FACTORS CONTRIBUTING TO WOMEN’S PSYCHOLOGICAL BIRTHING TRAUMA: VICTORIAN MIDWIVES’ PERSPECTIVES

SUMMARY
This article reports midwives’ perspectives on factors contributing to women’s psychological birthing trauma, including recommendations for practice. Interviews with 11 participants identified three themes:

1. ‘It’s this complete control of birth’ - how the healthcare system is patriarchal and assumes control of the woman and her process.
2. ‘No one actually informed me’ - women are kept ignorant, unable to confidently advocate for themselves.
3. ‘Feeling... she has... failed’ - the accumulating demands of external events overwhelming emotional needs.

The findings show that further research about healthcare providers’ views on factors contributing to women’s psychological birthing trauma is needed to improve Australian maternity services.

INTRODUCTION
The medicalisation of birth can undermine a woman’s ability to labour physiologically, potentially impacting her and her family, causing physical and psychological trauma. Instead of being an empowering time in a woman’s life, childbirth can be traumatic with long-lasting consequences. Birthing trauma results from a particular experience during labour and birth that has the outcome of threatened or actual significant injury or death to the woman and/or her infant. Postpartum mental health disorders associated with a traumatic birth experience include acute stress disorder or, more severely, post-traumatic stress disorder, characterised by intrusion symptoms, avoidance of stimuli, adverse alteration in cognition and/or mood, and arousal alteration and reactivity.

During the postpartum period, a woman with poor or declining mental health can have psychosocial difficulties, including an altered sense of self, disrupting the relationship between the mother and her infant, her partner and the medical staff involved in her care. Early difficulties in the mother-infant bond can negatively impact and slow the achievement of the

> AUTHORS

Bernadette Pulis (she/her)
Clinical Midwifery Educator, Peninsula Health, Victoria
Social @bernadette_pulis

Dr Carolyn Hastie (she/her)
Midwifery Lecturer, Griffith University, Queensland
Social @CarolynHastie

Dr Roslyn Donnellan-Fernandez (she/her)
Midwifery Lecturer, Griffith University, Queensland
Social @RozDFernandez

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child’s developmental milestones, including mental, emotional and social aspects. Breakdown of relationships with the partner can result from the woman’s feelings of helplessness, dread, and self-blame. Medical staff can also be negatively influenced by witnessing the traumatic birth experience, as secondary traumatic stress can occur through the team feeling sympathetic and empathetic towards the mothers.

Obstetric violence causes childbearing women to lose autonomy and feel confused and disempowered as society trains them to trust healthcare providers. A traumatic childbirth experience can also influence future decisions for women regarding where to give birth, and the method of birth – such as opting for a caesarean section, with whom she gives birth, or avoiding future pregnancies. The decision of a woman to freebirth, to give birth without the presence of a professional birthing care provider, is influenced by previous experiences of birthing trauma. Severe cases of birthing trauma can lead to maternal suicidal ideation and maternal neonaticide. As this information indicates, traumatic birth experiences can have negative consequences on a large scale for women and their families and encompass broader community and societal considerations.

With such a high incidence of women reporting trauma from childbirth, this interpretive descriptive qualitative research sought to answer the question, ‘What do Victorian midwives think are contributing factors to women’s psychological birthing trauma (PBT)?’

ETHICS APPROVAL
Ethical approval for this study was obtained through Griffith University Human Research Ethics Committee (Griffith University ethics reference number 2022/397).

METHODS
Interpretive description methodology enables reliable answers to research questions about health and illness experiences from interpretive, relational and holistic perspectives. This methodology was chosen to ensure the results reflected the knowledge and experiences of midwives working in Victoria, Australia, in answering the research question.

RESEARCH DESIGN
Midwives (n=11) working in any maternity setting, including public, private or continuity of carer models in Victoria, Australia, were recruited in July 2022 through purposeful sampling on social media and local midwifery networks. Data, including demographics (Table 1), was collected through semi-structured interviews. Data analysis was an iterative six-phase process of reflexive thematic analysis as described by Braun & Clarke. These phases involved:

Phase One: Familiarising yourself with the data
Phase Two: Generating initial codes
Phase Three: Searching for themes
Phase Four: Reviewing themes
Phase Five: Defining and naming themes
Phase Six: Producing the report

