Integrative Review: Women’s perceived birth trauma, healthcare provider actions and implications for women’s health

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Abstract

Despite the best of intentions of healthcare providers, childbirth may not occur the way that a mother wishes, resulting in psychological birth trauma. Although risks for psychological birth trauma related to characteristics of the mother and type of delivery are acknowledged, the culture surrounding labour and delivery is an important consideration. It is imperative that labour and delivery providers reflect on their own practices and how they contribute, both positively or negatively, to women’s birth experience. The purpose for this research was to explore the relationship between healthcare provider behaviours and women’s perceived birthing experiences. An integrative review methodology was utilized. A cornerstone article was identified and using the search engine features “cited by” and “similar/related”, two authors independently conducted identical search strategies resulting in 17 relevant titles. The titles were discussed to determine relevance to the review. The authors then independently critically appraised each article to establish a final of nine articles. The findings suggest that women’s perceived psychological birth trauma resides on a spectrum and that healthcare providers are the guardians of women’s perceived birth experiences. It remains unknown if healthcare provider actions are the single contributor to women’s perceived birth trauma. Future research is warranted to explore psychological birth trauma as it continues to negatively impact the lives of women and their families worldwide.

Keywords: Birth experiences, Birth Trauma, Healthcare providers, Integrative Review, Nurses

Introduction

Birth trauma, although not a widely understood topic, is described by one author as an event in labour and delivery that results in actual or threatened injury, or death to the mother, or her infant (Beck, 2004). Emergency events in labour and delivery (use of vacuum, forceps and emergency caesarean section) have been found to be associated not only with physical injury, but also psychological issues including post-traumatic stress disorder, symptoms of psychological trauma, and postpartum depression (Beck, 2004; Gamble & Creedy, 2005; Ayers, 2007 in Elmir et al. 2010; Zimmerman, 2013). For the purpose of this paper, psychological birth trauma is recognized as an event or occurrence during labour and childbirth that causes the mother to experience psychological injury and this event may or may not be associated with a single or
multiple events and/or result in physical injury.

There is a discrepancy between the woman’s perspective of giving birth and that of healthcare providers. Women may perceive birth as traumatic while it was considered routine by the healthcare practitioners present (Beck, 2004). Healthcare providers involved in labour and delivery include Registered Nurses, Midwives and Obstetricians. There is a gap in the literature related to healthcare providers’ actions related to women’s perceived birthing experiences.

The purpose of this study was to conduct an integrative review to answer the following question: what is known about the relationship between healthcare provider actions and women’s perceived psychological birth trauma?

Background & Purpose

According to Wu, Viswanathan and Ivy (2012) childbirth is a complex and dynamic process where the potential for new factors to manifest are possible at each phase in its development. It is important for healthcare providers involved in labour and delivery, to account for mother, fetal, family and system characteristics during childbirth, and to understand that many different events can change the progression and/or mode of delivery to facilitate the best outcomes for mother and baby (Wu et al., 2012). Despite the best of intentions of healthcare providers, childbirth may not occur the way that a mother wishes and may result in psychological birth trauma. Beck (2004) states that birth trauma lives in the eye of the beholder and many women who perceived their birthing experience as traumatic, were labeled as routine by the practitioners present.

Risk factors for psychological birth trauma are known. For example, emergency events in labour and delivery such as use of vacuum delivery, forceps delivery and emergency caesarean section have been found to be associated with post-traumatic stress disorder (Beck, 2004; Zimmerman, 2013), symptoms of psychological trauma and postpartum depression (Zimmerman, 2013). Pre-existing conditions or characteristics, both mental and physical, can predispose a mother to experience a traumatic birth. For example, a history of sexual abuse, a previous traumatic birth, and existing depression are risk factors connected to a traumatic birth (Zimmerman, 2013).

Additionally, advanced maternal age has also been identified as a risk factor for women who are more likely to experience emergency intervention during labour and delivery (Read et al., 1994; Roberts et al., 2002; Shamsa et al., 2013; Essex et al., 2013; Herstad et al., 2014).

Although risks for psychological birth trauma related to characteristics of the mother and type of delivery are acknowledged, the culture surrounding labour and delivery is an important consideration. In the past century, there has been an evolution of the birthing experience from a significant life event that occurred at home attended by midwives, family or friends to a medically managed inpatient stay at a hospital which has become a highly technological environment (Sherrod, 2017). This shift, particularly in North America, has resulted in a system that does not support mothering, education or empowering women’s strengths (Rothman, 1986). The result is that the labouring woman’s “...expectations and emotional needs are secondary, and the birth experience is overly standardized, task oriented,
needlessly aggressive, and physician and hospital controlled” (Sherrod 2017, p. 628). Healthcare providers who were educated and practice in this culture, may not have insight into its potential negative impact on women’s birthing experience.

