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How does the experience of a traumatic birth affect women's sense of self: A systematic review of qualitative and Kaupapa Māori studies.

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HOW DOES THE EXPERIENCE OF A TRAUMATIC BIRTH AFFECT WOMEN'S SENSE OF SELF: A SYSTEMATIC REVIEW OF QUALITATIVE AND KAUPAPA MĀORI STUDIES.

Abstract

Background. Birth trauma is a global phenomenon that is complex and multifaceted. Evidence shows that medical interventions can contribute to women's experiences of birth trauma. However, these experiences tend to be under-recognised by healthcare practitioners (HCP), which leads to a negative impact on maternal wellbeing that then affects relationships with infants and family. **Aim.** This qualitative systematic review was carried out through a feminist and decolonial lens, critically synthesising findings across existing studies that focus on women's experiences of a traumatic birth and provide an understanding about how it affects women's sense of self. **Methods.** A systematic search was carried out using EBSCOhost (Discovery) and Google Scholar databases. Peer reviewed studies between 2011 and 2024 were selected that explored women's experiences of a traumatic birth, focusing on their thoughts, feelings and beliefs. Searches rendered one mixed method, 11 qualitative and two Kaupapa Māori studies, resulting in 14 studies and in total over 15 articles. Twelve studies were critically appraised with the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (JBI) (Lockwood et al., 2015). The two Kaupapa Māori studies were appraised using Kaupapa Māori research principles, as described by Dr Linda Tuhiwai Smith (2012). The six step reflexive thematic analysis by Braun et al. (2023) was utilised for the synthesis. **Results.** Seven themes were identified; 'Being invisible and powerless,' 'sense of failure in unmet expectations,' 'emotional distress,' feeling suppressed, subordinated,' 'experiencing dehumanisation and violation of dignity,' 'psychological detachment as a coping mechanism,' and 'being seen, feeling connected and supported.' **Conclusion.** The institutionalisation of maternity care exposes women to experiences of traumatic birth, through the disempowered position women are placed in. This is further impacted by intersections of oppression related to race and age, as was evident for Māori women within Aotearoa. Maternity carers need to acknowledge and address how power dynamics within healthcare professionals' relationships with women impacts women's voices, choices and partnership within the birthing process.

Personal and Cultural Position

It is important to address the position of privilege and power within my own cultural identity as a 43-year-old, middle class Pākehā woman, tangata Tiriti of Aotearoa. I have acknowledged colonialism dating back to the 15th century with the Doctrine of Discovery, developed by the Catholic Church, Spain, Portugal and England (Miller, 2011) as an imposition of an ethnocentric worldview and religious ideas of superiority. It is through this law that indigenous nations and people were assimilated into a western way of thinking, through Crown institutions and systems, as well as the removal of land and self-sovereignty. It is this same imperialist ethnocentric worldview that pervades the medical systems and birthing practices of today, where medical systems can render women powerless and vulnerable to experiencing birth as traumatic (Keedle et al., 2022). While a feminist approach aids in addressing the power imbalance within current birthing practices, it does not necessarily address systemic racism (Markin & Coleman, 2023). The awareness of the history of Te Tiriti o Waitangi (Ministry of Health, 2020) and its principles are integral to guiding a reciprocal relationship between women's well-being and ethical medical research. This awareness is what informs my personal and professional identity as a mother to three children, wife, daughter, sister, registered nurse, birthing from within mentor, doula, lactation consultant, birth story listener and birth trauma counsellor. While I have had my own personal experiences of navigating maternity systems and birthing ideologies within obstetric teams as a birthing woman, I have not experienced my births as traumatic. However, as a doula I have been present and witnessed when women have experienced their birth as traumatic.

Introduction

Childbirth can be an empowering experience and a rite of passage into motherhood. However, one third of women currently report their birth as traumatic (Baptie et al., 2021). Experiencing birth as traumatic is incongruent with culturally dominant ideals of how birth should be, thereby marginalising women's experiences and impacting on maternal identity, attachment relationships with baby, and relationship breakdowns (Cronin-Fisher & Timmerman, 2023). While birth trauma is a global phenomenon, within Aotearoa birth

trauma awareness has begun to increase due to organisations such as Trauma and Birth Stress (TABS, 2016), Perinatal Anxiety and Depression Aotearoa (PADA, 2024), and Birth Trauma Aotearoa (BTA, 2024). In the wider context, on the 1st October 2012, the New Zealand Accident Compensation Corporation (ACC, 2023) began accepting specific physical birth injury claims, through the maternal birth injury pathway. While this is progressive given the origins of ACC was to provide support for working men in the 1970s (New Zealand Parliament, 2021), the psychological impacts of birth trauma for women continue to be underacknowledged and poorly recognised within Aotearoa and internationally (Ayers, 2007; Beck, 2004; Beck, 2015; Elmir et al., 2010; Greenfield et al., 2016, 2022). Therefore, funding towards psychological support for women and whānau remains inadequate (Ministry of Health, 2023). Pockets of funding exist within maternal mental health services for counselling; however, this requires health professionals to have an awareness of possible birth trauma symptoms or to actively screen for a woman's appraisal of her birth.

While birth trauma awareness continues to grow globally within research and the maternal health system, there is some dispute between women's experience of birth trauma and societal perspectives, including those of HCP, family and friends. One third of trauma is based on either self-identification or post-traumatic stress symptoms (PTSS). PTSS is a term used when women do not meet the full criteria of Post Traumatic Stress Disorder (PTSD). The prevalence of PTSD following childbirth ranges between 3% to 15% (Ayers et al., 2016; Baptie et al., 2021; Holt et al., 2018; Watson et al., 2021).

Beck (2004) states, however, that birth trauma is subjective and therefore 'lies in the eyes of the beholder' (p.28). Therefore, external identification of trauma for women should not be definitive, and rather be understood through women's perspectives. This lack of recognition and understanding of birth trauma and post-traumatic stress symptoms could be leading to inadequate support from health professionals, policy makers and funding authorities, which in turn impacts on maternal well-being (Watson et al., 2021).

Birth trauma is a complex phenomenon (Greenfield et al., 2016; Kuipers et al., 2024; Sun et al., 2023). Kuipers et al. (2024) conceptualises birth trauma as a traumatic birth experience that is embedded within a socio-ecological system that consists of three levels. The macro level consists of the broader social, political, cultural and institutional factors. The micro level involves societal influences whereby experiences of traumatic birth fail to be acknowledged within one's own belief about birth or from the interpersonal relationships

within healthcare settings, whereby the experience of trauma remains invisible. Lastly, the meso level refers to the relationship between the macro and micro levels such as the maternity ethos that consists of patriarchal and hierarchical beliefs that are supported by techno-medical dominant views that exercise power over birthing women. These aspects of the macro, micro and meso factors influence the environment that women birth in creating the 'perfect storm' (p.61) to sustain the perpetuation of traumatic birth experiences. Women's traumatic birth experiences can remain invisible and unacknowledged within a societal view of women's subordinate positioning (Keedle et al., 2022; Kuipers et al., 2024). This highlights how gendered discrimination is further perpetuated within the patriarchal and hierarchical ethos of medical and institutional healthcare systems. The environment that traumatic birth is experienced within is therefore sustained, leaving women feeling disempowered, violated and dehumanised (Keedle et al., 2022; Kuipers et al., 2024).

While the socio-ecological system affects traumatic birth experiences, Greenfield et al. (2016) state that a traumatic birth consists of "the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (p. 265). A traumatic birth experience can be defined through the perception of women's subjective feelings that occur during the labour and birth process. This may or may not involve physical injury; however, it does involve psychological distress and painful emotions that last into the postnatal period (Watson et al., 2021). Furthermore, Beck (2004) maintains that while a woman may subjectively experience childbirth as traumatic, the HCP may view the event or care as routine practice, which contradicts the woman's perception of the experience. This conflict of perspectives can further maintain an authoritarian medical perspective over the women's perspective (Keedle et al., 2022; Kuipers et al., 2024). This highlights a continuation of power imbalance within the health system that is working to position women at the centre of care, and the impact this power imbalance has when it does not acknowledge women's voices, despite placing women in the centre. These oppressive powers can impact on an individual's sense of self.

Power imbalance can exist in many ways within the birth space. Power is not inherently negative; however, it can become imbalanced within the birthing process when maternity systems fail to acknowledge the hierarchical and patriarchal power within the system and how this may shape health professionals' views and practices (Lindemann, 2012; Regitz-Zagrosek, 2012). Knowledge is power, and how knowledge is gained, viewed and

understood depends on the perspective of the observer, or as Foucault (2002) describes it, the 'gaze'. Power imbalances exist when systems and institutional structures, such as maternity systems, believe that guidelines, protocols and policies outweigh women's and whānau beliefs and values, without an informed conversation. These actions continue to oppress and marginalise women's autonomy. This same oppressive power is not new, and was used in the 1800s in the colonisation of New Zealand Māori, where Māori cultural practices were forbidden to take place due to the Tohunga Suppression Act and the marginalisation of indigenous practice within the Midwifery Act. Today, it is within the context of this same set of oppressive power dynamics that women may birth. Kuipers et al. (2024) make a point that women tend not to be aware of the socio-ecological system they are birthing in.