During the postpartum period, a woman with poor or declining mental health can have psychosocial difficulties, including an altered sense of self, disrupting the relationship between the mother and her infant, her partner and the medical staff involved in her care.
Table 1: Participant Demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Midwifery qualification</th>
<th>Additional tertiary qualifications</th>
<th>Years of midwifery experience</th>
<th>Practice setting</th>
<th>Current practising role</th>
<th>Model of care currently practising in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>35</td>
<td>Bachelor of Nursing and Midwifery</td>
<td>• Certificate III in Children’s Services • Certificate III in Hairdressing</td>
<td>6 years</td>
<td>• Urban Public hospital</td>
<td>• Registered Midwife and Nurse</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 2</td>
<td>30</td>
<td>Bachelor of Midwifery</td>
<td></td>
<td>8 years</td>
<td>• Urban Public hospital</td>
<td>• Associate Midwife Unit Manager</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 3</td>
<td>26</td>
<td>Bachelor of Nursing and Midwifery</td>
<td>• Graduate Diploma of Child, Family and Community Health</td>
<td>5 years</td>
<td>• Urban Public hospital • Local Shire</td>
<td>• Clinical Support Midwife • Maternal Child Health Nurse</td>
<td>• Obstetric-led maternity care • Maternal Child Health Nurse</td>
</tr>
<tr>
<td>Participant 4</td>
<td>27</td>
<td>Postgraduate Diploma of Midwifery</td>
<td>• Bachelor of Nursing • Diploma of Nursing • Studying Master of Primary Maternity Care</td>
<td>3 years</td>
<td>• Urban Public hospital</td>
<td>• Clinical Support Midwife</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 5</td>
<td>37</td>
<td>Bachelor of Midwifery</td>
<td>• Prescribing for Midwives</td>
<td>10 years</td>
<td>• Private Practice • Urban Public Hospital</td>
<td>• Private Practice Midwife • Clinical Midwife Specialist</td>
<td>• Private Maternity Care</td>
</tr>
<tr>
<td>Participant 6</td>
<td>47</td>
<td>Master of Midwifery</td>
<td>• Bachelor of Nursing</td>
<td>13 years</td>
<td>• Urban Public hospital</td>
<td>• Caseload Midwifery Project Manager</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 7</td>
<td>46</td>
<td>Bachelor of Midwifery</td>
<td>• Bachelor of Science/Computer Science</td>
<td>8 years</td>
<td>• Urban Public hospital</td>
<td>• Clinical Midwifery Educator</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 8</td>
<td>26</td>
<td>Bachelor of Nursing and Midwifery</td>
<td></td>
<td>5 years</td>
<td>• Urban Public hospital</td>
<td>• Clinical Midwifery Educator</td>
<td>• Obstetric-led maternity care</td>
</tr>
<tr>
<td>Participant 9</td>
<td>29</td>
<td>Postgraduate Diploma of Midwifery</td>
<td>• Bachelor of Nursing • Certificate III in Pharmacy Dispensary</td>
<td>4 years</td>
<td>• Urban Public hospital</td>
<td>• Registered Midwife and Nurse</td>
<td>• Obstetric-led maternity care • Special Care Nursery</td>
</tr>
<tr>
<td>Participant 10</td>
<td>32</td>
<td>Bachelor of Midwifery</td>
<td>• Honours Degree</td>
<td>12 years</td>
<td>• Urban Public hospital</td>
<td>• Women’s and Children's Education Stream Lead</td>
<td>• Obstetric-led maternity care</td>
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<tr>
<td>Participant 11</td>
<td>26</td>
<td>Bachelor of Nursing and Midwifery</td>
<td>• International Baccalaureate, United Kingdom</td>
<td>3 years</td>
<td>• Urban Public hospital</td>
<td>• Registered Midwife and Nurse</td>
<td>• Obstetric-led maternity care</td>
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RESEARCH FINDINGS

Data analysis identified three overarching themes illustrating what midwives think are contributing factors towards PBT in women. The first theme, ‘It’s this complete control of birth’...how the healthcare system is patriarchal and assumes control of the woman and her process’, with two sub-themes, ‘Language is a basic thing’ and ‘Walking away from a sacred space feeling traumatised and damaged’. The second theme, ‘No one actually informed me...women are kept ignorant, unable to confidently advocate for themselves’, has two sub-themes, ‘Providing women with options and opportunity’ and ‘Improving the curriculum in secondary and tertiary education’. The third theme results from the factors of the first and second themes, leading to a woman ‘Feeling...she has...failed’, which encapsulates the accumulating demands of external events overwhelming her emotional needs. There are four subthemes, ‘Having my best interests at heart’, ‘The disconnect between childbirth expectations and reality’, ‘Honouring that all pregnancies, all bodies, are different’, and the ‘The pressure put on mothers’.
### Table 2: Research Findings and Exemplars

