

## ORIGINAL ARTICLES

# Women's experiences of perceived traumatic vaginal birth in Australian maternity settings

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## ABSTRACT

**Objective:** Before the beginning of medicalisation in Australia during the 1950s, childbirth was the sole domain of women. Contemporary birthing practices have posed a more medicalised technological environment on women resulting in both good and bad outcomes. In recent surveys, 45.5% of Australian women reported experiencing birth as traumatic; with nearly 20% experiencing postnatal depression. While there have been some studies on women's trauma experiencing a caesarean section, minimal research has been completed into perceived traumatic experiences related to normal vaginal births.

**Methods:** This study utilized a qualitative methodology to explore psychological and emotional impact of women's experiences with perceived traumatic normal births. The research used an in-depth semi-structured interview and analysed the data within the phenomenological paradigm. The data analysis revealed nine themes: *I was determined to birth naturally; Not telling me what they were doing; I just had to force her to be born; it was really horrific; I know that is just what the system is like... they're hospital midwives... they're medical; I didn't feel connected to them; She stood up for me; After the birth, just horrible; I deserve a better birth.*

**Results:** Although the rates are unclear, these findings highlight that some women suffer trauma from their experience of a normal vaginal birth. The perceived causes include: midwives not always being with women and supporting physiological childbirth; women not being fully informed; power asymmetries and hegemony inside the birthing room; and a fetocentric model of care that left women feeling disrespected, disempowered and objectified.

**Conclusions:** The findings indicate a need for midwives to truly be with women and provide continuity of care, as well as supporting the physiological process of childbirth, medical and midwifery professional education on trauma awareness following birth, a rethinking of antenatal education programs to include coping strategies and greater midwifery support in the hospital post-natal stay.

**Key Words:** Psychological trauma, Normal birth, Midwifery, Interviews, Perceived, Experiences

## 1. INTRODUCTION

Before the beginning of medicalisation of birth in Australia during the 1950s, childbirth was the sole domain of women.<sup>[1]</sup> Women birthed in their own homes, attended to by women skilled as lay midwives educated under apprenticeships by women who had previous experience.<sup>[1]</sup> Women

began to birth in hospital around the 19th century during a period in time where birthing in hospitals become a legitimate social event.<sup>[2]</sup> Before the complete medicalisation of birth in the early 1950s, birthing rooms were largely absent of medical equipment with equality in relationships between the labouring woman and the midwife, hence the distribu-

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tion of power was egalitarian with particular attention on the labouring woman.<sup>[3]</sup>

Contemporary birthing practises, however, posed a more medicalised technological environment whereby women's needs are often secondary to the medical environment and staff.<sup>[4]</sup> Commonly women lie supine, alone with unfamiliar people in an unfamiliar environment (cold, sterile, bright).<sup>[5]</sup> In addition, the prior skills of the birth attendants have been replaced by technological equipment (for example, use of hand held pinnards replaced by large mechanical fetal monitoring equipment or cardiotocographs).<sup>[4]</sup> It has been argued that such invasive approaches such as probes, sensors and intravenous cannula's indicate ill health of the labouring woman and her unborn baby.<sup>[6]</sup> This poses a threat to women's wellbeing, especially psychological.<sup>[6-8]</sup> As a result of the increased removal of human connection and touch, there have been reports of increased desensitisation, even disembodiment of midwives and obstetricians from the labouring woman, and an associated increase in birth trauma experiences in maternity care settings.<sup>[7,9,10]</sup>

Birth trauma has been defined as "when the individual mother, father, or other witness believes the mother's or her baby's life was in danger, or that a serious threat to the mother's or her baby's physical or emotional integrity existed".<sup>[11]</sup> Other concepts such as "helplessness", "horror", "terror", "fear", "barbaric", "intrusive", "horrific" and "threat" commonly appears in sociological medical literature describing women's emotional responses to birth trauma.<sup>[9,12-14]</sup> All definitions suggest negative long-term outcomes for mother and baby and an emphasis placed on perceptions of the mother.<sup>[14]</sup>

