntarily catheterized during birth. I yelled NO. According to the nurse, this is "how it is done." Two people were holding down my legs. (van der Pijl et al., 2020)

	It felt like rape, I can still feel the hand (inside me). (van der Pijl et al., 2020) She used full force on my abdomen… She was pushing so heavily… I experienced so much pain… I closed my eyes and thought: I am not going to survive. (van der Pijl et al., 2020) **After 15 minutes the placenta is still not here. The resident is leaning on his elbow, pushing his full bodyweight into my abdomen. I am crying. Then he pulls on the umbilical cord. He thinks he needs so much force that he has to put one foot on the bed for leverage. (van der Pijl et al., 2020)**
3.1 Birth preferences not respected	**My husband could not enter the birth room. "It is forbidden" said the midwife… I really wanted my husband to be with me… As it was my first birth, I felt scared and needed his support. So I felt a little desperate and lonely at birth. Do you know that only because of this you can experience your birth negatively? Your partner is very important. (Aktaş & Aydin, 2019)** They didn't even bother to read my notes. (Brown et al., 2022) I never felt like my obstetrician really cared one way or another. He just really wanted everyone to have a pulse at the end of the day and, you know, not be sued… I never felt like he actually had any idea what I wanted and how I wanted the birth to be. (Buchanan et al., 2023) I imagine the majority of those women, especially first time moms, go in and just meekly, yeah you're the midwife, you're the doctor, just tell me what to do… so for me to have other ideas kind of went against what they were used to. (Bryne et al., 2017) It was a so, so, an alright experience, just the fact that nobody was there with me – was for me very hard and it made me, it made me more scared than anything else because nobody was there with me. (Chadwick et al., 2014) **I need to be in control next time, because they took all the control away from me and left me very vulnerable and I need to have that**

	control this time and my wishes respected in order for it to be a good experience. So that's why there's gonna be quite rigid birth plans. (Greenfield et al., 2019) **I felt so sick, I still had to look after this little baby, my husband couldn't stay with me. (Gregory & Maddern, 2023)** All of a sudden I got this injection after the baby was born, nobody had told me or asked me, they just did it… Afterwards it turned out to be synthetic Oxytocin, something I did not want… It was in my birth plan… I wanted the placenta to be born naturally, do it myself. It was important to me. I was overruled… Shocking, unbelievable. (Koster et al., 2020) **I didn't want this, it was in my birth plan that I didn't want all of that… I let it happen… What else could I do? Protocols were thrown at me, so to speak. (Koster et al., 2020)** **I would have benefited from my husband's presence for sure… I wanted him in the room with me… In this condition, husband is needed more! (Mayra et al., 2022)** **I… felt like I wasn't allowed to be part of the things that were important to me, and it made me feel like I was watching myself in the room and was just an object that was going to deliver a baby… I felt like I was ignored and excluded from decisions made about my body. I felt I had lost myself. (Olsen et al., 2022)** It was a no-epidural birth but there was a lot of intervention, even though I was fully dilated when I arrived at hospital. I was given oxytocin, fundal pressure was applied, and they had their hands in me the whole time. (Rodríguez-Almagro et al., 2019) All this time they did endless vaginal examinations, another thing I asked them not to do unless really necessary. I felt violated and humiliated. (Rodríguez-Almagro et al., 2019)