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-Theme</th>
<th>Concept</th>
<th>Exemplars</th>
</tr>
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<tbody>
<tr>
<td>“It’s this complete control of birth” … how the healthcare system is patriarchal and assumes control of the woman and her process.</td>
<td>Language is a basic thing</td>
<td>Fearful and risk-loaded language by healthcare providers</td>
<td>“[Discussing] with women about all the risks… that can go wrong when they’re in the early stage of labour and [communicating] bad signs to look for, often builds women into the mindset that is not progressive for spontaneous labour” (Participant 10)</td>
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<td></td>
<td></td>
<td>Lack of support and empathy from healthcare providers</td>
<td>“[Women are] feeling like they might not be listened to… when they come into the Pregnancy Assessment Unit… [The midwives say] you’re in early labour, go home. And the women come back, and we [midwives] just kind of dismiss it. And for them, they have never done this before… they don’t have the knowledge, so they don’t know it’s normal” (Participant 4)</td>
</tr>
<tr>
<td>Walking away from a sacred space feeling traumatised and damaged</td>
<td>Misogyny and control of women in the healthcare system</td>
<td>“Women are hated… women’s capacities have been controlled for as long as we know… women are taught to be quiet… taught to do what they’re told… to be ashamed of their bodies. Women are walking from a sacred experience, feeling traumatised and deeply damaged” (Participant 6)</td>
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<td></td>
<td>Lack of continuity of carer models over the pregnancy continuum</td>
<td>“I find it so interesting the two types of care that I provide about the private practice… [and] really get to figure out what their fears are around pregnancy, labour and birth, and the postpartum period. And we start to develop that relationship and trust. And… you just see them [women] labouring so differently as well because you can see that they trust you” (Participant 5)</td>
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<td></td>
<td>Institutionalisation of healthcare providers</td>
<td>“We now have a rather young workforce, [where] you’ve got all the beautiful wisdom that’s being lost from the… older midwives… And you’ve just got little foot soldiers of the patriarchy running around controlling women” (Participant 6)</td>
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<td></td>
<td>Staffing challenges in the healthcare sector</td>
<td>“[Healthcare providers are] pushing women out the door without full support… breastfeeding hasn’t established… [but] they’re independent with hand expressing” (Participant 5)</td>
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<tr>
<td>“No one actually informed me” … women are kept ignorant, unable to confidently advocate for themselves.</td>
<td>Providing women with options and opportunity</td>
<td>Lack of antenatal education that is unbiased to prepare women for labour and birth</td>
<td>“[Women] only get a birth planning and education appointment… which is a 40 minute appointment. They’re supposed to be offered to every woman, but the reality is, they’re only offered to women who are in the consultant obstetric care models” (Participant 7)</td>
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<td></td>
<td></td>
<td>Women to be proactive in seeking pregnancy education and different models of maternity care</td>
<td>“She went to the GP for a referral for a private midwife, and the GP said to her no, I don’t sign those, but here’s an obstetrician I can recommend... She [the woman] went and saw this obstetrician, had the private care with the plan of birthing publicly… and ended up with the works. And now she’s sitting there at home with the baby going, I don’t even know what happened. Why didn’t I see that private midwife from the first instance?” (Participant 5)</td>
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<td>Lack of gaining informed consent</td>
<td>“[When a] Code Pink (emergency caesarean) [is called], and there is minimal time to explain what is happening, and what will be happening. [There is] no chance to ask questions, and potentially [a woman is] being put under a general [anaesthetic] and missing the birth of her baby” (Participant 1)</td>
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<td>Improving the curriculum in secondary and tertiary education</td>
<td>“A woman I’m looking after today, didn’t understand that the IDC (indwelling catheter) went somewhere different to the vagina… [She had] a total lack of understanding of their own [anatomy and physiology]” (Participant 6)</td>
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<td></td>
<td>Curriculum in universities for midwives to increase awareness of birthing trauma</td>
<td>“You could get a better curriculum in universities… that actually pushes that real looking at yourself, [and] talk about trauma as a whole, trauma informed care, that nature of vicarious trauma, moral distress, moral injury, [and] how to advocate… Midwifery isn’t respected or acknowledged enough in this country. There’s just so many things that we could do to give credence to ourselves” (Participant 6)</td>
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Factors Contributing to Women’s Psychological Birthing Trauma: Victorian Midwives’ Perspectives

“Feeling... she has... failed” 
... the accumulating demands of external events overwhelming the emotional needs of women.