How colonisation has impacted Māori in the past continues today through themes of disconnection, dehumanisation, powerlessness and loss of control. Wepa and Te Huia (2006) stated that the 1904 Midwife Registration Act and the 1907 Tohunga Suppression Act prevented traditional Māori birthing practices. Pre-European birthing practice was interwoven within traditional Māori beliefs (Best, 2014; Hawaikirangi, 2021) where stories were shared about female entities, such as Papatūānuku, Hineahuone and Hinetitama who shaped understanding of the role and value of women. Traditionally birth took place in a whare kōhanga (nest house) (Best, 2014; Durie, 1998; Hawaikirangi, 2021) where women birthed upright, kneeling, or squatting. Tohunga were called upon when required for spiritual support (Wepa & Te Huia, 2006), offering karakia to the wāhine (women) and pēpi (baby). Kiddle et al. (2020) state that the aforementioned Acts prevented Māori from maintaining autonomy and suppressed cultural identity, rendering Māori powerless and dehumanised. Therefore, thorough consideration of the historical trauma caused by colonisation for Māori is important when conducting a systematic review about birth trauma in Aotearoa today. These themes also impact on other indigenous groups and minority cultures, with Markin and Coleman (2023) drawing attention to the role of gendered racism during childbirth trauma.

Aim

The subjective response of women, especially if their experiences of birth was traumatic, is essential to know about, as this may provide insight into the experiences of others. Through counselling and trauma therapy, it is recognised by Maté (2024) that 'trauma is not what happened to you, but what happened inside of you'. Therefore, the meaning which is assigned to it is what can impact one's self-concept or sense of self. Therefore, the research aim is to explore through systematic review methodology how the experience of a traumatic birth affects a woman's sense of self.

This research could provide insight for counsellors, health professionals, women and whānau regarding a women's intrapersonal relationship (meaning the relationship a woman has with herself) when they experience their birth as traumatic. While Beck (2015) explores events within birth as like a pebble that creates a ripple through water, so too does an impact of a traumatic birth ripple through women's understanding of themselves, their own well-being and their interpersonal relationships. Raising awareness of the psychological impacts of birth trauma and personal experiences ensures women's voices are heard and helps inform women, families, counsellors, HCPs, advocates and policymakers.

Methods

A qualitative systematic review was conducted to ensure a systematic, transparent, and robust search, appraisal, and synthesis process in order to provide substantiated evidence on how a traumatic birth affects a women's sense of self. Choosing a qualitative research question prioritises lived experience and sense-making, and provides a greater depth of information than what is achieved through quantitative research (Boland et al., 2017). Therefore, through a feminist theoretical lens and incorporating qualitative methodologies that privilege women's voices, researchers can address gendered power imbalances within research. Centralising women's stories enables me to advance my own understanding as to the meaning women can take from their experiences of birth. The initial stage involved structuring this systematic review in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Liberati et al., 2009). Secondly, eligible studies were selected through a search and selection process, critically

appraised in relation to quality, and synthesised through a reflexive thematic analysis (Braun et al., 2023).

The underpinning theoretical perspective is feminist and decolonial and acknowledges the dominance of the hierarchal and patriarchal constructions of knowledge. Therefore, it is integral to addressing existing power imbalances and how these colonial strategies continue to create race, class, and gender inequalities, contributing to marginalisation and social/health inequities (Keedle et al., 2022; Kiddle, 2020; Marshall et al., 2022). This foundational perspective is grounded within a critical realism epistemological paradigm, where "knowledge of reality is mediated by our perceptions and beliefs" (Thomas & Barnett-Page, 2009). The methodological positioning for this systematic review aligns with my ethical and cultural positioning as a female, Pākehā health care practitioner and counsellor.

Search Strategy (or Search Procedure)

To identify eligible studies, key words and sequences (see Table 1) were applied within an electronic database called EBSCOhost (Discovery), which included but was not limited to: CINAHL, Academic Source Premier, Complementary Index, APA Psyclnfo, Health Source and Scopus.

Table 1

Initial Keyword Search

	Key words
Line 1	"birth trauma" OR "traumatic birth*" OR "childbirth trauma" OR "traumatic childbirth*"
Line 2	experience* OR subjective OR sense* OR belief* OR values OR thoughts OR cognition* OR attitude* OR opinion* OR perspective* OR perception*
Line 3	qualitative OR phenomenolog* OR ethnograph* OR "grounded theory" OR interview* OR "focus group*".

Separate searches to further identify studies through Google Scholar were conducted using the same codes: "Birth trauma" OR "traumatic birth" OR "childbirth trauma" OR "traumatic childbirth" AND experience OR subjective OR sense OR belief OR values OR thoughts OR cognition OR attitude OR opinion OR perspective OR perception AND qualitative OR phenomenology OR ethnography OR "grounded theory" OR interview OR "focus group".

It was identified during the screening process that there was no Māori voice within the articles. This is significant as this systematic review is carried out in Aotearoa, where tangata whenua, wāhine Māori voices historically have been silenced (Kiddle, 2020; Simmonds, 2011). Hence, a second search was created with the guidance of cultural supervision and a Māori information specialist in order to actively uphold Te Tiriti o Waitangi through this research process (Ministry of Health, 2020). It was also considered important given the epistemological feminist and decolonial research standpoint aiming to address inequalities of marginalisation and oppression (Punch & Oancea, 2014; Smith, 2021; Sprague, 2005). The second search was also undertaken through EBSCOhost (Discovery) (see Table 2), but it expanded experiences of birth trauma into experiences of childbirth for wāhine Māori. The following Google Scholar key terms were used: childbirth* OR birth* AND Māori OR wāhine AND experience* OR subjective OR sense* OR belief* OR values OR thoughts OR cognition* OR attitude* OR opinion* OR perspective* OR perception* AND women.

Table 2

Māori Keyword Search

	Key words
Line 1	childbirth* OR birth*
Line 2	Māori OR wāhine
Line 3	experience* OR subjective OR sense* OR belief* OR values OR thoughts OR cognition* OR attitude* OR opinion* OR perspective* OR perception*.
Line 4	women

Inclusion and Exclusion Criteria

The titles and abstracts, and where necessary the full text of articles, were screened from both EBSCOhost searches to select studies that included findings about 'sense of self' in relation to experiences of a traumatic birth. From selected studies, the reference lists were scanned, in order to identify any further relatable studies. All studies from the two searches were required to meet all criteria outlined in Table 3.

Table 3

Inclusion Criteria

Criterion	Inclusion description
Population	Postnatal women (average age 18 years) who have subjective experience of a traumatic birth
Study design	Qualitative, mixed method (focusing on qualitative data) and Kaupapa Māori research
Phenomenon of interest	Experience of birth trauma classified during onset of labour to the birth of the placenta, may or may not be experienced previous trauma, anxiety or depression, psychological trauma looking at sense of self
Publication status	Peer reviewed and published
Publication date	Published after 2010 (due to a 2010 systematic review)
Publication language	Full-text available in the English Language

A study was excluded if it focused on physical trauma without psychological trauma, or the partner, support people or HCP experiences or perceptions of the birth experience. Articles focusing on experiences of a preterm birth (birth before 37 weeks gestation) were also excluded due to the complexity of intensive care experiences and long-term stay, which requires its own inquiry. Studies about the experience of miscarriage, stillbirth or death of a newborn were also excluded, due to the complexity of the grief process and the trauma of an absent newborn, which also requires a separate inquiry into women's experiences. Trans and non-binary people's experinces were excluded, due to lack of research, which requies a need for future research involving trans people.

Quality Assessment

To ensure quality assurance of findings, all articles were assessed through tools that aligned with the methodological approach. Twelve articles were assessed using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) in order to appraise possible bias within the research. The two Kaupapa Māori studies were appraised using Kaupapa Māori research principles, as described by Dr Linda Tuhiwai Smith (2012).

While it is recommended for reflexivity that assessments of articles be carried out with two appraisers (Lockwood et al., 2015), for transparency two out of 14 studies were reviewed within supervision, the rest were discussed within peer support sessions. The two Kaupapa Māori articles were critically assessed in collaboration with a cultural supervisor. The rationale being that Indigenous knowledge, specifically Māori knowledge within Aotearoa

New Zealand, sits within its own epistemology of how knowledge is gained and the making of meaning (Smith et al., 2016). This ensured a culturally safe process in order to uphold and maintain Mātauranga Māori. This was important to consider as a Pākehā researcher.