	The father wasn't allowed to be present at the C-section. (Rodríguez-Almagro et al., 2019) I felt alone, without my daughters or my husband, who they didn't let in. I had to keep my own spirits up otherwise I would have been really upset. (Rodríguez-Almagro et al., 2019) **You say goodbye to your husband… And then, like one bag in your hand, like an orphan, you go away. (Stankovic, 2017)** I just wanted to be able to trust myself, trust my body and have a care provider that would be able to trust me as well and not be operating through fear. (Tafe et al., 2023) I might have fibbed a few times. Again, women shouldn't have to fib, but I'm willing to stoop that low in order to get the birth that I want and need. (Tafe et al., 2023) **I was not to have a plan because… You don't get to choose how birth goes. (Tsakmakis et al., 2023)** I wasn't involved with it (childbirth) because all my requests were met with a no. (Thomson & Downe, 2008) My birth plan said: Stop the vaginal examination when I say "stop." A vaginal examination is being performed. I say: "Stop." She does not stop. My husband says: "Hey! – she says stop!" She just carries on. (van der Pijl et al., 2020)
3.2 Negative/inadequate birth environment	**While the capacity of the room should be maximum 4 people… They were 6-7 people… I was influenced by the women who suffered at the delivery room. I sometimes cried and my psychology was affected very badly. (Aktaş & Aydin, 2019)** I was really embarrassed during the vaginal examination at birth. You feel embarrassed and different, because you have never done anything like this before. There are no clothes on you… Your whole body is naked. People feel embarrassed. (Aktaş & Aydin, 2019)

	The midwife came to examine the vaginal orifice of another pregnant woman in the room. She told me to turn my face to the opposite side as that woman might be embarrassed. (Aktaş & Aydin, 2019) **I was ashamed because there were many strangers and faces that I did not recognize, because it is your private region, and like it or not, it makes one ashamed for people you do not know to see you there. (Aksu & Serçekuş, 2023)** Felt betrayed by a system that is supposedly there to care for me. (Beck, 2004a) Meals should be given in the hospital. Bathroom should be clean, room should be clean, bed should be clean. (Mayra et al., 2022) There should be only one bed, surrounded by curtains on all sides. (Mayra et al., 2022) The room should be clean, no smells, the floor should be clean. The bed should be such that the head can be raised up. There should be proper light, ventilation, working air conditioner and running fan specially in hot weather. If television is there that would be better. There should be a bed for my family too in the same room. (Mayra et al., 2022) Everyone was shouting at me and saying to me this is what we're going to do. It felt like everybody else around me was not calm and they were panicking, which in turn made me panic. (Murphy & Strong, 2018) You're supposed to sort of put your trust in the hospital, as it's the only safety net you really have, but you don't actually have that. (Olsen et al., 2022) Mothers aren't given much consideration in hospitals. For us, it's a brutal experience and in some places human warmth is really lacking. (Rodríguez-Almagro et al., 2019)

	There were loads of people in the delivery room, going in and out all the time. Nobody introduced themselves or explained what they were doing. (Rodríguez-Almagro et al., 2019) We are in the ward, it is all in glass, and they are there in their room, but it's all in glass so they can see us. (Stankovic, 2017) **It's all in glass and you see all the tables across you. So you can see every woman giving birth and they see you. (Stankovic, 2017)** I felt like I was part of a cattle yard, like with these other women… Dehumanizing is how I would put it. (Tafe et al., 2023) The worst moment was the time when I entered the operation room. There was a concrete bed with tiled walls. They transferred me to a bed that felt like a concrete slab, like a place that the dead persons are placed to be washed, it was like a death house. (Taghizadeh et al., 2014) **I just shed tears of loneliness. I just looked at the door and the walls, felt blue and cried. Giving birth in such a place is damn horrible. (Taghizadeh et al., 2021)** That environment and they were all strangers and I could not tell them everything that I needed. I was very lonely! The feeling of loneliness is so terrible. (Taghizadeh et al., 2021) **Now, I really tell all the family and acquaintances not to go to the hospital for childbirth. Because they treat you the worst there. A hospital is like quarantine, it is like a prison, and women are treated like criminals. (Taghizadeh et al., 2021)** **As a mother, I prefer warm colors to be used in hospital wards, because it is very important for me, for example, that instead of metal furniture the furniture of the childbirth room be wooden to give warmth. The current environment is not good for the birth room. Dumb colors are everywhere. (Taheri et al., 2020)**