<table>
<thead>
<tr>
<th>Pre-existing mental health</th>
<th>Physical birthing trauma</th>
<th>Health system trust can be displaced</th>
<th>The disconnect between childbirth expectations and reality</th>
<th>Physical environments</th>
<th>Labour and birth</th>
<th>Interventions during intrapartum care</th>
<th>Emergencies during or post-birth</th>
<th>The pressure put on mothers</th>
<th>Lack of family or friend support</th>
</tr>
</thead>
<tbody>
<tr>
<td>“[Women with] a history of sexual assault or any abuse from any source... [or] other incidents that could be in any way linked [can intensify PBT in women]” (Participant 8)</td>
<td>“[The] need to move away from the various historical perception[s] of physical birth trauma being so primarily focused, and that... all outcomes in maternity care, physical and psychological health, need to be addressed and managed completely equally into care” (Participant 10)</td>
<td>“...there’s... people’s previous experiences with the health care system. I think if they’re distrusting of medical professionals in general... repeatedly had presentations for something, and... saying they’re feeling like they have been written off... or if they feel like they’ve been treated unfairly... I definitely think they come in with a suspicion that doctors, nurses, not midwives, they may not have met us before, but definitely health professionals, don’t have my best interests at heart” (Participant 2)</td>
<td>“The physical hospital setting can be traumatic for women... They’re not very inviting for the support people, where they don’t create a space where more than just the birthing woman can sit or be near each other. And a lot of women hate lying in bed, and that’s where they end up” (Participant 10)</td>
<td>“The telling [of] a woman what her body is doing and where it’s based on... [the] partogram that was written by a man... It’s the expectation that we have on a woman’s body and how it should perform, and not what the woman experiences and her body” (Participant 6)</td>
<td>Multiple medical intrapartum interventions encompass the “cascade of interventions, continuous fetal monitoring, abnormal CTG (cardiotocographic) monitoring, assisted (instrumental) births, emergency caesareans, inserting IVC’s (intravenous cannula)” (Participant 3)</td>
<td>“Staff running into the room” can affect women (Participant 11)</td>
<td>“…How hard it [breastfeeding] is for some women... anyone who does struggle with breastfeeding, you would typically find in subsequent pregnancies that it’s a big thing for them” (Participant 8)</td>
<td>“She had a partner who suffered from anxiety and her being at home and distressed [in labour] was really causing his anxiety to become quite significant. So much so that he couldn’t drive her back to the hospital when they had decided to return, so things became more complex to them, and that they had to find somebody else to get them to hospital” (Participant 10)</td>
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**Table 3: Recommendations**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Strategies</th>
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</thead>
</table>
| Improving education | • Provide women and their partners with unbiased information, allowing informed decision-making.  
• Birth planning appointments are provided to all women.  
• Improved accessibility and content in childbirth education classes.  
• Provide up-to-date evidence-based education to maternity healthcare providers.  
• Provide compassionate training for healthcare providers.  
• Improve sexual and reproductive health education in primary and secondary schooling.  
• Acknowledge birthing trauma and moral injury curriculum in tertiary education. |
| Reforming healthcare | • Provide continuity of midwifery carer models to all women, irrespective of risk.  
• Increase accessibility to private midwifery care practices.  
• Expand debriefing clinics and perinatal mental health services. |
| Future research | • Understand the perspectives of other healthcare providers in maternity care, and areas across Australia, to highlight other factors and perspectives that contribute to PBT.  
• Investigate interventions to reduce and prevent PBT in women.  
• An appreciative enquiry into the implementation of interventions to improve PBT outcomes of women in the healthcare system. |
DISCUSSION

According to our understanding, this research project is the first to explore midwives’ perceptions of factors contributing to women’s psychological birth trauma.