Data Extraction and Synthesis Procedure

Data extraction was carried out in two steps. Firstly, standard descriptive information was extracted and tabulated, including author, aim, location, when conducted, qualitative approach, data collection method and analysis, recruitment and sample characteristics. Type of labour and mode of birth were also extracted and tabulated where possible providing additional insight into the birthing context. The second step involved extracting findings related to sense of self from the results sections of studies and placing these in the data extraction table. Next, Braun and Clarke's (Braun et al., 2023) six step process of reflexive thematic analysis was followed. This involved reading and rereading the articles in order to become familiar with researcher and participants' tone and language, concentrating on the results section of articles (step one). Both the women's quotes and researchers' statements about the women's experience of a traumatic birth were extracted, including expressed emotion, thoughts and beliefs. These findings were then coded using NVivo qualitative software (step two) and from here initial themes were generated (step three), reviewed (step four), then themes were refined and defined to capture the core concepts (step 5) which produced the theme's story (step six). Throughout this process, the developing themes were discussed and concerns were addressed within fortnightly supervision sessions and peer support groups. This helped to maintain reflexivity and through collaborative discussion it brought different perspectives that enhanced the rigour and credibility (Punch & Oancea, 2014), while themes were analysed, defined, and named.

Ethical Considerations

This systematic review is a requirement for undertaking a Masters-level research project. This secondary research review does not require full ethical approval. However, a low-risk notification report was required for ethical risk assessment, which I carried out with my research supervisor, cultural supervisor and research students within Masters of Counselling. For this, the Massey University code of ethical conduct (Massey University, 2017), New Zealand Association of Counsellors code of ethics research section (New Zealand

Association of Counsellors, 2020) and Te Ara Tika (Hudson et al., 2010) were reflected upon by the researcher and interwoven throughout the construction of the systematic review to the dissemination of findings. Limiting potential research bias and supporting the researcher's own wellbeing was addressed through maintaining an active reflexive process. This included fortnightly group supervisions, personal supervision sessions, research retreats, cultural supervision and journaling, and incorporating Tihei-wa Mauri Ora (Piripi & Body, 2013) as a tool for self-reflection.

Results

Study Selection

The initial 'birth trauma' search, which was carried out using EBSCO-host discovery and Google Scholar, identified 849 potential papers. After duplicates were removed, 310 papers remained for title and abstract screening. Subsequently, 284 were excluded, therefore 26 remained for eligibility screening of the full text. Thirteen studies were excluded due to being a systematic review or conference abstract, having an unsuitable topic focus or limited depth in the presentation of the findings. Reference lists of relevant articles were hand searched, rendering no furthers studies to add. Therefore, this step resulted in 12 studies being selected (with two articles being about the same study (see Figure 1).

As shown in Figure 2, the search of EBSCO-host discovery and Google Scholar to identify articles relating to 'childbirth and wāhine Māori' resulted in 183 potential papers. After de-duplication, 68 articles remained, of which 64 were excluded during title and abstract screening. Four full text articles were assessed against inclusion and exclusion criteria and a further two were excluded due to unsuitable focus. Reference lists of relevant articles were hand searched rendering no further articles. Together, the searches resulted in a total of 15 articles or 14 studies being included.

Figure 1

Flow Diagram Showing Search and Selection of Studies about Birth Trauma.

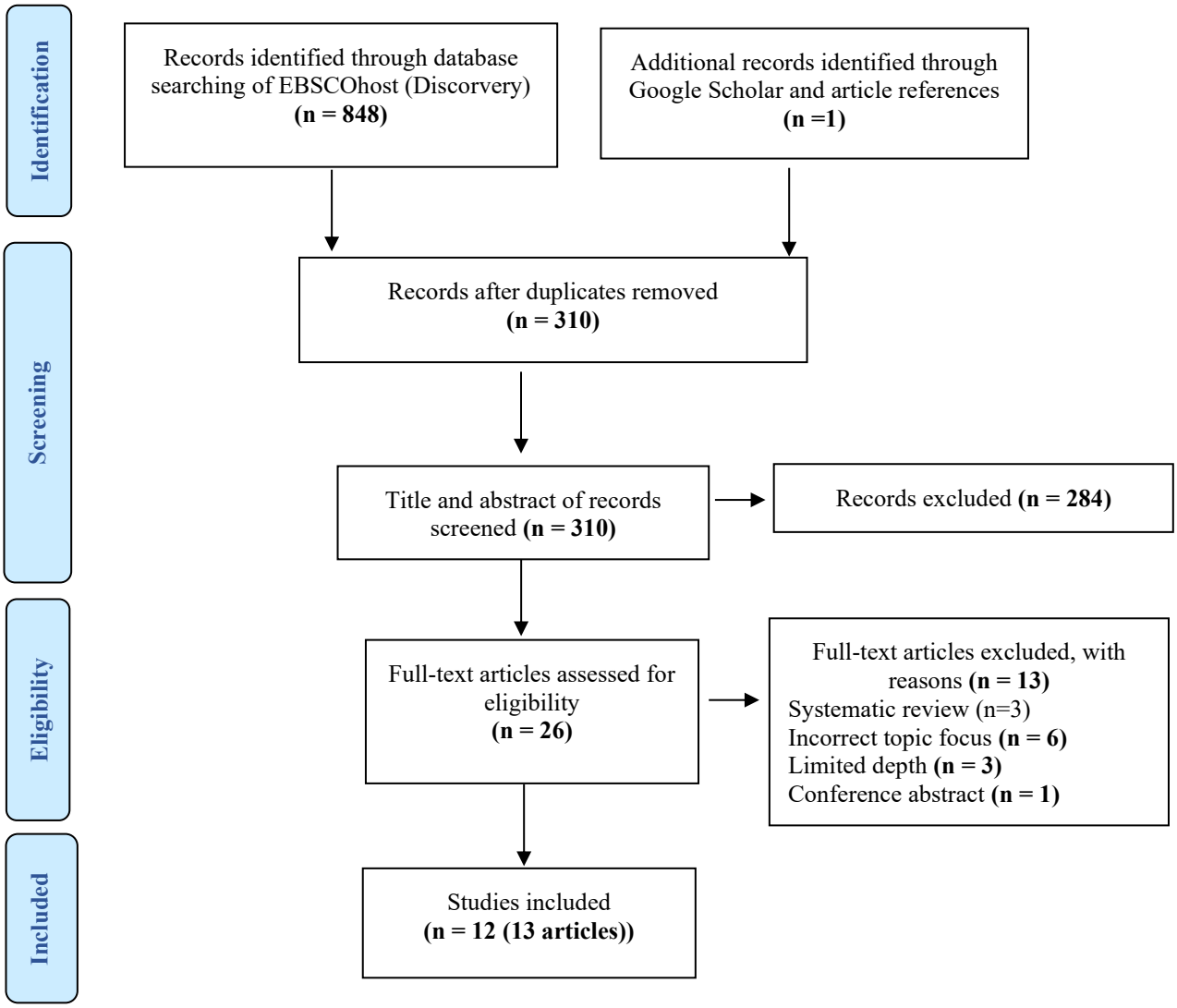

Figure 2

Flow Diagram Showing Search and Selection of Studies about wāhine Māori experiences of Childbirth