	It is awful that women do not have a private environment for labour, so the hospitals need to be rebuilt and everyone have their own room. I think nobody pays attention that the childbirth environment should be charming, cozy, and warm. (Taheri et al., 2020) **There were about nine people standing around me but I never felt so alone in my life. (van der Pijl et al., 2020)** **I felt horrible when witnessing the childbirth process of other women… When I saw they had a rough time, I felt more scared. (Zhang et al., 2020)**
3.3 More than a healthy baby	My husband did not support me at all. How I wanted to give birth and my feelings were not important at all. The only thing he thought was to succeed in getting a healthy baby. (Aksu & Serçekuş, 2023) I would have done *anything* to have this baby and did *everything*, even stuff I didn't want to. All I get told when dealing with the residual emotional effects is, "You should be happy with the outcome." (Beck, 2004a) **I was so devastated at people's lack of empathy. I told myself what a bad person I was for needing to talk. (Beck, 2004b)** **And so, in some ways, then the feelings of feeling traumatized and devastated and disappointed and upset in some way so invalid because I should just be happy that I was saved and that my baby's safe and You've got a healthy baby. So, stop complaining kind of feeling. (Buchanan, 2023)** **This is not acknowledged at all in the medical model, it's all about the baby and you're not nourished as a woman and a new mother which is a part of the birth experience, I don't think you can separate it. (Buchanan et al., 2023)** They keep saying that to me because he was born big and healthy, so they just keep 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. (Bryne et al., 2017) I have assumed that the important thing is that the baby was fine, that I was fine, and that's it. (Donate-Manzanares et al., 2021) I just got made to feel like (infant) was the priority and I was the afterthought… I was just another person clogging up their beds and they didn't have time for me. (Gregory & Maddern, 2023) **Yes, I had a healthy baby… But at what cost emotionally, personally? (Koster et al., 2020)** **She said, "What are you crying for?" Not an arm round me or anything… Because she said what are you crying for, I thought, "Oh my God, should I not be crying then?" (Murphy & Strong, 2018)** I needed a professional to be calm and say to me don't worry, this is what we're going to do or this is what you need to do to help us to get this baby out. (Murphy & Strong, 2018) If somebody professional had come along in the few hours after, maybe the next day after the birth, and said, "This is what's happened, I can see on your notes this is how the labor went. Are you ok, do you want to talk about what happened? And, "Let's look at you and the baby knowing what has happened, is this baby now ok? (Murphy & Strong, 2018) **They didn't think it was that unusual for the delivery to last that long or for me to lose so much blood… I really didn't need to hear that. I needed to hear that this was a difficult experience, so that only made it worse. (Olsen et al., 2022)** **Anyone reading a discharge summary would be like, oh, what an amazing birth on paper. But in terms of how I was made to feel, worse than a dog, I was treated so poorly. (Tafe et al., 2023)** I was like, do you have any idea what just happened? And they were like, "Yeah, but don't worry about that, (your baby's) really healthy, like you're

	really lucky. At least you've got, it's worth it because you've got a healthy baby. (Tsakmakis et al., 2023) **An obstetrician who I didn't know and had no involvement with the birth came to my bed… I said, like, I was hoping to have a bit of a debrief. And she said, "We tend to only do a formal debrief if the birth has been particularly traumatic… You know, a lot of blood loss, or the baby is really unwell, or the baby dies, or whatever. And so, in your case, your birth was actually very normal." So, she basically was like, "You shouldn't be feeling like that." And I suspect… She was doing her best to alleviate my concerns and to make me feel better. But… Now knowing a little bit more about trauma, I can say that telling someone what they went through wasn't traumatic is not how you help someone. (Tsakmakis et al., 2023)** Yes, I got offered a debrief several times, which I initially kept declining 'cause I didn't want to go back there at the start. I didn't want to see any of them. I didn't want to step foot in there. But then I read my discharge report, and saw that the information on there, there was information missing. So, I ended up organizing the debrief, because I wanted those things fixed up, at least. And the reason I avoided it for so long is because I sort of knew how it was going to go. That I would just sort of get excuses as to why it was the way it was. And that's exactly what happened. It just felt like they were reading off a script of things that they have to stay. (Tsakmakis et al., 2023) (A horrifying labour due to medical error) "Oh well, at least you've got two (children)" said the obstetrician. I was never allowed to be pregnant again. (van der Pijl et al., 2020)