Currently one of the most commonly found causes referenced in psychology literature associated with post-traumatic stress disorder (PTSD) are mothers experiencing birth trauma. Specific obstetric experiences, and factors in the development of birth trauma include:

- Forceps birth, and caesareans.<sup>[7,15]</sup>
- Episiotomy, vaginal tear, vacuum birth, general anaesthetic, emergency caesarean, baby being placed in intensive care unit, medical complications for mother or infant, injuries to either mother or infant, premature birth, or baby being born with a medical illness or disability.<sup>[15]</sup>

The effects of this birth trauma can be profound. For instance, a meta-ethnographic review by Harris and Ayers,<sup>[16]</sup> revealed four main categories of emotion women experience associated with birth trauma. These include: (1) Feeling invisible or out of control; (2) Feeling trapped; (3) Being

treated inhumanely; and, (4) Reporting a rollercoaster of emotions.<sup>[16]</sup> These emotional categories lead the critical mind into the arena of human rights and, the questioning of when and how does obstetric intervention become abusive or violent.

Victoria has an average of 73,969 women birthing annually in major maternity settings.<sup>[17]</sup> In Victoria, 69.8 percent of women birth in public hospital settings.<sup>[18]</sup> Melbourne public maternity care settings include a range of options including private obstetric care, shared care between midwives and a woman's local GP, caseload midwifery or group midwifery practise where a woman is cared for by a midwife from a small team attached to a hospital, obstetric led care for high risk women, and family birth centre ([www.thewomens.org.au](http://www.thewomens.org.au)). It is estimated that of these women nearly 20 percent of birthing women experience post-natal depression (PND) (Peri-natal depression 2010). There is uncertainty as to how many of these cases of PND are caused by post-traumatic stress associated with birth trauma. It is estimated that birth trauma is experienced by approximately half of all birthing women in Victoria.<sup>[15,19]</sup> Birth trauma has been associated with negative experiences for women and this holds potentially long-term negative consequences for the new mother, her baby and family. The consequences of this trauma in turn impacts on the woman's community through loss of income, participation, fragmented relationships and withdrawal from community participation.<sup>[3,6,8,12,19]</sup> In addition, there is a reported increased demand on the economic and health workforces as birth traumatised women tend to increase their use of medical services.<sup>[15]</sup>

The current data on birth trauma and associated emotional responses have been reviewed with both causative psychological, physiological and emotional consequences. Predominantly these studies were quantitative and following caesarean section or instrumental births. There are no current studies on women's qualitative experiences of perceived birth trauma following normal vaginal births in an Australian context. Neither are there any current studies on how health service provision may either enable or inhibit women's experiences of perceived trauma. This study addresses this gap. The aim of the study was to discover women's experiences of, and uncover the social phenomena of perceived psychologically and emotionally trauma following a normal vaginal birth inside metropolitan public maternity hospitals in Australia. For the purposes of this research, the definition of "normal vaginal birth" includes an instrument free vaginal birth without the use of any pain relief or manual turning of the baby.

## 2. METHOD

In order to explore women's experiences of psychologically and emotionally traumatic birth, a qualitative approach using descriptive phenomenology was employed.<sup>[20]</sup> Qualitative research aims to explore and understand the meaning individuals or groups assign as a social or human problem.<sup>[20]</sup> Using a qualitative method is useful when little is known about a topic of phenomenon.<sup>[20]</sup> Women were recruited using convenience sampling through posters distributed to 48 Maternal and Child health centres in Victoria, and through the use of social media page. The poster specifically requested women who had experienced perceived trauma following a normal vaginal birth. Maternal and Child Health nurses provide ongoing care to women and their infants in the community following the postnatal period. This resulted in 7 first time mothers who had birthed in a Victorian public maternity hospital within the past five years and self-identified as having experienced psychological or emotional birth trauma following a normal vaginal birth being recruited. Despite having a normal vaginal birth, all of these women had an obstetrician in the birthing room at the time of the birth. Women were interviewed using a semi structured interview guide developed from the literature. The interviews were audio recorded and transcribed verbatim. Ethics approval was obtained from RMIT University human research ethics committee. Data analysis was undertaken using thematic analysis techniques.<sup>[20]</sup> In other words, meaning was coded thematically from the data, identifying and describing the ideas both explicit and implicit within the data to form themes and subthemes.<sup>[20]</sup>