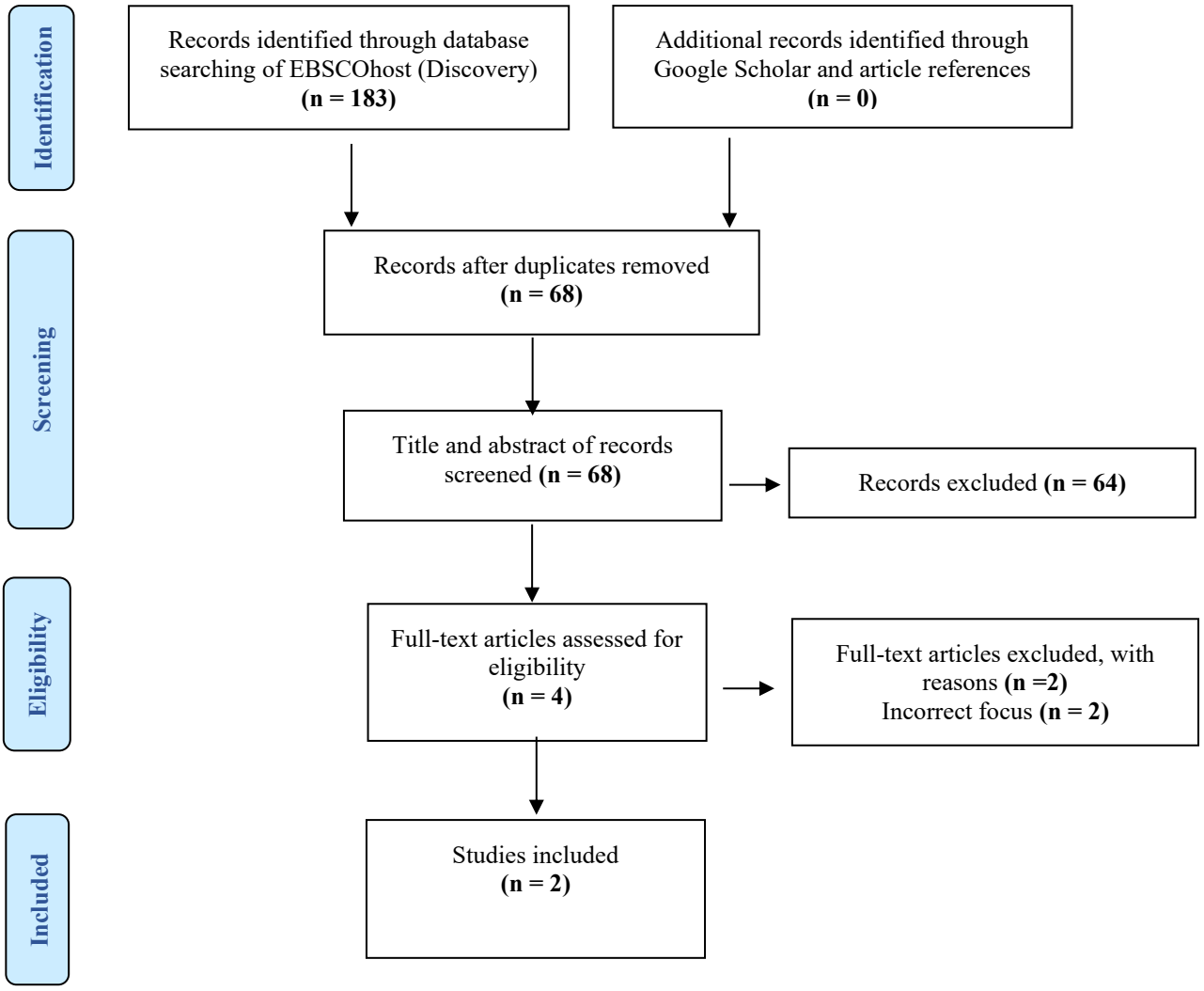

Table 4

Data Extraction Table of Study Characteristics and Findings

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Abdollahpour & Motaghi (2019) Describing mothers' lived experiences which make them perceive their childbirth as traumatic. Iran Conducted: 2016	Qualitative, descriptive phenomenological study, semi-structured interviews (face to face) Colaizzi phenomenological methodology approach to analyses.	A purposive sample of 29 women who were in Nohe-Day Hospital for 48 hours in the postpartum ward; 7 had reported having a traumatic birth experience. -Women's experiences were defined by DSM-V-A criteria. -Parity: 1-6, mean: 2.4 (SD: 2.7) -Age 18-41, mean: 28.4 (SD: 6.6) -48hrs since birth -Ethnicity: Not identified - No mention of previous trauma or mental health	Not recorded	Emotional experience: refusal to admit to hospital, due to only being in early labour, excruciating pain, staff's neglect and lack of understanding, being ignored. Separated from family and support people. Mothers' physique and body is questioned, mother perception Legal experiences and human dignity: women's rights were not respected and the mother was invisible to medical staff. Clinical experiences: unavoidable childbirth complications: preexisting medical concerns. Avoidable childbirth complications: i.e., curettage, revision placenta and invasive therapies Environmental experiences: Lack of proper supervision and management	lack of control - felt exhausted, feeble and incapable, helplessness Angry: feeling abandoned Felt fearful Despair and disappointment Feeling incompetent: sadness and sorrow Feeling disrespected, no one is telling me what is going on. We are not treated like human beings I thought I or my child might die

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Baptie et. al, (2021) Identify and compare experiences of childbirth for mothers who reflect on birth as a traumatic or non-traumatic event. UK Conducted: February – April 2020	Qualitative: Phenomenological, semi-structured interviews (over the phone), thematic analysis	A sample of 14 women from a separate longitudinal study, were recruited through social media. 7 reported having a traumatic birth experience. -Primiparous: 3/7 -Multiparous: 4/7 -Age 24-41 -3-5 months since birth -Ethnicity: Six White, one mixed race. - No mention of previous trauma or mental health	Induction: 1/7 Forceps: 1/7 Planned caesarean section: 3/7 Emergency caesarean: 2/7 Vaginal birth: 2/7	Inconsistency in staff or lack of staffing, during labour, birth and postnatal. Impersonalized care, ignored. Birth environment, no choice, disconnected, undignified. Poor communication, procedures performed without consent being gained. Limited information.	Overarching powerless Distrust Disappointment Let down, feeling robbed of a special experience Lacking control, fearful, Feeling physically disconnected from their bodies, feeling detachment. Vulnerable, exposed, and defeated, fearful for themselves or their baby. Feeling unsafe

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Brown et al. (2022) To understand the process of fostering resilience after a traumatic birth. UK Conducted: Not mentioned	Qualitative, semi-structured interviews (face to face), constructivist grounded theory	A sample of 8 women were recruited using a snowball technique through word of mouth, and website advertisement though National Childbirth Trust. -only women who classified themselves as having overcome the experience of a traumatic birth -those currently experiencing postnatal depression and/or PTSD symptoms were excluded. -Primiparous: 4/8 -Multiparous: 4/8 -Age: 30-50 -6-15 years since birth -Ethnicity: 6 White British, and 2 Black British - No mention of previous trauma or mental health	Not specifically mentioned	Lack of care, not informed about complications Women's pain and distress ignored or not being supported by health professionals. Lack of two-way communication between HCP and women. No discussion or consent Complications	I don't know or don't understand. Feeling terrified, felt do not matter My body was invaded, felt invisible, at times violated. I had no choice and no control Potential for their own death.

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Byrne et al. (2017) Explore the subjective experience of birth trauma among first time mothers in Ireland Ireland Conducted: Not mentioned.	Mixed method, included semi-structed interview (face to face), interpretative phenomenological analysis (IPA)	Women were recruited through an Irish online pregnancy and parenting forum. -Total: 7, primiparous mothers who reported birth trauma, without significant symptoms of peripartum depression (PPD) -Experiencing symptoms of PTSD but do not necessarily meet diagnostic criteria for PTSD. -One participant was diagnosed with PTSD. -Age 27-34 -2 to 8 months since birth - Ethnicity: Not identified -History of previous trauma and mental health issues	Induction: 5/7 Epidural: 5/7 Ventouse: 2/7 Natural: 1/7 Pethidine: 3/7 Episiotomy: 1/7 Emergency Caesarean: 1/7 Caesarean: 1/7 Vaginal: 5	Impersonal system of non-individualized care Failing to achieve collaboration during childbirth Acted upon during childbirth a 'production line' Pain and overwhelming childbirth experience Playing a game- requiring unquestioning cooperation Failing to fit within the childbirth system Coping mechanism failed	Lack of control Women felt undermined, excluded and isolated Dismissed, dehumanised and passive Detached self, coping through dissociation Resistance and avoidance to unpack I am not good enough Self-blame Doubt

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Evans (2024) To understand the lived experiences of birth trauma among African American women. USA Conducted: Not mentioned.	Qualitative, descriptive phenomenological, In-depth interviews (unsure if face to face or online). Thematic analysis	Flyers were posted on several birth trauma support pages on Facebook - 6 African American women who self-reported to have experienced birth trauma at some point in their lives. -all participants were diagnosed with PTSD post birth. -Primiparous: 2/6 -Multiparous: 4/6 -Age 18-41 - within 1 year since birth - Ethnicity: African American -History of racial discrimination	Not specifically mentioned	Hospital staff not understanding women's reality Feeling incapable to birth Racism in society paralleling the birth experience Medical staff disregarding women's voice Skin colour affecting medical treatment during birthing experience	Feeling alone, Feeling misunderstood, Doubting oneself/feeling incapable Loss of hope, hopeless Feeling so angry, feeling brushed off Prompt to action – not treated fairly due to the colour of my skin

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Ketley et al. (2024) To explore how women experience post-traumatic growth following a traumatic birth. UK Conducted: Not mentioned.	Qualitative, semi-structured interviews (face to face), interpretative phenomenological analysis (IPA)	8 women were recruited through social media (though living in England). Self-defined birth trauma and reported post traumatic growth. -Primary care PTSD screen used to exclude those experiencing trauma symptoms. -Primiparous: 4/8 -Multiparous: 4/8 -Age: 30-39 -0 to 5 years since birth -Ethnicity: White British - No mention of previous trauma or mental health	Not specifically mentioned	Shattered assumption expectation vs reality. Stories shaped from professionals, family, friends and TV – differed from their reality. Societal and cultural influences. Medicalised birth Underwent unwanted interventions, did not received pain management	Challenged identity as women and mothers. Sense of shock or betrayal Feeling of loss Feeling guilty and that they had 'failed' or their body had failed them Feeling of not doing birth properly Lack of power