Healthcare providers may not realize the long-term impact of their practices, but women are starting to raise their voices to highlight concerns about their childbirth experiences. The Reproductive Justice Story (2018), now known as the Obstetric Justice Story, is an example of an organized, women-centered approach to address ‘mistreatment and abuse’ (para 1) in the province of Ontario, Canada. Women are encouraged to blog their stories onto the website and the organization is planning for a province-wide survey about birth trauma. As women work to highlight the issues of the psychological impact of their birthing experiences and to demand changes to the health care system, it is imperative that labour and delivery providers reflect on their own practices and how they contribute, both positively or negatively, to women’s birth experience.

The Review Aim

The purpose of the integrative review was to explore the impact of healthcare provider behaviours on women’s birthing experiences.

Design

An integrative review allowed for articles with differing research methods to be considered, reviewed and analyzed together to come to a comprehensive understanding about the chosen concept (Whittemore & Knafl, 2005). The five stage process presented by Whittemore and Knafl (2005) provided a framework for this review. The steps include; problem identification, literature search, data evaluation, data analysis and presentation.

Search Methods

Initial searches of CINAHL, PubMed, and ProQuest Nursing & Allied Health databases included the following key terms: birth trauma, woman/female, experience/perception, health care provider influence/effect. The first result among more than 1,000,000 articles was Beck’s article, “Birth Trauma: In the eye of the beholder” (2004). This seminal article is a widely referenced work that uses qualitative research to explore the experience of birth trauma from the perspective of the women who lived it, therefore it was used to anchor and refine the search strategy. PubMed and Google Scholar databases have a feature that identifies similar/related articles. This, along with “Cited by” searches in these databases, established a reservoir of research relevant to the question at hand. Limits to search results included publication from 2004 to present, published in English, and the population studied had to have some North American representation.

Search Outcome

Using the Beck (2004) as the cornerstone of the literature search, the PubMed and Google Scholar’s “Cited by” and “Similar”/ “Related” article searches led to a total of 560 results. Two of the authors of this paper reviewed all titles and abstracts of the results to determine applicability to the research question and applied limits; seventeen articles remained for detailed reading. Detailed reading and discussion excluded eight more articles for a final count of nine.
Quality Appraisal

The seventeen articles that met the inclusion criteria were critically appraised utilizing the internationally recognized Critical Appraisal Skills Programme checklist for qualitative research (2012). Four articles are qualitative and other methodologies included: mixed methods (two), meta-synthesis (one), secondary analysis (one) and meta-ethnography (one).

Data Abstraction

According to Whittemore and Knafl (2005), data analysis in the integrative review process is the least developed step and therefore it is vital that a systematic method is clearly identified prior to conducting data analysis. Descriptive phenomenological method by Colaizzi (1978); as seen in Morrow, Rodriguez and King (2015) was chosen to conduct the data abstraction portion of this review. The method includes seven steps (familiarization, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description, producing the fundamental structure, seeking verification of the fundamental structure).

Synthesis

The authors organized the articles in tables identifying their purpose, methods and findings and then using these tables as a starting point for meticulous review of material highlighting phrases directly in the articles pertaining to the research question. This led to extensive review of highlighted phrases, formulating notes and bracketing personal experiences. Phrases were reviewed and coded based on their description and exhaustive description was established. The final step was accomplished by circling back to the research question to engage in reflection ensuring that the conclusions made from the analysis answered the research question.

Results

The findings of the integrative review revealed that the relationship between healthcare provider actions and women’s perceived psychological birth trauma is substantial. The overarching theme identified by the review was that healthcare providers are the guardians of women’s perceived birth experiences. This finding supports Beck’s (2004) original statement that suggests that the perception of psychological birth trauma is individualistic. This review proposes an addition to Beck’s original theory that psychological birth trauma lives not only ‘in the eye of the beholder’ but that it also resides on a spectrum. The review revealed that healthcare provider actions were one of the main the catalysts that influenced women’s perceptions of their birth. Power and acknowledgement were found to be the two prominent provider actions that drove women’s perception of psychological birth trauma. Additionally, women’s expectations were also found to have a significant influence on the perception of psychological birth trauma. This triad supports the conclusion that the perception of psychological birth trauma lives on a spectrum and ultimately, healthcare providers serve as the guardians of birth experiences.

