



Birth Space – Supportive or Coercive?

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By Shellie Poulter

What is important in a birth space? Low lighting, access to water and other comfort measures, a relaxing soundtrack? Or is the sanctity of a birth space about something more than the physical environment? For me, it feels of utmost importance to consider the communication and language, both verbal and non-verbal, that is used surrounding and within someone's birth space and how this may affect the birthing environment, the birthing dyad and anyone else who may have been invited in.

People speak of their birth experiences as being powerful, life changing, affirming, amazing, but they also speak of these experiences as horrific, traumatising, humiliating. How people are treated at the time of their birth is etched in their minds. The words spoken to them, and the way they were treated in the perinatal space is remembered more vividly than the physical pain and discomfort. Were they spoken to with compassion or cruelty? With support or coercion?

Birth supporters, whatever their role, have the power to make any birth situation better through compassionate behaviour and by enabling informed consent. Likewise, we have the power to make it worse with coercion, no matter how kindly it is offered. The current system is not serving anyone. Doctors and midwives are burning out and leaving in droves; women and their babies are being caused significant iatrogenic harm.^{1 2 3 4} A new tub on a labour ward - that often lies empty - or some twinkling lights are nice gestures, but these gestures are not leading to long-lasting, fundamental changes in how we approach the birth space. Change that is so desperately needed for the health and wellbeing of everyone in the birth space - from babies and parents to doctors and midwives.

How people within a birthing space interact with the person birthing and their companions, is of vital importance, not just in that moment, but for the family as it is developing. Our communication and language, both verbal and non-verbal; our care to ensure true informed consent; and our capacity to provide genuine and compassionate care - all are crucial for the short and long-term well-being of all involved. In the seventeen years I have been in birthing spaces, I have witnessed genuine and compassionate care, but I have also witnessed gaslighting, coercive control, and obstetric violence. When I have questioned these behaviours or highlighted them, I have often been met with aggressive defence, attack, or denial. It is essential that we find a way as a community to reflect on how we can improve women's experiences.

There currently exists a belief within the healthcare system that women have unrealistic expectations of birth – and that it is these unrealistic expectations that are leading to high rates of post-traumatic stress disorder (PTSD).⁵

However, PTSD is more likely to occur following events which are perceived to have been intentionally perpetrated rather than those following accidents,⁶ which is particularly pertinent in the context of childbirth.⁷ Research shows that women are more likely to be traumatised when the level of care - rather than the events of birth - do not meet their expectations.⁸ The difference between birthing people's expectations of their level of care and their actual experience has shown to be predictive of PTSD.⁹

There is substantial research demonstrating that support during labour and birth improves both physical and psychological outcomes for the birthing dyad.¹⁰ Women who are traumatised often describe interactions with staff that left them feeling rushed, bullied, judged, ignored, or that access to pain relief was actively withheld or delayed when requested. The Journal of Perinatal Education cited that up to 45% of new mothers report experiencing birth trauma.¹¹ Research also shows that many maternity staff are suffering secondary trauma.¹² This is not acceptable for families, and it is not acceptable for maternity staff.

We are innately programmed to be compassionate and work as a team for our survival.¹³ There are reward mechanisms in our physiology, whereby it *feels* good to help people. We are also programmed to protect ourselves from danger. When we experience trauma or sense danger, even unconsciously¹⁴, our higher brain function shuts down and our fight, flight, freeze, fawn response kicks in. The danger does not need to be overt; it can simply be hidden in the words used to gain the mother's compliance. Even the label of 'high risk' is sufficient to trigger a response. It is an automatic response taken care of by the autonomic nervous system. One understanding of this, Stephen Porges's Polyvagal Theory,¹⁵ may be helpful when considering interactions within the birth space.

Polyvagal theory describes a three-part hierarchical system that has evolved over millions of years. The Parasympathetic Dorsal Vagal system – playing dead or dissociating – is the most primitive form of defence. The sympathetic nervous system - enabling the fight, flight, fawn responses - gives protection through action. And the ventral vagal system - connecting, interacting and communicating - enables the most developed responses for remaining safe.