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Koster et al. (2019) To explore women's traumatic childbirth experiences in order to make maternity care professionals more aware of women's intrapartum care needs. Netherlands Conducted: March-May 2016 (two articles covering the same study) Frontein-Kuipers et al. (2018) To explore and articulate women's recall of emotional birth trauma experiences. Netherlands Conducted: March-May 2016	Qualitative, grounded theory design with a constant comparison method. Semi-structured interviews (face to face) interpretive analysis Qualitative, feminist perspective, narrative interviews (face to face) thematic analysis - voice of the 'I' were extracted, to form I-poems	36 women were included, recruited through Facebook through snowballing. -women self-identified as experiencing psychological distress with an enduring emotional effect. Proficient in Dutch language -This study was part of a larger project 'women's centered care' -Primiparous: 32/36 -Multiparous: 4/36 -Age: 19-41 -3months and 3 years since birth -Ethnicity: Not identified -History of mental health or past trauma was excluded from study	Induction: 18/36 Spontaneous vaginal birth: 22/36 Instrumental vaginal birth: 4/36 Caesarean birth: 10/36 Freebirths after a traumatic birth experience 3/36	Lack of information and consent – maternity care professionals' unilateral decision making during intrapartum care, lacking informed-consent. Feeling excluded – women's mal-adaptive response to the HCP one-sided decision making, Discrepancies – inconsistency between women's expectations and the reality of labour and birth – on an intrapersonal level. The journey – unmet hopes and expectations of women during pregnancy, birth and thereafter. The 'I' in the storm – women's notions of painful thoughts and memories. The other – women's responses to the interaction with HCP. The environment – sensory awareness of the birthing environment.	I had no control, shocked I had no power, I felt ignored, paralysed and numb. Leaving women feeling distant, alienated and estranged from the childbirth event and the experience. Dehumanised I felt so bad, I just wanted to do it over again, an unfit mother and women. Feeling unprepared and overwhelmed. A sense of unexpectedness and unmet needs. Anger, feeling scared, being frightened, upset, panic and mental defeat Felt ignored and dismissed, dehumanized, undermined and excluded. Lack of privacy and lack of dignity

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Lawrie et al. (2024) To understand the experience of wāhine Māori who experienced a caesarean delivery. To identify how Healthcare systems can better meet their needs. Aotearoa NZ Conducted:	Kaupapa Māori research, Kaupapa Māori principles, individual interviews (2 in person and 2 over zoom). Braun and Clarke's thematic analysis	4 wāhine Māori were recruited through the researchers' networks. 3 out of 4 where known to the interviewer. All participants experienced at least one caesarean delivery in Aotearoa. Self-defined negative birth experience. -Asked to describe their experience of giving birth via caesarean. -Parity 1-4. -Age: 27-33 -0 to 6 years since birth -Ethnicity: Māori -Impacts of colonisation and intergeneration trauma	Induction: 2/4 Caesarean: 4/4	Lack of bodily autonomy Feeling as though choices were taken away Caesarean presented as the only option Not being able to set physical boundaries. Hospital staff rushed Unexpected birthing experience Reality not matching the prevailing discourse that birth is meant to be, the best thing that happens to you. Society expects certain emotions and gratitude	Feeling out of control Perceived lack of choice Unable to stand up for myself Don't feel comfortable enough to set boundaries ask for what is wanted or needed. I didn't know I could say no. I felt like a number Feeling denied in their ideal birthing experience I am sad That's not enough

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Morris et al. (2023) How does the victimization of women's bodies in medical interactions contribute to their experience of gendered violence? USA Conducted: July 2017- March 2018	Qualitative, feminist standpoint epistemology, semi-structured interviews via phone, Braun and Clark's thematic analysis.	101 women were recruited via Facebook and reddit pages through an on-line survey. -asked to describe their experience of forced or coerced procedures during birth. -Parity 1-7. -Age: 18-39 -0 to 27 years since birth -Ethnicity: White 84% Hispanic 10%, African American 2%, Multiracial 2%, Asian American 1% - 1 disclosed history rape, 1 PTSD after birth	Not specifically mentioned	Feeling as though during their labours and births they were sexually assaulted or raped Structure of hospital protocols Frequent cervical exams after saying No! No consent for cervical check Partners enforcing hospital protocols and not advocating for their partner. Forced catheterisation, nurse got partner to lay on birthing women Unconsented anal checks post birth –not sexual in nature	Dissociation, anxiety, self-blame, not reporting the abuse - powerlessness Felt owned and processed no control It was horrific, referred to worse than being raped at age 14yrs It was humiliating. I felt violated

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Murphy & Strong (2018) Focus on the events during and after the birth while also setting the births in their medical context. UK Conducted: Not mentioned.	Qualitative, semi-structured interviews (face to face), Narrative analysis	Women were recruited through a perinatal counselling contact list, from South East National Health Service (NHS). -Total: 4 women who experienced birth trauma during their first birth. 3 had gone onto have children since - Age 30-42years -3 to 8 years since birth - Ethnicity: White British -1 women history of sexual abuse and PTSD -1 women had PTSD postnatally.	Epidural: 2/4 Gas and air: 2/4 Membrane sweep: 1/4 Pethidine: 2/4 Episiotomy: 1/4 Ventouse: 1/4 Emergency Caesarean: 3/4 Vaginal: 1/4	Experiencing birth trauma: Medical procedures for birth preparation and in labour Unbearable pain Being invisible: absence of engagement between staff and patient, uncaring in a health focused environment. Lack of medical accountability Staff just getting on with it: Routine for clinical staff Latent messages from nursing staff; be in control of emotions. Accept the experience, no matter how testing.	Lack of control Sense of powerlessness, fear She thought she was going to die Existential threat To sense of self-integrity, Passivity Feeling left out, invisibility, sense of disembodiment. She didn't know where her baby had gone, this led to confusion and anxiety. Dismissed sense of distress

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Stevenson et al. (2016) To explore birthing experiences of Māori women under 20 years of age and understand the maternity health care system from their perspective. Aotearoa New Zealand Conducted: 2010-2013	Kaupapa Māori research, longitudinal qualitative, Mana Wāhine methodology. Semi structured interviews, kanohi-ki-te-kanohi (face to face). Interpretive phenomenological analysis (IPA)	16 wāhine Māori who were involved in the E Hine study were invited to participate in sharing their birth experience. Wāhine were recruited through local health, education and social services. -Under 20 years of age when pregnant. -Majority of wāhine were primiparous. -Age: under 20 years -0 to 6 years since birth -Ethnicity: Māori - Colonisation, 1 disclosed history of domestic violence	Not specifically mentioned	System issues Poor communication Miscommunication Inconsistency in care Discrimination and inadequate care in early labour Separation from baby and whānau	 Freaking out I didn't know what was happening Scared and unaware Frustrated Great discomfort and pain not being believed It was really hard, separation anxiety
Sutton et al. (2023) Examines the expectations that a group of women had regarding pain relief, how these expectations developed and what happened to requests for pain relief in labour. Australia	Qualitative study, case series design and limited longitudinal approach, carried out over 2 years. Grounded theory, semi-structured interviews (Face to face) hierarchical thematic analysis.	15 women were recruited through low-risk outpatient clinic at a public hospital in Melbourne Australia. First-time mothers intending to have a 'natural' birth. -Researcher defined if birth was traumatic due to their criterion. -Primiparous: 15/15 -Age: 22-32 -Carried out as soon as possible after birth. -Ethnicity: Not identified	Epidural: 7/15 Pudendal block 1/15 Spinal block: 1/15 Gas and air: 15/15 Pethidine: 2/15 Sterile water injection: 2/15 forceps: 3/15 Syntocin: 4/15 Induction: 1/15 Emergency Caesarean: 2/15 Vaginal: 13/15	Expectation not matching reality of birth: Birth dissonance, pain of birth outweighs their expectation. Women's request for pain relief denied by caregivers Have to have interventions and technology used during birth Society expectation – perceived expectation that it is better to aim for a natural birth. Assumption that pain in labour is part of natural birth and essential	Felt that they had failed Felt ignored I was really angry Felt disempowered

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Conducted: Not mentioned		- No mention of previous trauma or mental health		process of the 'rendering' of a mother.	
Taghizadeh et al. (2014) To understand psychological birth trauma from the perception of Iranian mothers. Iran Conducted: September 2011 to February 2012	Qualitative, descriptive phenomenological, In-depth interviews (Face to face) Conventional content analysis	23 Iranian mothers were recruited through Tehran and Isfahan health centres. Criterion of PTSD and DSM-IV-R were used to recognize birth trauma. -Primiparous: Unclear -Multiparous: Unclear -Age 18-50 years -72hrs – 32 years since birth -Ethnicity: Not identified -No mention of previous trauma or mental health.	Unclear	Childbirth suffering On set of labour Admitted to the hospital Requiring surgery Operating room Lack of coping skills to deal with the fear	Feelings of fear, anxiety, helplessness and sense of impending death (collapse) Powerlessness Loss of existence Loss of control

Author(s), aim, location and when conducted	Qualitative approach, data collection method and analysis	Recruitment and sample characteristics	Type of labour (interventions used) and mode of birth	Act that leads to experience of trauma	Findings related to sense of self
Zhang et al. (2020) To explore Chinese women's lived experiences of psychological birth trauma during labour and birth. China Conducted: May to August 2018	Qualitative, descriptive phenomenological approach, in-depth semi-structured interviews (face to face). Colaizzi's method of phenomenological analyze	24 women were recruited using purposive sampling from obstetric wards of a hospital in Wuhan, China. -Women self-identified themselves as experiencing a traumatic birth. -Primiparous: 13/24 -Multiparous: 11/24 -Age: 29-35 -0-1 week since birth -Ethnicity: Not identified -No mention of previous trauma or mental health	Natural childbirth: 9/24 Inducing labour: 2/24 Planned cesarean section: 10/24 Emergency cesarean section: 3/24	Intensity and endurance of the pain were far beyond what they had imagined Inaccessibility to labor analgesia Society pressure for natural birth as normal and makes you stronger as a mother Burden of expectation Lack of support from family and medical care Request for pain relief rejected	Fear of labor pain and loss of self-control Felt like near death Not feeling heard or understood I failed to push my baby out I felt petrified Felt upset and fragile Felt neglected and forgotten Powerless, abandon Loss of confidence and being left in the lurch

Summary of study characteristics from data extraction

As shown in Table 4, the 14 selected studies were conducted between 2011 and 2024. Seven were carried out between 2011 and 2020, and seven were carried out in the last four years. They were carried out in various countries: one each in Ireland, the Netherlands and Australia; two each in Iran, China, USA and Aotearoa; and four in the UK. Ethnicity was unspecified in studies from Australia, China, Iran, Ireland, and the Netherlands. UK studies mainly involved White British participants, with some Black British and mixed-race individuals. USA studies focused on African Americans and a diverse group including White, Hispanic, African American, multiracial, and Asian American participants. Aotearoa studies centred on Māori participants. In six studies, some of the participants reported prior experiences of trauma before the traumatic birth experience, for example, sexual abuse, domestic violence, colonisation, intergenerational trauma, racial discrimination.