## 3. RESULTS

The 7 women in this study ranged in ages from 25 to 35 plus years and all their children were aged between eight months and five years of age. Women came from household incomes ranging from \$24,000 p/a to \$75,000 p/a. These figures reflect all women birthing in Victoria.<sup>[18]</sup> All women were partnered at the time of birth. While all women experienced a normal vaginal birth, the women who participated in this study did have obstetricians present in the birthing room during the moments of birth.

The data analysis revealed nine themes. Quotes from the interviews are used to demonstrate the findings of the study. These are identified by the use of pseudonyms to protect the identity of the women. The themes identified from the data included: *I was determined to birth naturally; Not telling me what they were doing; I just had to force the baby to be born; I felt traumatised, it was really horrific; ... they're hospital midwives. ... they're medical; I didn't feel connected to them; She stood up for me; After the birth, just horrible / Your stuck*

*with the consequences; and I deserve a better birth.* Each of these will be discussed in detail with quotes from the women to support the analysis.

### 3.1 Theme 1: I was determined to birth naturally

All of the women who participated in this study aimed to have an intervention free normal natural/vaginal birth. Most women attended either the hospital run childbirth preparation classes or ones that were independently run. In addition, most of the women undertook independent pre reading to prepare themselves for the birth. For the women in the study they felt a normal vaginal birth was an ideal outcome and did as much preparation as possible to achieve this. In other words:

I wanted it to be as natural as possible. – Mary

The women however, were realistic about the fact that things may not always go as planned and felt prepared for any unexpected events that may impact on their experiences of a normal vaginal birth. As a result of gaining knowledge from attending the childbirth preparation classes and/or reading, the women commented that they felt prepared for their labour and birth. Such that they:

... wasn't feeling stressed about birth. – Sophie

Despite (or maybe as a consequence) of this preparation, women felt that they could not adapt accordingly to the changing situation. Furthermore, the women felt unprepared to make choices in the event of an adverse outcome during labour. For instance, Bianca's expressed how she felt when her strong desire for a natural birth impacted negatively on her capacity to change dynamically to her situation:

I went in there with a really kind of single mindedness of what I wanted to do and I wasn't going to let any, you know, male dominated patriarchal system force me into all that stuff. it was almost to my own detriment I guess, that I definitely stuck to my guns for a long time... I was crying because things weren't going the way I had hoped they would. – Bianca

### 3.2 Theme 2: Not telling me what they were doing

This theme explored how women perceived that at various times they were not provided with critical information which they perceived could have dramatically impacted how their birthing process went. There were a number of ways that this critical information was withheld. For instance, women expressed that midwives and obstetricians did not inform them about what was going on. This meant that women felt as though their choices were denied and taken away, best described as:

They were taking control of me and my body without my permission. – Hilda

This resulted in women not understanding what was happening to them based on a lack of information they received:

I just hadn't had the knowledge, no one said this is why this is happening. – Mary

Woman commented that what they wanted was to have respectful communication between themselves and midwives and obstetricians. Instead the women felt they were not listened to and their questions were left unanswered:

I felt generally like I was uninformed. Not because I didn't ask questions but because they chose what they wanted to tell me... I felt like it wasn't ok for me to ask questions. – Charlotte

In regard to informed consent, women responded almost unanimously that they did not feel informed about procedures, risks, or options, nor asked their consent for certain procedures to be done. Some women also experienced these procedures or interventions being done to them without anyone telling them what was happening before hand at all:

The midwife or doctor didn't explain procedures or ask for consent... that didn't happen. – Charlotte

There was also a shared feeling among the women of having midwives and obstetricians act in an authoritarian manner toward them:

They (midwives and obstetricians) weren't that keen to give me a lot of information. The doctor was very, because I said so, kind of (sic). Because I said that's what's best, you know. – Charlotte

This authoritarianism had developed into fear, anxiety and panic for some of the women which lead into further feelings of trauma and violation:

So I was really flat, my legs were up and I was really far back so I couldn't see what they were doing and I was thinking "what the hell are they doing?" I was so scared, I think I was frozen... I couldn't communicate with anyone and no one was communicating with me... it was really horrible. – Alex

Women also felt midwives and obstetricians knew information but kept it from them, withholding important physiological information regarding their babies and their bodies. If women had known, this could have potentially changed the course of their birthing experience and prevented a traumatic birth:

No one had mentioned that he (baby) was posterior. When I got my notes it said that, on her (midwife) initial consultation straightaway she said "baby posterior", she'd circled baby posterior, but she hadn't told me that. – Alex

### 3.3 Theme 3: I just had to force the baby to be born

Each of the women reflected that they felt pressured to have their babies quickly. This was either for the purpose of the midwives and obstetricians who women felt were rushed, or for their own desire to have the experience over as quickly as possible in order to end the trauma:

I just had to like force her to be born as soon as possible to make them all stop. – Hilda

Women felt staff were rushing, pressured and unavailable to support them. This was defying the natural processes of labour and birth, forcing women to feel out of control and not able to push their bodies beyond their physical limitations:

My impression of her [the midwife] was she was extremely rushed, trying to get somewhere... I thought she must have been ready to go home, we just felt she was in a big hurry. – Alex

Further to this sense of urgency to birth, women perceived a fetocentric model of care, whereby each woman felt they were less important, even invisible to midwives and obstetricians in comparison to their baby:

I felt like Poppy was important and I was just a piece of meat, they were going to get the baby out one way or the other. – Alex

Added to this, women felt their voices were unheard and were simply a vessel for which to get the baby out of. In other words:

So it wasn't really about me anymore. – Bianca

Along with this sense of urgency, women also felt they were being coerced into procedures or drugs that they did not necessarily want:

The midwife came in and she was like – they kept offering me drugs every five minutes. – Sophie

The use of fear to persuade women to consent to procedures was also found throughout the interviews. Women experienced midwives and obstetricians using authoritarian language and attitudes that placed women as victims, coercing them into consenting to interventions based on the premise of the safety of their unborn child:

So she (doctor) threw me the – you know you’re going to put your baby at risk card, so we agreed to an induction. – Charlotte

### 3.4 Theme 4: I felt... traumatised, it was really horrific

This section explores how women felt deeply traumatised by their birthing experiences. These feelings sent women into survival strategies such as disembodiment or disassociation. On reflection and the retelling of their birth stories, women often became distressed in sharing this information with the researcher, despite the event being some time previously. Their perceptions and recall of their birthing experiences ranged from wishing they would die to feeling as though they were violently assaulted. Each woman expressed a disturbing degree of trauma and violence during labour, and each woman perceived this trauma to be partially due to the emotional abandonment of the midwives and obstetricians present at their labours:

I felt abandoned and traumatised... it was horrific. It was the absolute worst, the singular worst experience of my life... I’ve always explained it like I felt like I’d been gang raped, I felt like a truck had been driven through my vagina... no one cared. – Mary

Terror, fear, and feeling tortured were also commonly heard terms throughout the interviews. Women felt that they were nullified as people and so heavily traumatized they were completely lost of all sense of humanness:

I felt like I was butchered... tortured for a fair amount of it. – Alex

For some women they were in such shock, they let go completely of their birth plans and ideas. This traumatic experience had, therefore, pushed them past their limitations:

By the end of it I didn’t really care about the baby. I was like whatever just grab a leg and rip it out, don’t care... I was so traumatised I just didn’t really care. – Bianca

Women throughout the interviews expressed a shared feeling of being meaningless and that their bodies were treated with

very little respect. The degree of torment and trauma varied, however most women had an experience of feeling they were treated in a manner that was unexpected and abusive:

I was screaming like I was being murdered and I didn’t feel like anyone was aware of what was happening to me and I like started to black out every now and then, no one was communicating with me, I felt like I was abandoned, no one was caring for me... – Alex

For a few of the women they had reached a point where death was a preference over enduring any more of the trauma of birth. The women felt so completely out of control and in such terror, pain and horror, they either believed death was imminent or they wished it upon themselves with conviction that it would be a better experience than to continue birthing:

I got the point where I thought “if I die now that’s good”. – Mary

The effects of traumatic childbirth were not only exclusively felt by the woman giving birth. This extended to the woman’s entire family and support team/network, who were also affected by the impact of birth and any associated trauma. Partners, birth support people and even staff were reported as showing signs of trauma throughout the interviews. This resulted in them being rendered incapable of supporting them, therefore furthering their feelings of abandonment:

Her husband was freaking out and so like, my mother went, apparently she went and had a big cry in the waiting room. – Bianca

### 3.5 Theme 5: ...they’re hospital midwives...they’re medical

Throughout the interviews women expressed how the midwives they were working with were radically different to how they had perceived midwives to be. Women felt midwives were more attuned to following protocol and policy rather than working with them in a partnership. Furthermore, it also appeared that the midwives were lacking in midwifery skills, confidence and authority inside the hospital. This left women disheartened and somewhat complacent about their treatment by these midwives, almost excusing them:

I know that is just what the system is like... they’re hospital midwives... they’re medical, they don’t make the decisions themselves they just look to the Dr. – Sonia

Women also often felt let down and unsupported by midwives, not listened to, dismissed and ignored. The extent of this feeling is illustrated in the following:

I was asking for help and my body just took over, I couldn't control me screaming or not screaming it wasn't a choice. I had a midwife come in and tell me basically I was wasting energy which is completely incorrect... that's not the support you need in that moment. – Alex

It was clear from the data that midwives were not applying education they receive in normal physiological birth, trusting in women's capacity to birth and managing a labour for a normal healthy mother and baby. Using movement, positions and non-pharmaceutical pain relief options were common expectations women had that their midwives would be experts in. Women also expected that their midwives would keep them informed of what was happening during labour with their progress and the health of their babies. This expectation was often unmet, creating distrust and feelings of betrayal for women toward their midwives:

Nobody was kind of saying you know we're kind of looking at it from a physiological kind of way, let's try and do some massage or what about we do this... all of that would have been helpful. Either the midwife didn't know or didn't say, she didn't seem to have any of the skills to support a natural birth. – Bianca

Some of the women perceived a power hierarchy between midwives and obstetricians, feeling the midwives were not capable of supporting them or advocating for them as a result. This ultimately led to a huge fracture in the relationship between women and their midwives and a sense of power asymmetry that confronted their ideas about hospital intentions and how capable they were in supporting this mother:

I felt as though they (midwives) had to stand back when the obstetricians entered the room... it felt like they couldn't say anything... I didn't always trust them, that they would stand up for me... or stand up for what they felt was right or what they felt that I thought was right to the doctors... – Charlotte

Many of the women commented that they experienced midwives and obstetricians speaking negatively toward them or using language that disempowered them leaving them feeling vulnerable and powerless. In addition, women experienced midwives and obstetricians raising their voices and yelling at them if they did not passively agree to their requests:

I was told that I needed to be quiet by a senior midwife, she just kinda bowled in pushed my

partner out of the way and got in my face, just turned down the gas, took it off me and said "this is too high" and told me I was wasting my energy, I did not feel safe at all. – Alex

Women also knew inherently the type of support they did need from midwives but each felt they did not receive it:

I felt like if I had more actual support, not just somebody standing on the other side of the bed yelling out something to me, but somebody actually coming in and being part of it and working that through with me, that would have been really, really helpful. – Bianca

### 3.6 Theme 6: I didn't feel connected to them

Women emphasised how the midwife caring for them was unknown to them until they met them during labour. For a number of reasons, including them not knowing the individual midwife, most women felt disconnected to their midwives:

Straight away there was no rapport, there was no connection... there was no trust... I guess because I'd never met her before and she just wasn't particularly my sort of person... it wasn't even a professional relationship. There was no courtesy or respect. – Mary

Fundamentally, the role of the midwife is to work with women to support them in feeling empowered and capable during their labour. Women most commonly did not feel any support and referenced feeling isolated, alone and unsupported:

I felt very alone. With all the people in the room it didn't feel like they were helping me at all, and I didn't expect them to be able to take it away or to help me but it felt like if they weren't there it wouldn't have made a difference. – Bianca

Power dynamics and distorted asymmetries were evident throughout the interviews with women expressing how they felt their midwives were in control of the women's experiences and their bodies. Women felt the birth was often more about the midwife in control rather than the woman herself:

She held all the power and I was in such, you know at my most vulnerable... I had been totally open, totally laid bare and laid raw, and she hadn't done anything to help me. – Mary

While women had initially expected to feel safe with their midwives, but knew they would feel disconnected to the obstetricians:

I had in my mind a wariness of Doctors. I wasn't really interested in anything she had to say... the Dr. she was the evil one who's going to try to have interventions that were going to spiral out of control, it was like a giant medical conspiracy.  
– Bianca

### 3.7 Theme 7: She stood up for me

In contrast, two women reported feeling connected, and supported by their midwives. This enabled these women to feel safe, supported, and trusting in the options their midwives were advising them of:

The midwives generally made me feel supported and calm and confident in my abilities... I had 4 different changes of midwives... but they were all lovely and really supportive She stood up for me. – Charlotte

The importance of human touch, connection and empathy shown by staff in the birthing suite had a powerful and positive effect on these two women:

I'll always remember she stroked my arm and that was the first time anyone had shown me any comfort. And I remember, and she said "You're okay", and I remember thinking "Why are you the first person to have done this? It's nearly over and you're the first person to have shown any compassion". – Mary

Simple acts of physicality, movement and gentle reassuring techniques left a positive imprint on the relationship between these mothers and their midwives:

The midwife was really good. She didn't necessarily do much, but she would come and squat down to my level next to me. So she was right down on the same level and she wasn't kind of like a voice coming from outside, she'd almost come into my zone and then touch base with me so I could be aware she was there. I really appreciated that. – Bianca

### 3.8 Theme 8: After the birth, just horrible

The expectation that birth trauma includes only birth itself has been misleading. From these interviews women reported post birth to also be a time of torment and trauma. The implications of trauma varied between women but commonly included the results of continuing intervention and physical limitations due to these:

That first night I couldn't get up because of my legs being still numb and I had a catheter in...

it felt like for the first 12 hours I had to keep asking the staff to pass me my baby... I felt quite disconnected. . . I didn't change her first nappy, I didn't put her first clothes on... and the midwife who was working that night didn't offer. I could have done those things... it wasn't until sometime after that I realised I'd missed out on those really big first type things. – Charlotte

Furthermore, women were left feeling traumatised and shocked post birth. Their birth not only did not go as planned, it left them feeling deeply traumatised and impacted on their daily lives. Many of the women recall not remembering their babies during this time, how they functioned daily or how they felt about their births:

I was so bewildered by what had happened, I was very confused... the first two months I don't remember a lot of it. – Alex

Birth trauma affected women differently, however each woman felt a deep impact that affected her bond with her baby, her relationship with her partner and most importantly her sense of self. The experience of the trauma affected women daily in many ways, strong feelings of anger, regret, confusion and devastation were predominant for the women in this study:

I was having flashbacks I was constantly reliving the birth... I just couldn't let it all go. . . I wasn't sleeping, I was angry 80% of the time. – Mary

For some of the women, when reflecting on the birth in the postnatal period, even though they had felt disempowered during labour and unable to make choices, they blamed themselves for the adverse outcomes of birth. Women felt they were responsible for any events and this spiraled into regret and anger:

Angry, disappointed, let down, frustrated with myself that I didn't prepare better, doing more research, yeah but mostly I know that I was let down by a medical system and that's not my fault. – Sonia

The longer term impacts of this kind of traumatic birth is evident throughout the interviews. It can be clearly seen the devastating effects on women postnatally and how these experiences also affected their children and partners. Women were left with memories that meant birth equated to deep trauma, fear, pain and suffering:

It (birth) was horrific. It was the absolute worst, the singular, like worst, experience of my life. And ill carry that forever, even though I've dealt with it, that will always be his birth. – Mary