Power

In each article, women described a significant power imbalance during their labour and childbirth between themselves and their healthcare providers. The review suggested that women felt inferior to their
healthcare providers during their birthing experience leading women to have feelings of; disrespect, irrelevance to the birthing process, bullied, betrayed and powerless (Beck, 2004; Beck, 2006; Grestener Goldbort, 2009; Elmir et al., 2010; Puia, 2013; Attanasio, McPherson, & Kozhimannil, 2015; Ledford et al. 2016; Reed et al., 2017; Beck, 2018). Childbirth was described by women as “something that was done to them” rather than something they had accomplished (Beck 2004; Beck 2006; Grestener Goldbort, 2009; Puia 2013; Beck 2018).

Women described that healthcare providers failed to include women in decision making, would not explain reasons for procedures/interventions and would proceed with an intervention or procedure without consent (Beck, 2004; Beck, 2006; Grestener Goldbort, 2009; Elmir et al., 2010; Puia, 2013; Attanasio et al. 2015; Ledford et al. 2016; Reed et al., 2017; Beck, 2018). The following quotes from the research findings illustrates the women’s experiences:

“I was steamrolled with unnecessary intervention and didn’t get to speak with a doctor about my options, risks vs benefits… I feel like the nurses, doctors and hospital only did what was in their best interest, not mine… it was a nightmare (Reed et al., 2017, p.4).”

“Maybe kind of going over induction with me more. That would have been helpful. I didn’t know I had to be induced, and there was no telling but you know after my forty week visit… it would have been nice if they had gone over exactly what their methods are then I could have discussed maybe a more natural route (Ledford et al., 2016, p. 526).”

“I felt like I didn’t even have the power to say ‘I don’t want a resident’. I just felt like every ounce of power or saying that I had over what was happening to me was totally gone. And it, I think [crying] that was the, was one of the biggest things that affected me, that I’ve have to heal from (Grestener Goldbort, 2009, p. 60).”

Additionally, women felt like a teaching tool for students as a result of healthcare providers not asking for consent before allowing students to observe, leaving women feeling as though they had no control and no choice (Beck 2004; Beck 2006; Grestener Goldbort 2009; Beck 2018). The women who participates in these researches explain: “Was only a meat on a slab for inspection (Porter et al., 2007, p. 151; as seen in Puia, 2013, p. 45). “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, p. 4).”

Some women described their interactions with healthcare providers verbally abusive and some physically abusive, comparing their birth experience to being raped (Beck 2004; Beck 2006; Puia 2013; Reed et al., 2017; Beck 2018).

“I was crying and screaming in pain telling her no and to stop and she carried on (Reed, et al., 2017, p. 6).”

“I still have nightmares about the delivery doctor as a barbaric rapist and I wake up crying. To me, he played a major part in violating my body (Beck, 2018, p. 101).”

“I had more midwives than I can count, attempt an internal examination and one yelled at me to ‘relax!’ because she couldn’t force her fingers in (Reed et al., 2017, p. 6).”

“To be shoved like that just because you are panicking… don’t take it out on me. I
am the patient (Fries, 2007, p. 63; as seen in Puia, 2013, p. 45).”

“While I was trying to cover my bottom by holding the gown, the nurse took my hands from the gown. I felt raped and my dignity was taken from me (Beck, 2004, p. 32).”

Other women said that healthcare providers used threats to force women to proceed with an intervention, leaving women feeling forced and bullied into a choice regarding birth outcomes (Beck 2004; Beck 2006; Reed et al., 2017; Beck 2018). For example, the “dead baby threat” was brought up by some women as an example.

“Forced into a C-section with dead baby threat (Reed, et al. 2017, p. 5).” “Do you want a dead baby (Reed et al., 2017, p. 5)?”

“All in all, I felt very bullied and even violated. It was the feeling of disempowerment and not having the right to do with my body what I wished – and that someone else could force me to do something against my will (Reed et al., 2017, p. 5).”

Acknowledgment

Acknowledgement from healthcare providers was found to have a significant impact on women’s birthing experiences. Women were more likely to report a negative birthing experience when they were not acknowledged by their healthcare providers (Beck, 2004; Beck, 2006; Grestener Goldbort, 2009; Elmir et al., 2010; Puia, 2013; Attanasio et al. 2015; Ledford et al. 2016; Reed et al., 2017; Beck, 2018).