The Fawn response¹⁶ is particularly interesting in terms of understanding behaviours in the birth space, as the response is heightened in a high oxytocin state, indicating that birthing people may be more susceptible to coercion.

At the same time, with many midwives and doctors suffering secondary trauma, their language is frequently aimed – not to communicate and form connections - but to control and coerce people to choose the path that feels safest to them (the doctor or midwife). This lack of connection is a further self-protective behaviour, associated with compassion fatigue and burnout, which are at elevated levels in maternity care.¹⁷

Although there is widespread agreement that it is unethical to perform medical procedures without informed consent (or by using undue pressure or coercion to gain consent), there is widespread evidence that it occurs across the world. In a recent Dutch study, 7% of women reported unconsented vaginal examinations, 36-38% unconsented foetal monitoring and 42% unconsented episiotomies.¹⁸ Women both in the Netherlands and the UK report minimal information provision and lack of choice regarding procedures such as episiotomies, which can be experienced as distressing and can play a significant role in self-reported negative and traumatic birth experiences.^{19,20} Informed consent means that the person must be given all of the information about what the treatment or procedure involves, including the benefits and risks. Reasonable alternatives should be discussed, as should the likely repercussions (if any) of declining the procedure. It should be made clear to the birthing person that participation is voluntary and that their consent, if given, can be withdrawn at any time, without giving a reason and without cost.²¹ In the UK informed consent is a legal requirement for any medical procedure and is reinforced by professional guidelines. Treating without valid consent may be considered an assault or battery and a case can be made for civil or criminal proceedings. Yet I was recently told the following by a former midwife: “I always remember my colleagues looking confused as to why I would go into such detail explaining the true risks and benefits of vaginal exams to women.”

What does informed consent look like? Here are two different examples of how maternity staff might use language in the same situation.

Example 1. Using language to coerce

“We need to know where you are in your labour in order to admit you. It is hospital policy that you need to be four centimetres dilated; just so you know before we start, there is a very small risk of infection, or accidentally breaking your waters. So if you’re ok to just hop

up on the bed and we can do a little vaginal exam? Don't worry I can close the curtain."

Example 2. Gaining informed consent

"I don't see a preference here regarding vaginal examinations (VEs) in your notes. Is it okay for me to speak with you about them now? If you need me to pause at any time, just let me know. You can decline for any reason and at any time and I will support you in your decision. I would like to offer some information for you to make the decision that feels right for you. You are welcome to ask questions or ask me to stop at any time.

It is an expectation of my role to offer you a VE every four hours under the hospital policy and guidelines; however it is not evidence-based to assess labour progress in this way. Current evidence shows that the understanding of labour progress patterns on which the policies are based is not correct,²² but this form of monitoring is still widely used under NHS guidelines.

There is no evidence that vaginal exams can accurately assess labour progress or outcomes for you and your baby.²³ There is evidence that they may negatively influence your labour progress and that the risk of infection to your baby is increased with each subsequent examination.²⁴ Some people like to know an estimate of the dilation of their cervix, even though it doesn't give an accurate indication of how long the labour will take from here, and most report being 'satisfied' with their VE experience.²⁵ Others find it painful and or embarrassing,²⁶ and for a few, a VE is associated with PTSD.²⁷ So, it is completely up to you.

What the cervix is doing at the moment of a VE does not indicate what the cervix is going to do in the future. Therefore, the findings cannot effectively inform decisions about pain medication or other interventions. The measurements are subjective and inconsistent between practitioners: The accuracy between practitioners is less than 50%.²⁸ A VE can result in accidental rupturing of the membranes: It is not uncommon to accidentally break the amniotic sac and this alters the birth process and increases risk for the baby.

If you decide to go ahead, I would like you to understand that you can remove your consent at any time and for any reason, you can tell me to stop or signal to me to stop and I will immediately remove my hand and that is absolutely fine. There are other signs of labour progress that we can look out for that do not involve a VE. Do you have any questions or want me to explain anything further? I can give you some time to see what feels right for you."