### 3.9 Theme 9: I deserve a better birth

The devastating impact of trauma could be easily seen in each woman's response to their future family plans. Women's future plans varied from wanting a private obstetrician to enable the woman to feel completely in control of her birth with a planned caesarean. One of the reasons for choosing an obstetrician to care for them was because this was the only way they could have:

Continuity of care... my doctor right through the pregnancy. – Sophie

Another mother felt she was so traumatised and let down by the medical system she will never have another child. The majority of the women stated they would go on to have a homebirth with a private practicing midwife with whom they could build a relationship with based on respect, communication and care. In other words, they wanted a trusting professional relationship where the midwife would become part of the family for the course of her pregnancy, birth and postnatal period. The emphasis for this choice was placed on the type of relationship they wanted with their midwives in the future, a caring and supportive team for her to give birth in an environment where the women felt safe, that is at home. Each woman felt the cost was irrelevant in the purpose of creating safety and trust with their midwives. Although none felt they could afford it financially, they all stated it was not optional to go through the public system in the future and would do whatever it took to pay for midwives and have the birth they want:

A midwife that cared for me throughout my pregnancy and birth and postnatally as well. – Charlotte

Such was the desire for support for these women, there was also mention of:

I would definitely be saving up for a doula and if it was low risk birth again I would probably stay at home. – Hilda

Women participated in various healing modalities to help them deal with the trauma following their birthing experiences. This included various types of counselling, psychology, psychiatry and other healing modalities to come to terms with their birthing experiences. Some of the women went

on to develop complex post-traumatic stress disorder requiring long term systemic support while others went on to feel they had emotionally healed from this experience but would forever remember it as a life changing trauma.

## 4. DISCUSSION

Women in this study prepared themselves for their desired natural birth by doing a lot of pre reading and attending hospital and independently run childbirth preparation classes. Despite this preparation, women felt they were not able to adapt to change and were unprepared to make choices. Past research and current knowledge indicates that women who had access to wider ranges of knowledge can negotiate, contest and resist medical control reducing the likelihood of trauma perceptions.<sup>[21,22]</sup> The findings from this research, however, indicate that access to knowledge did not support these women in negotiating, contesting or resisting medical control. Women reported being overwhelmed and lost, under prepared and under resourced for anything outside of "normal", "natural" childbirth. There have been a number of studies that have identified that childbirth preparation classes do not adequately prepare women for childbirth, including effect on pain relief or childbirth outcomes.<sup>[23–26]</sup> Despite this evidence and suggestions for improving, this appears to still be an issue for the women in this research.

Women in this research commented that they often felt let down by the maternity services to have a natural birth and be supported once any slight variation interfered with a normal physiological labour. In addition, midwives were not supporting women to work with their bodies for optimal fetal positioning<sup>[27]</sup> or offered non-pharmacological pain relieving options.<sup>[28]</sup> Since the early 1960s in Australia and UK, consumer organisations, women's groups and health professionals were concerned that maternity services neglected important emotional and social aspects of childbirth.<sup>[29–31]</sup> Women wanted change in a number of areas. That is, more personalised care and support from the midwife, experience birth as natural as possible and hospitals to support them to do this. There was a call from childbirth advocacy groups for the acknowledgement of the childbearing experience as a normal event.<sup>[32]</sup> This resulted in a number of maternity service inquiries at both jurisdiction<sup>[33–35]</sup> and national levels in Australia.<sup>[36,37]</sup> These inquiries provided an opportunity to evaluate existing maternity services and make recommendations for improvement in the areas of women centred care and physiological childbirth.<sup>[31]</sup> However, the findings from this research indicated that once again these changes have not been fully implemented into clinical practice.