The research methods consisted of one mixed methods paper, 11 qualitative papers, and two Kaupapa Māori research papers. Three studies conducted interviews within one week of the woman experiencing birth trauma, three within three months to one year after birth, and eight explored experiences from one to 32 years post traumatic birth experience. Four studies focused on first-time mothers, while 10 studies included both first-time mothers and mothers who had experienced trauma with later pregnancies. Half the studies did not specify the type of labour or mode of birth. However, the other half reported high interventions and caesarean birth rates.

Quality of the Studies

As shown in Table 5, the majority of studies (11 qualitative and one mixed methods) adequately addressed congruity. However, the Taghizadeh et al. (2014) study included a table that was filled with errors and incomprehensible to both myself and my research supervisor. While the tables were incomprehensible, the qualitative findings adequately addressed the research questions through the direct quotes that Iranian women shared, and therefore the study was kept for synthesis. A common trend was the lack of consideration given to researcher positionality, with this occurring for half of the articles. This raises concerns regarding possible cultural and ethical considerations, in relation to the researchers potential bias and reduces transparency within the findings.

Table 5

Quality Assessment of Studies using JBI Critical Appraisal Checklist for Qualitative Research

Checklist Question	Abdollahpour & Motghi (2019), Iran	Baptie et al. (2021), UK	Brown et al. (2022), UK	Byrne et al. (2017), Ireland	Evans (2022), USA	Ketley et al. (2022), UK	Koster et al. (2020), Netherlands	Fontein-Kuipers et al. (2018), Netherlands	Morris et al (2023), USA	Murphy & Strong (2018), UK	Sutton et al. (2023), Australia	Taghizadeh et al. (2014), Iran	Zhang et al. (2020), China
Congruity between philosophical perspective and research methodology?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Congruity between research methodology and research objectives?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Congruity between research methodology and data collection methods?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Congruity between research methodology and representation/ analysis of data?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	?	✓
Congruity between research methodology and interpretation of results?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Statement of researcher theoretical/cultural position?	×	×	✓	×	×	✓	✓	✓	×	?	✓	?	✓
Influence of the researcher on the research, and vice-versa, addressed?	✓	×	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participants' voices adequately represented?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Evidence of ethical approval?	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	✓
Conclusions flow from analysis/ interpretation of data?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	?	✓
Include study?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Yes (item adequately addressed); × No (item not adequately addressed); ? = unclear (insufficient information provided)

As mentioned earlier, the two Kaupapa Māori articles were critically appraised through Kaupapa Māori principles in order to align with Māori knowledge and values. The findings are shown in Table 6. In both articles, Māori voices were upheld and honoured. Kaupapa Māori principles guide research for Māori by Māori, was emphasised in the articles as well as the process to avoid victim blame and instead provide action points on what works, what does not work and how to move forward in both studies. As I am Pākehā and do not whakapapa to Māori, my appraisal is from an outsider standpoint and is limited by my own understanding of Kaupapa Māori worldviews. However, this process, which was conducted in conjunction with a cultural supervisor, has enriched my understanding of Kaupapa Māori research. One common weave across both the qualitative research and Kaupapa Māori research was a desire to uphold and honour the voices of women/wāhine.

Table 6

Kaupapa Māori research principles, as described by Dr Linda Tuhiwai Smith (2012)

Principles	Lawrie et al. (2024), Aotearoa NZ	Stevenson et al. (2016), Aotearoa NZ
Aroha ki te tangata (a respect for people).	✓	✓
Kanohi kitea (the seen face; that is, present yourself to people face-to-face).	✓	✓
Titiro, whakarongo, kōrero (look, listen, speak).	✓	✓
Manaaki i te tangata (share and host people, be generous).	✓	✓
Kia tūpato (be cautious).	✓	✓
Kaua e takahi i te mana o te tangata (do not trample over the mana of the people).	✓	✓
Kaua e mahaki (do not flaunt your knowledge).	✓	✓
Mā te Māori (there must be benefits for Māori in undertaking this project).	✓	✓
Kia ngakau pono, kia mākohakoha, kia manawanui, (work with integrity, an open-mind and commitment).	✓	✓

✓ Yes (item adequately addressed); × No (item not adequately addressed); ? = unclear (insufficient information provide)

Synthesis of the Findings

Table 4 shows the data synthesis findings about women's sense of self during a traumatic birth for each of the 14 included studies. The research question for each of the 14 studies determined the direction of the study and hence women's stories. For instance, the Sutton et

al. (2023) study focused on pain relief outcomes and was the only study that defined if the birth was traumatic based on their own definition and categorisation. The six step reflexive thematic analysis (Braun et al., 2023) required time, openness and reflexive exploration to identify seven themes. Once the intersections were identified, seven themes were developed. Table 7 highlights their presence across the studies. Table 8 presents each of the seven themes, including 'feeling invisible and powerless,' 'sense of failure in unmet expectations,' 'emotional distress,' 'feeling supressed, subordinated,' 'experiencing dehumanisation and violation of dignity,' 'psychological detachment as a coping mechanism,' 'being seen, feeling connected and supported.'

Table 7

Themes relating to women's experience of traumatic birth across articles

THEMES	Abdollahpour & Motghi (2019)	Baptie et al. (2021	Brown et al. (2022)	Byrne et al. (2017)	Evans (2022)	Ketley et al. (2022)	Koster et al. (2020)	Lawrie et al. (2024)	Fontein-Kuipers et al. (2018)	Morris et al. (2023)	Murphy & Strong (2018)	Stevenson et al. (2016)	Sutton et al. (2023)	Taghizadeh et al. (2014)	Zhang et al. (2020)
Feeling invisible and powerless	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sense of failure in unmet expectations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emotional distress	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Feeling supressed, subordinated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Experiencing dehumanisation and violation of dignity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Sexual assault/rape									✓	✓	✓				
Discrimination					✓							✓			
Psychological detachment as a coping mechanism	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓			✓	✓
Being seen, feeling connected and supported	✓			✓			✓	✓			✓	✓			

✓ Yes (theme present); (theme not present)

A notable finding was that these themes do not stand alone, rather they are interwoven, often in relationship with each other. For instance, it was recognised that the actions that lead to women's sense of self being impacted by 'being invisible and powerless,' 'sense of failure to

meet expectations,' 'emotional distress,' and 'feeling suppressed, subordinated', were at times present within 'experiencing dehumanisation and violation of dignity' and vice versa (See Table 8).

Being invisible and powerless

As seen in Table 8, all 14 studies showed that women felt invisible within the birthing process and powerless when their autonomy was undermined through being ignored, dismissed and excluded from decision making. These experiences for women contributed to experiencing trauma during birth. Women explained that 'No one was talking to me' (Baptie et al., 2021, p. 179), which left them feeling helpless or ignited a fear response; 'I got real freaked out cos I didn't know what was happening' (Stevenson et al., 2019, p. 129). When women expressed their voice during labour and birth, they felt defeated due to being ignored, for instance '…I am a human being. Do you hear what I am saying? Do you take me seriously? I am here! What are you doing to me? I want you to listen to me I need an explanation [gives up]' (Fontein-Kuipers et al., 2018, p. 32).

Sense of failure in unmet expectations

This theme highlights that women's expectations of birth are based on the values and beliefs that shape their identity as a mother, which exacerbated the feelings of helplessness. It identifies that when discrepancies occur between expectations and the reality of the women's experience, they can feel guilt, shame, low self-worth. 'I felt like a failure, an unfit woman and mother' (Koster et al., 2019, p. 796). There are internal and external expectations that can impact on women's identity as a mother, that are judged on birthing outcomes or meeting expectations of the birth process within themselves or others. Such as: 'it was nothing like I expected' (Lawrie et al., 2024, p. 10) or 'I still failed to push my baby out' (Zang et al., 2020, p. 6).