**Theme 1: ‘It’s this complete control of birth’ - how the healthcare system is patriarchal and assumes control of the woman and her process**

Participants acknowledged that healthcare providers could contribute to women’s psychological birth trauma (PBT) by using fearful and risk-loaded language, displaying a lack of empathy and support, and paying superficial attention to childbearing women. Midwives perceive that women are walking away from what the midwives believe is a sacred space, feeling traumatised and damaged. Midwives reported that childbearing women are being controlled by negativity, which undermines their sense of self and abilities, creating self-doubt and confusion.6,12 Negative and undermining behaviour in situations of unequal social power is known as gaslighting.12 Midwives in this study confirmed that women felt that healthcare providers were being duplicitious. An Australian survey by Keedle, et al.,6 identified that women felt ‘dehumanised’, ‘violated’ and ‘powerless’ with their experiences of obstetric violence, reporting bullying, coercion and non-empathetic care. A study by McLeish and Redshaw13 demonstrated that a lack of continuity of care in the healthcare system prevents the development of rapport, trust and understanding between the woman and the healthcare provider. Similarly, a lack of choice of care provider does not allow women to build a trusting relationship with the healthcare professional.14

The psychological wellbeing of women is not at the forefront of mainstream maternity care practice; instead, compliance with the maternity system’s institutionalised and behavioural norms is the focus.1 Pregnancy and birth are portrayed to have a physical focus, with healthcare providers preferring the assessment and management of the woman.1 Participants recognised that healthcare provider relationships with women could be affected by a woman’s previous experience within the healthcare system, whether negative or positive. Negative experiences for women, as described by participant midwives, included a lack of active listening to women by healthcare providers in the birthing room, disempowerment and women being told what to do by healthcare providers. This poor care correlates with the domestication of women’s bodies and the role of shame in obstetric violence.6,15 If a woman’s care during labour and birth is described as mistreatment, disrespectful or inhumane, it should be recognised as obstetric and gendered violence.6,15

Structural violence in the healthcare system is recognised as the base of obstetric violence.16,17 Structural violence, also referred to as social injustice,17 occurs where there are unequal power relations and, therefore, unequal life chances. In maternity care, structural violence is enacted when women in labour are treated like objects, silenced and unable to exercise their autonomy or meet their needs. Such social injustice is found in a healthcare system steeped in the values of the patriarch.15 Another example of structural violence in maternity care is how participants described the healthcare system structure as unsupportive of women over the pregnancy continuum. Childbearing women value continuity of midwifery care (CoMC).18,19 They are more satisfied, and their outcomes are better than when they have maternity care in a fragmented model.20 Limited CoMC models are available to childbearing women because health services do not provide them.21 The lack of meaningful, supportive relationships with a midwife was particularly troublesome for childbearing women during the COVID-19 pandemic. Participants described how visitor and birth support restrictions in hospitals at that time were enacted to protect healthcare providers and women from contracting and spreading COVID-19. Midwives in continuity models were redeployed to mainstream care. These new rules meant women were deprived of the support they expected and needed in the labour room.

Participants considered the overarching issues of PBT in women, identifying the influence of the patriarchal society, misogyny and the effect of the en culturation of women on the maternity system. The failings of the maternity system identified by participants included the controlling practices of doctors and midwives. They taught these controlling practices to the junior workforce, institutionalising and influencing them to continue this form of practice. Cohen Shabot and Korem15 reported that women are told ‘you should be grateful’ for a healthy baby’, and ‘everybody goes through that’,15 regarding a traumatic birthing experience, thereby compelling and controlling women to be silenced, shamed and disciplined as a birthing woman and new mother. The language used in talking to women, such as that reported by Cohen Shabot and Korem,15 was acknowledged by participants as a simple thing that healthcare providers can change to improve women’s experiences.