Women described feelings of irrelevance and abandonment when their healthcare providers only focused on the clinical outcome, describing that the safe arrival of a healthy baby took center stage while their traumatic delivery was overlooked (Beck 2004; Beck 2006; Grestener Goldbort, 2009; Puia 2013; Beck 2018). The following findings support this lack of acknowledgement: “Why put a damper on this celebration by focusing on the mother’s traumatic experience giving birth (Beck, 2004, p. 34).”

“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, 2004, p.34). “They were there to take care of the baby and not you and that’s the end of it (Grestener Goldbort 2009, p. 59). “It’s like, I was a body, I was a piece of meat that needed to have a procedure done to get this child out and when that was over then it’s fine, and it’s done (Grestener Goldbort, 2009, p. 59).”

Other women felt that healthcare providers would disregard that a traumatic event had occurred and felt traumatized by the lack of acknowledgment (Beck 2004; Grestener Goldbort, 2009; Elmir et al., 2010) as illustrated in previous research: “And I think that’s what made me angry is that I felt like, you really trust someone to take care of you and then you don’t get good care and you get bad care. And then nobody will acknowledge it (Grestener Goldbort, 2009, p. 59). “What a mother perceives as birth trauma may be seen quite differently through the eyes of obstetric care providers, who may view it as a routine delivery and just another day at the hospital (Beck, 2004, p. 28). “They needed their birth trauma to be acknowledged and some felt quite angry if this need was not met (Elmir et al., 2010, p. 2149).”

When healthcare providers neglected women’s embodied knowledge, women felt disregarded as important and irrelevant to the
Women’s Expectations

Women’s expectations were noted to be a major contributing factor to negative feelings about their childbirth experience. When the quality of care received, continuity of care between providers and provider attitudes did not meet women’s expectations, there was an obvious negative impact on their childbirth experiences (Beck, 2004; Beck, 2006; Grestener Goldbort, 2009; Elmir et al., 2010; Puia, 2013; Attanasio et al. 2015; Ledford et al. 2016; Reed et al., 2017; Beck, 2018).

Women who participated in the studies expected a certain level of care and felt that when that was not fulfilled that there was a lack of caring from their providers. Additionally, women expected providers to explain procedures/information regarding their care/pregnancy; when that was not done, women felt a void in the care they received and that ultimately resulted in a lack of trust (Beck 2004; Beck, 2006; Beck, 2018; Grestener Goldbort, 2009; Puia, 2013; Ledford, 2016).

“During labour, I had expected pain, and I had expected a powerful experience, I expected that, if necessary, medical staff would intervene to keep us safe. Why didn’t anyone use their professional judgment? That was what I expected from them. I have posttraumatic stress disorder (Beck, 2004, p.33).” Another participant in Beck’s study explains (2004, p. 33), I remember believing that the labor and delivery team would know what was right and would be there should things go wrong. That was my first mistake. They didn’t and they weren’t! (2004, p. 33)"

Women mentioned that continuity of care amongst providers was an important component to them that they had expected and was most often disregarded during their childbirth experience (Beck, 2004; Elmir et al., 2010; Ledford et al., 2016). Clinicians at times failed to communicate among themselves, which influenced the women’s perceptions of their deliveries as traumatic. For example, for one woman who had experienced a previous serious vasovagal reaction before pregnancy and it came time for her to receive an epidural. She was terrified because the midwife did not tell the anesthetist about her history (Beck, 2004, p.33).

“It’s really personal when you’re seeing one doctor and, you know, you don’t have to keep telling your life story over and over again to every single doctor (Ledford et al., 2016, p.526).”

Discussion

This review suggests that psychological birth trauma resides on a spectrum and healthcare providers have the ability to influence women’s perception as they are the guardians of women’s perceived birthing experiences. Healthcare providers have the ability to strip away women’s protective layers via their actions and behaviours, exposing them to psychological birth trauma or to engage women in ways that empower, dignify and protect them during the birth process. Clearly it is essential for healthcare providers to consider their behaviours when caring for women during labour and delivery. Addressing the issue of power, acknowledgement and women’s expectations is dynamic and complex requiring a multi-pronged approach addressing both individual, as well as organizational and system issues.
Mitigating psychological birth trauma starts well before labour and delivery. Women’s knowledge levels about issues that may arise, as well as their expectations for labour and delivery should be assessed and addressed throughout their pregnancies (Ledford et al., 2016; Puia, 2013). Lack of knowledge and preparation can exacerbate women’s fears, alleviating these fears could include detailed knowledge about birthing methods of individual providers and organizations and the opportunity to see instruments and written policies and procedures ahead of time (Ledford et al., 2016).