Women described internalising societal expectation of how birth experiences should be as '…you didn't give birth - you took the easy way out…you did this, because you had an emergency c-section…' (Sutton et al., 2023, p. 6). Women also experienced invalidation when their expectations had not been achieved; 'you're supposed to be like, grateful that, that you're safe, that you're healthy, your baby's healthy, that neither of you died. But like, that's

not enough' (Lawrie et al., 2024, p. 10). Women also experienced a sense of feeling robbed of a positive birthing experience when the hospital failed to provide adequate services:

> I chose this hospital because I had known it could provide the service of painless childbirth. But when I was moved to the birth room, the doctor told me that the hospital had only one anesthetist who had the expertise of labor analgesia, and the very one was not available at the moment due to a business trip. I could not believe my ears when I heard it. The pain was so excruciating that I wanted to knock my head against the wall. Nobody had informed me that only one doctor could practice the technique in such a general hospital and that he was not on duty (Zang et al., 2020, p. 4).

Therefore, women's expectations impacted their self-evaluation of birth and therefore their identity, and included feelings of guilt, shame, sorrow, shock and betrayal when expectations were not met.

Emotional Distress

This theme describes women's distressing emotions that contributed to the experience of a traumatic birth, including feelings of despair, panic, anxiety and feeling alone or abandoned due to agonising and excruciating pain, the ideal of birth not meeting the reality of their experience or being invisible. External social factors also impacted on women's distress during birth, such as: 'Distressed as home birth became unmanageable. Series of negative interactions with hospital staff. Unwanted caesarean. Husband unwell during labour process (later diagnosed cancer) – felt alone' (Ketley et al., 2024, p. 130).

It was also found within six of the studies that women experienced a perceived threat of death to themselves or their baby, whether this was due to birth complications, agonising pain or lack of control. This imposed an existential threat to the sense of self. Whereby women questioned their own ability or their child's ability to survive childbirth. 'I felt my body was going to be split in two. I felt like I was going to die' (Murphy & Strong, 2018, p. 627) and 'at every moment I was thinking either I or my child would die' (Abdollahpour & Motaghi, 2019, p. 26). In a couple of situations women even wished for death in order for the pain to end. 'Felt terrified – feared losing baby (previous miscarriage) and pain unmanageable – wished for death' (Ketley et al., 2024, p. 130).

Feeling suppressed, subordinated

Women felt suppressed into powerless positions within their own birth which contributed to the experience of a traumatic birth, due to institutional authority and a hierarchical system that maintains a power imbalance:

> Then she [midwife] said: I am going to cut you now. That came as a complete and utter shock to my system", somebody deciding for me ... she did not ask ... she should have asked ... I felt ignored, paternalized and numbed, she obviously did not understand how important it was to me (Koster et al., 2020, p. 795).

Some women expressed that there is an expectation from health care professionals for women to adopt a passive role, such as: 'I like at least feeling like I had enough information before I consent … I felt like she was rolling her eyes at me… like I wasn't just agreeing blindly, 'yes you do whatever you need to do', you know?' (Bryne et al., 2021, p. 5). Other women adopted a passive role that consisted of unquestioning cooperation; 'Yeah so anyway, she booked me in for an induction, which I didn't want, I knew that my baby was not ready, I knew that I was not ready. I didn't know that I could say no' (Lawrie et al., 2024, p. 7).

Four studies noted that women also adopted a passive role due to fear, uncertainty or not feeling understood. This was demonstrated through an internal risk assessment that women carried out of health care providers, where women suppressed asking for alternatives or resisted health care recommendations as it may have resulted in lower quality of care. 'I was worried that if I said no, I wouldn't have anyone to care for me during my labour and delivery' (Lawrie et al., 2024, p. 7). This was evident within studies where racism, discrimination and marginalisation were raised.

Experiencing dehumanisation and violation of dignity

Dehumanisation was experienced throughout 13 of the studies, where women felt invisible, powerless and questioned their own human rights. This was expressed as; 'I wish you were treated like human beings' (Abdollahpour & Motaghi, 2019, p. 28), 'What about me? I'm

still….I'm not just an incubator like' (Byrne et al., 2017, p. 5), 'I am more than just a womb' (Fontein-Kuipers et al., 2018, p. 33). These feelings of being objectified were caused through actions such as: lack of informed consent, focus being the baby or maternal physical wellbeing over the mother's psychological wellbeing, along with practices and attitudes of health care providers.

What was striking within the findings of this theme was that women's sense of self was impacted by birth experiences that corresponded with sexual assault, rape, or discrimination. As shown in Table 7, Fontein-Kuipers et al. (2018), Morris et al. (2023) and Murphy and Strong (2018) highlight that the action of HCP was considered as equivalent to sexual assault. A participant from Morris et al. (2023, p. 63) stated "I feel like a rape victim." Another woman stated "It was literally like being raped. It was horrific ... And I have been raped before…. Like that is more traumatic to me than having been raped as a 14-year-old" (Morris et al., 2023, p. 62). This woman was referring to being pinned down for a procedure that she had declined.

Evans (2022) and Stevenson et al. (2016) found that women felt discriminated against during their birthing process, therefore experiencing frustration, anger and powerlessness. A participant from the Evans study (2022, p. 734) stated "I was just so mad . . . this was about the colour of my skin and I just knew it", 'I wonder if they would have treated me like this if I were not black". While Evans' (2016) participant addressed discrimination through race, two of Stevenson et al.'s (2016) four participants addressed it more broadly, with one sharing, "I felt like we were a bit discriminated there at hospital" (p. 129). There is a possibility within this study that discrimination could be related to race and/or age as all participants were Māori women under 20 years. Experiences of discrimination were evident within the studies that focused on minority groups and specific research carried out with African Americans or Māori participants. These two studies highlight the importance of diverse participants within research in order to understand different perspectives within experiences of birth. This demonstrates the impacts discrimination and marginalisation have on women's sense of self within the birth experience and how this contributes to experiences of birth trauma.

Psychological detachment as a copying mechanism

Within 12 of the studies women felt detached, no longer engaged in their birth, experiencing dissociation or as if they were in a dream. Dissociation was described as ‘‘Elvis has left the building’ (Byrne et al., 2017. p. 6). Another experienced this as, ‘It wasn’t me who had given birth, it was somebody else. I should have been happy, I wanted to be happy ... I felt left out, let [name partner] take her off me to hold her’ (Koster et al., 2020, p. 795). While most women experienced dissociation as negative, others found the disconnect positive when it was initiated by them, ‘in that moment and in the meditation the pain was … I was almost like external from pain. I could disconnect my mind from my body almost. That’s what I did to preserve myself’ (Brown et al., 2022, p. 104). This acknowledges that having a sense of control over detachment had an empowering effect rather than a disempowering one, as when detachments happen unconsciously.

It was noted that detachment/dissociation had a higher probably of occurring for those who had a history of previous trauma, especially in birthing again after previous trauma. Experiencing detachment from themselves in birth left women feeling disconnected and a sense of failure as they felt altered within themselves when it was not expected. It was also often impacted by feeling alone due to maternal wellbeing not being enquired about by health care providers.

Being seen, feeling connected, within the birthing process

Being seen and feeling connected is another significant theme where six out of the 14 studies sought information for what might have helped or where women felt supported within the traumatic experience of birth (see Table 8). For instance; ‘I was physically shaking and so cold and they put this great big blanket over me. In the end, it got to the stage where [they] had to talk me down and imagine something and take me out of the scenario I was in to calm me down’ (Murphy & Strong, 2018, p. 627). This demonstrates an incident where both physical and psychological support was provided to enable the participant to calm down.

This theme addresses the actions that are beneficial for women such as aligning to women’s values and beliefs. For Māori this is important as cultural world views are collective, therefore values and beliefs are founded on upholding tikanga and incorporating whānau for support; ‘Well I wanted to have her as culturally, to my culture, well our culture as much as I

could. I wanted to try and keep the tikanga of it all' (Lawrie et al., 2024, p. 9) and 'My mum is a real big help' (Stevenson et al., 2016, p. 128). This also speaks to spiritual beliefs and customs that not only apply for Māori but also apply cross culturally to other marginalised ethnic groups that birth within a medical health system. For Māori participants; 'it was evident that having their values and beliefs respected was an important part of cultivating a positive environment to give birth' (Lawrie et al., 2024, p. 9).

Women are aware when health care providers generally care and are attentive, through being able to recognise physiological distress. For instance, in Murphy and Strong (2018) a participant states "They've got to remember every woman walking through that door is in a really vulnerable situation and offer that care and support… that they're attentive and have empathy with how you might be feeling" (p. 631).