A BioMed Central (BMC) pregnancy and childbirth paper explored women's descriptions of childbirth trauma relating to care provider actions and interactions.²⁹ Four themes were identified in the data: 'prioritising the care provider's agenda'; 'disregarding embodied knowledge'; 'lies and threats'; and 'violation'. Women felt that care providers prioritised their own agendas over the needs of the woman. In

some cases, women became learning resources for hospital staff to observe or practise on. Women's own embodied knowledge about labour progress and fetal well-being were disregarded in favour of care providers' clinical assessments. Care providers used lies and threats to coerce women into complying with procedures, in particular, the lies and threats related to the well-being of the baby. Actions were also described as abusive and violent and for some triggered memories of sexual assault.

According to the perceptions and experiences of fathers, there was a significant lack of communication between birthing teams and fathers. Fathers experienced a sense of marginalisation before, during and after traumatic childbirth.³⁰

It is important that we shine a light on the abusive and disrespectful 'care' that some people experience. We need to see and acknowledge that midwives and doctors are doing this. In my experience, many interactions with hospital staff feel akin to that of an abusive relationship; rather than there being informed consent, there is coercive control. How can we recognise the difference? Defined by Women's Aid Federation of England, coercive control is 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.³¹ Examples of this in maternity care may include the following:

1. Isolating you from friends & family: *"Your partner must wait outside whilst you are in triage"*
2. Closely monitoring your activity: *"We need to monitor x, y, z or your baby might become distressed or die"*
3. Denying your freedom: *"You have to wait until the doctor has spoken with you", or "You can only have a home birth if it is signed off by the consultant"*
4. Gaslighting (claiming it's your fault your baby might die): *"Look at that monitor, you can see when you are pushing you are hurting your baby, you need to stop pushing"* (said to a mother on a synthetic oxytocin drip)
5. Constantly criticising you, putting you down: *"If you think it's bad now, wait until it really gets going; you are only 2cm dilated."*
6. Forcing you to live by their rules: *"You cannot get in the pool until you are 4cm."*
7. Parental alienation, turning your baby against you: *"Your baby is getting tired now, you need to let us cut you, it is in your baby's best interest."*
8. Policing your lifestyle/choices: *"Your BMI (body mass index) is rather high, you won't be allowed a water birth."*
9. Making jealous accusations: *"Well, we'd all like a natural birth but..."*
10. Depriving you of access to help/support: *"We need to do a vaginal exam before I let you have gas and air to make sure we don't run out."*
11. Regulating your bodily autonomy: *"No drinking or eating in case you need a caesarean."*

12. Making violent threats: *“We’ll cut you if you don’t get your baby out on the next push.”*

13. Blackmailing you (pretending to be trustworthy to get information to use against you): *“Was your birth really a BBA (born before arrival) or was it an intended free birth?”*

I have either witnessed these points first-hand while with my clients, or they are things that were said to me by clients relaying past traumatic birth experiences. The trauma in a birth space is felt by everyone there, including mothers, birthing people, partners, babies, doulas, doctors and midwives. Many people don’t want to acknowledge that this is happening - or even to think about it - because it feels so awful and it is happening to such a great extent.³² If we can’t talk about it, how can we change it?

As a doula I work with people from different ethnic and socio-economic backgrounds, both privately and with charities. The disparity between how middle-class white families and other ethnic communities are treated within the birthing space (even with a white middle class doula present) is obvious and chilling. If English is not the first language, this disparity, in my experience, is exacerbated. These are a few examples of interactions I have witnessed whilst supporting women who have a first language other than English:

“This woman [your doula and birth partner] needs to leave and you need to birth alone.”

[Midwife to mother as the midwife entered the room for the first time]

“I am assuming this child has a different father to the last one.” [Midwife to mother during the initial stages of admittance for induction.]

“I am going to cut her; it is in her best interest.” [Midwife to colleagues in mother’s hearing as midwife approached the mother’s perineum with episiotomy scissors without any attempt to consult with the mother before approaching.]

In the birthing population, 26% of women say they felt they were not always involved in decisions about their care during labour and birth.³³ However, when women seeking asylum in the UK were surveyed,³⁴ 77% said they were not involved in decisions about their care and 87.5% had outstanding questions about their care. When the same cohort received doula support, only 25% said they did not understand everything about their care and only 27% had outstanding questions.