Furthermore, women felt that midwives were not skilled in supporting women to have a natural normal birth and were



more interested in ensuring they practiced under the authority of obstetricians and hospital policy. One of the reasons that this may have been the case was that the women in this study commented that they had obstetricians in the room. This potentially placed a medicalised model of care on the women's labours, more so than a typical vaginal birth, simply due to the presence of one or more obstetrician in the birthing room. It would appear from this study that midwives continue to prefer a traditional mentality and shielded themselves behind obstetricians.<sup>[31]</sup> This choice often resulted from midwives lack of confidence that resulted from previous professional conflicts had with obstetricians (Cochrane, 1995). A further issue identified by Waldenstrom<sup>[38]</sup> is that midwives are too dependent on obstetricians for managing childbirth care, even when the process was normal. Midwives' perceptions of childbirth could be distorted when faced with obstetric catastrophe.<sup>[39]</sup> The midwife then seeks consolidation in the hospital safety net and their role as an obstetric handmaiden.<sup>[31]</sup> For women in this research it would appear that midwives were not acting in the true sense of being with women and working against women rather than with them. Midwives instead need to therefore be truly with women and support the women through physiological childbirth, including keeping her informed.

In addition, it is clear that healthcare professionals have over medicalised birth with an overtly medical model of care in partnership with a conceptualised version of the physiology of childbirth that requires medical involvement.<sup>[10]</sup> This therefore creates a hegemonic authoritarian attitude that can only be managed by skills that involve medical management.<sup>[10]</sup> This was instead of the traditional midwifery skills of working with a woman to maximise physiological childbirth. This is supported by the literature which indicates how contemporary birthing practices have become more medicalised and fetocentric.<sup>[6]</sup> Furthermore, that this more medicalised environment and clinical practices do in fact increase a woman's risk of birth trauma perceptions and related post-traumatic stress.<sup>[6-8]</sup> Women reported that at some stage during their labour that they had no power, control of autonomy and that they had no choice other than to 'trust' the staff making the decisions for them.

There already exists a plethora of evidence that indicates that midwives and obstetricians do not seek informed consent for procedures during childbirth while ignoring women's opinions or requests and subjecting women to authoritarian decision making about her body or baby.<sup>[4,6,7,10,16,40,41]</sup> There is evidence indicating that women who experience caesareans and other emergencies in childbirth are often not treated as individuals, are ignored and subject to authoritarian decision making and subject to manipulation and coercion

by midwives and obstetricians.<sup>[6,40]</sup> This then contributes significantly to perceptions of birth trauma and resultant post-traumatic stress disorder.<sup>[7,9,12,16,19,40]</sup> It is almost expected that during an emergency midwives and obstetricians may need to focus on the task at hand more than communication with the women.<sup>[28]</sup> These findings indicate that in fact women who are having normal vaginal births are still having information withheld from them that impact on their perceptions of birth as negative and traumatic. Healthcare professionals were acting as an authority over women that rendered them voiceless, powerless and nullified. This is supported by current evidence indicating that midwives and obstetricians often feel entitled to perform in this manner with a "we know what is best" attitude.<sup>[12,13]</sup> Such an attitude furthers the mistrust and can lead to heightened feelings of trauma due to lack of rapport and support the women have with healthcare professionals. Women throughout this research also reported varying degrees of abuse by health professionals. This supports existing knowledge of health professionals acting in an abusive manner towards women leading to fractured relationships.<sup>[7,10,16]</sup> Broken relationships between women and healthcare professionals encompass a lack of trust as a result of the abuse of staff and power roles over women.<sup>[16,39]</sup>

## 5. CONCLUSION

Current research demonstrates the impact of birth trauma for women who have had a caesarean or instrumental birth but does not include women who have had a normal vaginal birth.<sup>[42]</sup> The perceptions that birth trauma is only linked to obstetric interventions or complications is therefore disproved by these results. It is important, therefore, to acknowledge that a woman who has had a normal vaginal birth may perceive this as traumatic. Emotional and psychological birth trauma perceptions are not indicative of a physically traumatic birth but rather it can occur to any women under any level of stress. All women regardless of her birthing experience, must be treated with the care needed to prevent this type of birth trauma from happening through continuity of midwifery care. Informing midwives and obstetricians regarding the findings from this research may assist further in supporting women. Rethinking how antenatal education is provided may also assist women with coping strategies to help them navigate through childbirth and prevent perceived birth trauma.

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## CONFLICTS OF INTEREST DISCLOSURE

The authors declare no conflicts of interest.

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