**Theme 2: ‘No one actually informed me’ - women are kept ignorant, unable to confidently advocate for themselves**

The participants in this study were aware of the poor education provided to women and birthing partners within the healthcare and secondary and tertiary education systems. Poor education places women in a vulnerable position. When women do not have adequate information and understanding about the birthing process, they have no choice but to put their trust in the care provider to provide good care. Midwives in this study identified problems with obtaining informed consent for routine procedures and emergencies. They contend these problems are due to women not having the background information to make informed decisions about their care. These findings correlate with a study by Reed, et al.,7 investigating women’s descriptions of childbirth trauma related to care provider actions and interactions. When comparing the results in Reed, et al.,7 and this study, all midwifery participants acknowledged the lack of informed consent and the provision of biased information for procedures in the delivery suite. According to the participants, caregivers often used coercive techniques to get women to comply with the hospital policies and procedures, including their recommendations for managing labour and birth.1 Participants midwives in my study identified that the lack of CoMC models disadvantages women. They are disadvantaged by a lack of compassion and empathy when providing education and also by poor childbirth education class content and minimal postnatal...
FACTORS CONTRIBUTING TO WOMEN’S PSYCHOLOGICAL BIRTHING TRAUMA: VICTORIAN MIDWIVES’ PERSPECTIVES
education provided by midwives in fragmented maternity services where relationship-based care is not prioritised. These disadvantages identified by the participants in this study demonstrate that women were actively prevented from having knowledge, empowerment and full control over their bodies.

Participants identified that education in the antepartum period to prepare women for birth regarding intrapartum procedures was lacking. Birth planning appointments in the healthcare system are not prioritised, as not all women are provided with this appointment. This lack of essential education disadvantages women and creates the potential for PBT. However, some participants in the study questioned why women were not proactive in seeking their own education, or different models of care to suit their needs. Education of sexual and reproductive health in secondary schools is deficient, and girls are leaving school uninformed about their bodies.22 The tertiary setting lacks education in trauma-informed care, moral distress and moral injury. It is not preparing midwives to look deep within themselves and understand how to advocate for women.

Theme 3: ‘Feeling... she has... failed’ ...the accumulating demands of external events overwhelming the emotional needs of women

Participants were aware of previous physical and psychological adverse life and previous birth outcomes contributing to women’s PBT over the pregnancy continuum. The participants’ identification of pre-existing mental health disorders’ contribution to PBT reflects the findings of an Irish study23 investigating midwives’ competency and practice in assessing and managing perinatal mental health. Both this and the Irish study identify the need to train and support midwives to determine and address perinatal mental health problems. This Victorian study indicated that the high workload of the midwife, lack of CoMC within the healthcare system and a lack of trust between women and healthcare providers prevents women from disclosing pre-existing mental health disorders and can contribute to women’s feeling of failure.

Previous negative experiences with the healthcare system and feeling as though they were written off or treated unfairly were mentioned by a participant to lead women to suspect that the health professionals do not have their best interests at heart. Participants acknowledged that experiences such as previous physical trauma, previous pregnancy loss, difficulty in conception, unexpected events involving the newborn, negative language used by healthcare providers and the cascade of interventions during intrapartum care in the hospital were elements that could overwhelm the emotional needs of women, leaving them vulnerable to traumatic experiences.

A study of midwives’ views in Wuhan, China, identified that women’s reliance on support from medical staff and their lack of care and information led to trauma.24 Similar to women’s experiences in an Indian study,25 negative experiences of unconsented birthing interventions, abuse and lack of privacy were identified by participants as contributors to a woman’s PBT. These negative birthing experiences were attributed to significant misogyny issues, including structural and relational control of birth in a patriarchal society.

Unanticipated events such as the disconnect between hospital and home birthing environments, the preference for labouring women to be passively on the bed and the restriction of natural labour movements due to electronic fetal surveillance were considered by the midwives in this study to add to women's feelings of failure. Lack of support by partners and others was identified as a contributor. The midwives acknowledged that a partner may be unsupportive for reasons such as being exhausted during the birthing process, having different birthing opinions compared to the woman, and experiencing their own trauma, which has implications for their relationship. Negative portrayals and false expectations of birth, deviations from birthing preferences and negative experiences shared by family and friends were noted as contributors to women’s feelings of failure by the midwives. Participants indicated that whilst the woman’s assessment and management followed maternity system norms,1 disregard for her knowledge and birth plan by healthcare providers added to a sense of failure and subsequent experience of PBT. This finding aligned with studies on the woman’s perspective of PBT.1,22
CONCLUSION

This study has investigated the perspective of Victorian midwives determining the factors contributing towards women's PBT. Recommendations for future practice in improving education, reforming healthcare and future research are summarised in Table 4. This will better enable women to make informed decisions about their care, be respected by, and have trusting relationships with, healthcare providers and feel psychologically safe and advocated by maternity care providers. Childbirth should be an empowering time in a woman's life and can be through the prevention of contributing factors of PBT. TPM

REFERENCES