What does compassionate care in the birth environment look like? It requires an individualised approach, as we all have different values and place importance on different things. I believe it benefits from good antenatal education, where there has been time for exploration of birth, of what medical care may be offered and the implications of this, and of alternative approaches to care (although this was shown not to be essential in the Happy Baby Pilot Study)²¹. During the birth itself, there should be introductions when appropriate and a deeply held awareness that we are in the birth space by invitation and not by right. Our purpose is to help people feel comfortable, safe, and supported and we are to remain in the

background unless needed. We are to hold space lovingly and respectfully and offer information and support. The choices that feel right for the birthing person should be respected and honoured.

With the release of catecholamines at key points during labour, attention and alertness are heightened synergistically. How someone is treated during their perinatal period is therefore strongly imprinted in their memory. Childbirth experience has the potential to strengthen self-confidence and trust in others or lead to deep-rooted feelings of failure and distrust. In marginalised communities, treatment around birth has great potential for helping to begin healing discriminatory-related trauma or it has the potential to deeply compound it for the next generation.

How do you want to be remembered?

Because you will be.

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1 Khaskheli et al, Iatrogenic risks and maternal health: Issues and outcomes Pak J Med Sci. 2014 Jan;30(1):111-5. Doi: 10.12669/pjms.301.4062

2 Aibar et al, Patient safety and adverse events related with obstetric care Arch Gynecol Obstet. 2015 Apr;291(4):825-30 doi:10.1007/s00404-014-3/ Epub2014 Sep 23

3 Forster et al, Adverse events detected by clinical surveillance on an obstetric service Obstet Gynecol, 2006 Nov;108(5):1073-83. DOI: 10.1097/01.AOG.0000242565.28432.7c

4 Vincent et al, Adverse events in British hospitals: preliminary retrospective record review BMJ 2001 ; 322:517

5 Webb, R., Ayers, S., Bogaerts, A. *et al.* When birth is not as expected: a systematic review of the impact of a mismatch between expectations and experiences. *BMC Pregnancy Childbirth* **21**, 475 (2021). <https://doi.org/10.1186/s12884-021-03898-z>

6 Charuvastra A, Cloitre M. Social Bonds and Posttraumatic Stress Disorder. *Annual Review of Psychology*. 2008;59:301-28.

7 Ford E, Ayers S. Stressful events and support during birth: The effect on anxiety, mood and perceived control. *Journal of Anxiety Disorders*. 2009;23:260-8.

8 Ayers S. Post-traumatic Stress Disorder Following Childbirth Unpublished Ph.D Thesis, University of London; 1999.

9 Soderquist J, Wijma K, Wijma B. Traumatic Stress after Childbirth: the role of obstetric variables. *Journal of Psychosomatic Obstetrics and Gynecology*. 2002;23:31-9.

10 Hodnett ED, Gates S, Hofmeyr G, Sakala C. Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*. 2003(3):Art No.: CD003766. DOI:10.1002/14651858.CD003766.

11 Beck et al, Traumatic Childbirth and Its Aftermath: Is There Anything Positive?. *Journal of Perinatal Education*, 2018 Jun; 27(3): 175–184. doi: 10.1891/1058-1243.27.3.175

12 Kendall-Tackett and Tatano Beck Secondary Traumatic Stress and Moral Injury in Maternity Care Providers: A Narrative and Exploratory Review *Front. Glob. Women's Health* 04 May 2022 Sec. Maternal Health Vol 3-2022 doi 10.3389/fgwh.2022.835811

13 Dana Foundation (2019) In Sync: How Humans are Hard-Wired for Social Relationships - Report from Neuroscience 2019

<https://dana.org/article/in-sync-how-humans-are-hard-wired-for-social-relationships/>

14 Editor's note: The ability to unconsciously sense danger is referred to as neuroception. It is explained in this article by Stephen Porges. Porges SW (2022) Polyvagal Theory: A Science of Safety. *Front. Integr. Neurosci*. 16:871227. doi: 10.3389/fnint.2022.871227

15 Polyvagal Institute (2022) What is The Polyvagal Theory?

<https://www.polyvagalinstitute.org/whatispolyvagalththeory>

16 Editor's note: In this context, fawning is a trauma response where a person develops people-pleasing behaviours to avoid conflict and establish a sense of safety.