Organizational policies dedicated to the rights of the labouring woman and her significant others may help to ensure that there is informed consent during each stage of the birthing process. In order to maintain their power, women need to be fully informed and consent to each aspect of labour and delivery (Elmir et al., 2010). “For consent to be valid it must be voluntarily and freely given; the person consenting must not be under any undue influence or coercion; and there must be no misrepresentation as to the nature or necessity of the procedure” (Reed et al., 2017, p. 7).

Healthcare providers should reflect on their practice and alter their approaches to ensure that women are fully informed about, and included in each decision about their birthing process. This practice starts from the outset and should be formalized in healthcare provider education programs and modelled by preceptors and instructors.

Role of Nurses

The integrative review included nurses as one of several health care providers involved with women during labour and delivery. The focus of this review was with literature from North America, where the majority of births continue to happen in hospital settings and, regardless of who ‘catches’ the baby, nurses are almost always involved in labour support and present at the deliveries. Given this, nurses have enormous potential to influence women’s birth experiences. Nurses are in an ideal position to educate, advocate, and empower women and play an important role in supporting women through their birthing journey. Non-operative techniques employed by nursing such as one to one nursing support, oxytocin and partogram use and delayed pushing for women with epidurals, has the ability to decrease the incidence of OVB (Society of Obstetricians and Gynecologists of Canada, 2019). In a Cochrane review, it was identified that women who had continuous support throughout their labour were more likely to have a spontaneous vaginal birth and less likely to report negative feelings about their birthing experience and required less intrapartum analgesia (Hodnett, Gates, Hofmeyr, & Sakala, 2013). Although many other care providers are present for birth, in the North American hospital setting, it is the nursing staff that spend the most time with patients during their labour experience.

Although nursing arises from a holistic model, which promotes individualized care, promotion of comfort, and addressing emotional needs (Payant et al., 2008), the focus on technology and the medical model has resulted in significant changes in nursing care of women in labour and delivery (Barret & Stark, 2010; Fleming, Smart & Eide, 2011). Providing nursing care that not only allows for a safe birth but also a normal birth has become a challenge (Zwelling, 2008). Nurses require insight about the potential negative impact of their practices on women’s psychological well being. Ongoing education and review is necessary. Nurses need to have the resources...
to be able to advocate for women during labour and delivery to the best possible outcomes. The conclusion that healthcare providers are the guardians to women’s birthing experiences directly aligns with the literature that highlights the benefits of one to one nursing care and how it positively impacts overall birth outcomes (Hodnett, Gates, Hofmeyr, & Sakala, 2013).

Future Research

Although this review has revealed insight to the relationship between healthcare provider actions and women’s perceived birth experiences, a gap remains as it is unknown about other factors that contribute to psychological birth trauma. This review suggests that psychological birth trauma resides on a spectrum and that healthcare provider actions are a main driver when it comes to influencing women’s birthing experiences. However, the question still remains surrounding predisposing risk factors related to the emotional turmoil of psychological birth trauma. Needless to say, research is required to better identify additional risk factors for psychological birth trauma so that women who may be at risk can be identified and mitigating strategies, such as education and support, can be implemented.

Limitations

The article search was limited to only include literature in English by authors from North America. This was done in an attempt to better understand the experiences of women’s birthing experiences and the relationship to healthcare provider actions in a specific obstetrical setting. Although limiting the search geography restricts the study, it is also a strength as it highlights the need for research specific to the North American obstetrical setting and patient population.

Conclusion

This integrative review suggests that psychological birth trauma resides on a spectrum and healthcare providers are the guardians to women’s perceived birth experiences. Healthcare providers have the ability to protect women from negative emotional experiences related to their birth or the ability to expose them to psychological birth trauma via their actions. Three key themes were highlighted in this review: power, acknowledgement and women’s expectations. It was identified in this review that healthcare providers may use their power to negatively or positively influence women’s birthing experiences. It was also noted that when healthcare provider’s actions around acknowledgement of the women has the ability to influence her experience. It was also highlighted that women come to the birthing experience with certain expectations and when healthcare providers meet or fall short of these expectations, women’s perception of their birthing experience is influenced. However, it is uncertain if all women who experience psychological birth trauma are exposed to negative healthcare provider actions. And if they are not exposed to negative healthcare provider actions, what are the other potential causes/risk factors that cause/influence psychological birth trauma. This gap warrants a need for research to better understand psychological birth trauma and how it is related to the other unique and dynamic processes of childbirth.

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