AIMS For a better birth...

Research Review: "Women's descriptions of childbirth trauma relating to care provider actions and interactions."

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AIMS Journal, 2019, Vol 30, No 4

Gemma McKenzie reviews Reed R. Sharman R. and Inglis C. (2017) Women's descriptions of childbirth trauma relating to care provider actions and interactions. BMC Pregnancy and Childbirth, 17:21

Background to the study

The authors highlight that around one third of all women experience birth trauma. This can result in mental health problems such as post-traumatic stress disorder and post-natal depression. The consequences of this can include a disruption in family relationships, such as the mother-baby bond, which may potentially affect a mother and child's later emotional wellbeing.

What was the aim of the study?

The researchers aimed to understand women's experiences of birth trauma.

How did they do this?

The researchers created a survey which they promoted on social media. The survey contained a number of questions, but the research article was based solely on the responses given to one question in particular: "describe the birth trauma experience, and what you found traumatising." Once the responses had been collected, the researchers analysed them by drawing out the themes that appeared in the answers that the women had given.

Results

A total of 943 women responded to the survey, and, out of these, 748 (79%) completed the relevant question. The majority of women came from Australia and Oceania (36.8%), North America (34.2%) and Europe (25.5%). A very small number of women came from South America (2.1%), Asia (0.9%), South Africa (0.5%) and the Middle East (0.2%). Although some women described their trauma as stemming from events such as premature labour, haemorrhage or concerns regarding their baby's wellbeing, the majority (66.7%) described care provider actions and interactions as the traumatic element in their experience.

The researchers recognised four overarching themes that appeared in women's responses:

1. **Care providers prioritised their own agenda over the needs of the woman.**

The authors gave various examples of this, including obstetricians making it clear that they wanted the woman to give birth soon so that they could go home. In some cases, this desire to speed things up led women to experience unnecessary medical interventions such as caesarean sections.

Other women reported being used as a learning resource for staff, often without the woman's consent. One woman described "20 people in theatre and half were sitting down on phones and chatting away while I had someone train with forceps on me" (p.4). It appeared that women having unusual births were also subjected to this, particularly those attempting breech vaginal births.

2. **Women's embodied knowledge (i.e. their understanding of what they could feel happening in their own body) was disregarded.**

From the data collected by the researchers it appeared that care providers dismissed women's embodied knowledge. Instead, care providers relied on their own clinical assessments of events. This was particularly apparent when women complained of being in pain or in labour. Women's natural urge to push was also disregarded, with some women being told to stop pushing until care providers deemed it appropriate. In one example given, a woman reported her midwife spending an "hour yelling at me not to push and trying to talk me into an epidural" (p.4). Similar reports were given when women intuitively felt that there was a problem with their baby. When women attempted to inform care providers, their embodied knowledge was disregarded.

3. **Women experienced lies and threats from care providers.**

Some women reported being lied to by care providers in order to coerce them into unnecessary interventions. This frequently centred on lies regarding the risks to their unborn baby if they did not comply with medical demands. If women did not comply, threats of having their baby taken from them were also used. A common threat was the "dead baby threat." An example given by the authors was one woman who attempted to decline an intervention being asked: "Do you want a dead baby?" (p.5).

4. **Women were violated by care providers.**

The violation women described included feelings of being bullied and disempowered, with some respondents using language such as rape and mutilation. In addition to this, some women reported physical violence and assault, often to get them to consent to interventions. One woman described how during a cervical check the obstetrician "grabbed my cervix and pinched it. She would not let go until I consented to letting her break my water. I was in tears from the pain…" (p.6).

Some women screamed "no" as care providers carried out procedures, in particular vaginal examinations. Other women described being pinned down by maternity staff during procedures or tethered to the bed

with equipment. Further examples given by the authors included women having their legs forcibly opened and being physically pushed onto their backs. Women who had experienced previous sexual abuse or rape described how this form of violation triggered previous distressing memories, with one woman reporting that the birth was more traumatising than her experience of sexual abuse as a child.

AIMS' response

It is impossible to know how many of these examples relate to women's experiences of giving birth in the UK. As the authors note, it is also impossible to know whether these examples are from births that took place last year or twenty years previously. However, from AIMS' experience from women who contact us through our helpline, these examples are not new, and sadly not surprising.

As the rates of induction and caesarean sections sky rocket, and as maternity services become stretched and overburdened with staff focusing on guidelines and policy, compassion and emotional support for women become side lined. Yet women's rights and individual needs should be central to all maternity care. Birth is not just a physiological process, but for many women an emotional and spiritual experience too. What this study highlights is that when maternity staff fail to respect a woman and her rights, or cater for her emotional needs, it can have a devastating effect on her later wellbeing. With the reports of physical abuse and violation it also raises questions about society's perception of pregnant women more generally, particularly with regards to staff's belief that it is appropriate to manhandle a labouring woman in such a way, and to disregard her rights to informed consent and bodily integrity.

For maternity staff this study reiterates that they should be mindful of the words they use and the behaviour they display towards labouring women. They should also remember that appropriate emotional support may result in a much more positive birth experience for the pregnant women they work with. For those women who have experienced birth trauma, it appears that the problem is widespread. In short, you are not alone. And for the birth activist, it is clear that our work is nowhere near complete.