17 O'Riordan et al, Interventions to improve wellbeing among obstetricians and midwives at Cork University Maternity Hospital, *Irish Journal of Medical Science* Oct 2019, 1971 – 189, 701-709 (2020)

18 Van der Pijl MS, Klein Essink M, van der Linden T. Consent and refusal during labour and birth: a survey among 11,418 women in the Netherlands 2022

19 Van der Pijl MSG, Hollander MH, van der Linden T, et al. Left powerless: a qualitative social media content analysis of the Dutch #breakthesilence campaign on negative and traumatic experiences of labour and birth. *PLoS One* 2020;15(5):e0233114–21.

20 Djanogly T, Nicholls J, Whitten M, et al. Choice in episiotomy – fact or fantasy: a qualitative study of women’s experiences of the consent process. *BMC Pregnancy Childbirth* 2022;22(1):1–7

21 Birthrights (2023) Consent: The key facts <https://www.birthrights.org.uk/factsheets/consenting-to-treatment/>

22 Dekker R. (2022) Friedman’s Curve and Failure to Progress: A Leading Cause of Unplanned Cesareans <https://evidencebasedbirth.com/friedmans-curve-and-failure-to-progress-a-leading-cause-of-unplanned-c-sections/>

23 BJM (2023) Offering vaginal examinations <https://www.britishjournalofmidwifery.com/content/comment/offering-vaginal-examinations/>

24 Gluck O, Mizrachi Y, Ganer Herman H, Bar J, Kovo M, Weiner E. The correlation between the number of vaginal examinations during active labor and febrile morbidity, a retrospective cohort study. *BMC Pregnancy Childbirth*. 2020 Apr 25;20(1):246. doi: 10.1186/s12884-020-02925-9. PMID: 32334543; PMCID: PMC7183634.

25 Lewin D, Fearon B, Hemmings V, Johnson G. Women's experiences of vaginal examinations in labour. *Midwifery*. 2005 Sep;21(3):267-77. DOI: 10.1016/j.midw.2004.10.003

26 Muliira RS, Seshan V, Ramasubramaniam S. Improving vaginal examinations performed by midwives. *Sultan Qaboos Univ Med J*. 2013 Aug;13(3):442-9. Epub 2013 Jun 25. PMID: 23984031; PMCID: PMC3749030.

27 Reed, R., Sharman, R. & Inglis, C. Women’s descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth* 17, 21 (2017). <https://doi.org/10.1186/s12884-016-1197-0>

28 Mohaghegh Z, Jahanfar S, Abedi P, El Aziz MAA. Reliability of ultrasound versus digital vaginal

examination in detecting cervical dilatation during labor: a diagnostic test accuracy systematic review. *Ultrasound J.* 2021 Aug 17;13(1):37. doi: 10.1186/s13089-021-00239-1. PMID: 34403002; PMCID: PMC8371058.

[29](#) Reed, R., Sharman, R. & Inglis, C. Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth* 17, 21 (2017). <https://doi.org/10.1186/s12884-016-1197-0>

[30](#) Inglis et al, Paternal Mental health Following Perceived Traumatic Childbirth, *Midwifery*, Vol.41, pp125-131;2016

[31](#) Women's aid, What is coercive control? <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/>

[32](#) Bettina E.F. Schoene, Claudia Oblasser, Kathrin Stoll, Mechthild M. Gross. (2023)

Midwifery students witnessing violence during labour and birth and their attitudes towards supporting normal labour: A cross-sectional survey. *Midwifery*, Volume 119, 103626, ISSN 0266-6138, <https://doi.org/10.1016/j.midw.2023.103626>.

[33](#) NHS England (2015). National Review of Maternity Services: Assessment of quality in maternity services.

[34](#) Happy Baby Community (2020) Birth companion pilot for London initial accommodation for asylum seekers. London [Online]