Table 8

Results of Reflexive Thematic Synthesis

THEMES		QUOTES FROM STUDY PARTICIPANTS
Being invisible and powerless	Women experienced their bodily autonomy being undermined, feeling powerless and helpless during their birthing experience.	"She [midwife] just did her thing, decided what to do and did it. It was shocking. I had no control. I did not consent. I had no power, no say in the matter. It felt as if somebody else controlled the birth and it sure wasn't me (.. .) There was no room for me" (Koster et al., 2020, p. 794-795).
Sense of failure in unmet expectations	Women's identity was affected through childbirth failing to meet their expectations, that were constructed from values and beliefs, which led to guilt, shame, and failure.	'In the end I had a caesarean (...) I had not at all expected that to happen, it was so not what I had envisaged or wanted. (…) I felt so bad (...) I felt like a failure, an unfit woman and mother' (Koster et al., 2019, p. 796).
Emotional distress	Describes the intensity of distressing emotions due to an agonising and excruciating pain, the reality of their experience or being invisible that contributed to their experience of a traumatic birth.	I do remember distinctly in my mind everybody shouting at me saying, "Get this baby out," and I remember thinking and feeling like my body was about to split in half… Unbearable pain, I felt my body was going to be split in two. I felt like I was going to die. (Murphy & Strong, 2018, p. 627)
Feeling suppressed, subordinated	Women's individual needs are suppressed due to institutional authority and a hierarchical system that maintains a power imbalance.	I don't think, I think I had to push to discuss it with anyone and even when someone discusses the choices with you it's not really a discussion; it's more like this is how it happens. So, I didn't really, like there wasn't much choice and that carries through for the rest of the story too. It's kind of like a production line and you just have go down this line and do what you're told. (Bryne et al., 2017, p. 6)
Experiencing dehumanisation and violation of dignity	Women expressed feeling dehumanised, insignificant and unworthy through acts of gendered violence, gender and racial discrimination, sexual assault and rape.	' ... but the surrender of control and the fact that ... I was owned and processed, that's what it was."…"If someone put a hand on my throat and put something up my vagina, everyone would say, 'Oh my God, you poor thing, you should cut his dick off.' ... But if you're in labor, ... probably one of the biggest milestones in your life, and somebody goes in there and is doing something that's hurting you that you wouldn't let any stranger ever do, you tell them not to, and they continue .. . everyone tells you, 'What are you whining about?'" (Morris et al., 2023, p. 62).
Psychological detachment as a coping mechanism	Women expressed feeling detached from their birth experience or detached from themselves.	"Eh, I still can't, it was fast and it was like it happened to somebody else, and I think because I had my eyes closed for a lot of it, that kind of contributed to that feeling, but I suppose having my eyes closed and having everything that I didn't want to happen, happen, I don't know, like when you get to that point of, there's a certain pain threshold, I don't know like you're not even in your own body anymore like I'm not really here, it's like it's happening in a dream or something …." (Byrne et al., 2017, p. 7).
Being seen, feeling connected and supported	Even though the birth was traumatic, women shared moments of connection and support that lessened the trauma experience.	"I think everything that happened to me with the good things that the midwives did actually made it less traumatic, the fact that I was informed all the way through, the fact that they talked to me all the way through" (Bryne et al., 2017, p. 6).

Discussion

This research used a qualitative systematic review methodology to explore how a traumatic birth affects woman's sense of self. The studies showed that within the experience of a traumatic birth, a woman's sense of self is impacted significantly through experiences of invisibility, powerlessness, suppression, detachment, disconnection, dehumanisation, discrimination and violation. This led to feelings of being stuck, intense fear, helplessness, horror, despair, failure, guilt, shame, insignificance and unworthiness. These findings aligned with previous birth trauma research where it was found to negatively alter women's self-perception and identity (Ayers, 2007; Watson et al., 2021).

Exploring women's subjective thoughts, feelings and beliefs within the experience of traumatic birth highlighted the intensity and range of emotional distress that included at times a real or perceived threat of death to women themselves or their child. These qualitative findings are inconsistent within the findings from the Boorman et al. (2014) quantitative study, in which they found a higher rate of women who perceived threat to life in childbirth did not experience an intense emotional response (when they removed the DSM-IV A2 criteria). However, Ayers et al. (2018) found a 2% increase in births classified as traumatic, when the A2 criteria was removed. The inconsistencies could be due to the way the questions are asked or defined within these studies which could have accounted for the inconsistent findings. However, according to Pai et al. (2017) the discrepancy between these two studies may be due to the changes between the DSM-lV and DSM-5. Moreover, utilising measures that objectively define trauma through screening tools are criticised due to the contentious and misleading wording of 'diagnosis' across practice and disciplines (Feary & Marinoff, 2014). The DSM criteria has been considered the gold standard of trauma assessment within health sciences, however not all women who experience a traumatic birth develop PTSD, therefore it does not adequately acknowledge women's experiences (Beck, 2004; Greenfield et al., 2016). It also does not apply a cross cultural lens to experiences of trauma (Kiyimba & Anderson, 2022). Furthermore, utilising objective measures to quantify experiences limits the possibility of acknowledging the impacts on women's identity.

While emotional distress may appear obvious from the outside perspective, some women can experience separation, detachment, or dissociation, which can mean that they feel altered or stuck within the traumatic birth experience. This aligns with wider trauma literature where

trauma is experienced as a loss of connection to ourselves (mentally, emotionally, physically), others, and to the world around (Maté, 2024). From a Māori world view, Te Whare Tapa Whā (Durie, 2017) is a model of health consisting of tinana (physical), whānau (family), hinengaro (mental) and wairua (spiritual) dimensions; the relationship between them all is interconnected and cannot be separated. Therefore, trauma not only can disconnect one from the self or others, but also can cause injury to the spirit (Kiyimba & Anderson, 2022). Fleming (2018) further expands the significance of extrapersonal relationships for Te Ao Māori to connections to whenua (land and the natural world) and whānau extending to hapu, iwi and communities.

The way in which trauma is understood within culture, also impacts on the meaning that is assigned to a traumatic birth experience (Fleming, 2018; Kuipers et al., 2024; Pihama et al., 2017). A crucial element expressed by those with trauma was feeling a loss of connection, therefore connections are a vital dynamic between HCP, women and whānau. An action towards assessing possible distress could be asking 'how did you find your birthing experience?' or 'did you at any point during your birth feel under threat, or that you or your baby's life was at risk?' While seeking an understanding from the women's own self-evaluation of the birth, there are individual complexities where the new mother may not feel safe enough to express her perspective to others for fear of HCP, friends, family or society rejecting her experience of birth trauma, which can lead to disenfranchised grief according to DeGroot and Vik (2017). Awareness of birth trauma and direct questions to gauge feelings and experience could be an action that HCPs implement in practice, thereby acknowledging women's experiences of psychological birth trauma. This may begin to shift societal narratives that trivialise women's experiences.

Experiences of birth trauma are not necessarily isolated events related to the mode of birth or certain interventions during labour/birth. Experiences of birth trauma are enabled through the disempowered position of women within institutionalised maternity care. These findings are supported by Kuipers et al. (2024) multidisciplinary review whereby socio-ecological factors sustain and perpetuate the conditions for experiences of birth trauma to continue. Within this systematic review, the hierarchical relationship between the HCP and birthing women demonstrated a power imbalance that was an underlying thread woven across the themes. However, an exception to this was experienced when women felt heard, with their needs and values being acknowledged. This relationship is essential in respecting women's autonomy

and their right to choose based on information sharing and discussions. This was clearly demonstrated within the theme 'being seen, feeling connected and supported' which demonstrated how feeling connected to HCPs or whanau lowered the intensity of the traumatic experience. This was facilitated by actions of midwives who stayed connected to women through talking and sharing information during the traumatic event. This experience may have been different in Aotearoa given midwives typically have an established relationship with women prior to birth, therefore when birth takes an unexpected direction, the relationship can enable women to feel connected, supported and seen, which aligned to findings from Elmir et al. (2010). However, unique to this research was that for Māori being seen included upholding tikanga and involving whānau support. This is an example of women-centred care that is founded on the principles of Rogers (1961) Person Centred Therapy, which focuses on addressing power dynamics, therefore, establishing relationships based on trust and respecting individual values, needs and preferences.

All studies revealed themes of women feeling powerless, invisible, suppressed and having their autonomy undermined. Women's autonomy being undermined is supported through wider literature, due to power imbalances within the maternity health systems that continue to maintain gender discrimination (Keedle et al., 2019; Lindemann, 2012; Marshall et al., 2022). The Māori and African American studies highlighted race and age as further intersecting discriminatory factors in the experiencing of traumatic birth (Keedle et al., 2022; Miller & Baker, 2021). While racial discrimination was experienced by both Māori and African American groups, there are different histories of racial oppression toward each of the two groups. Therefore, within the context of Aotearoa, addressing discrimination requires attention to honouring women's autonomy within the maternal health system and, for Māori, taking into account the historical trauma of Te Tiriti o Waitangi breaches. Te Tiriti o Waitangi (Ministry of Health, 2020) provides a foundation for establishing and strengthening relationships between the Crown and Māori (Kiddle, 2020). The Kaupapa Māori research promotes mana Motuhake, which advocates for Māori self-determination and exercise of their own authority, where Māori live by Māori values and tikanga (Lawrie et al., 2024; Stevenson et al., 2016). Mana Motuhake sits within the Ministry of Health (2020) action plan Pae ora, where the principles of Te Tiriti o Waitangi are an ethical obligation within the code of ethics and standards of practices for all HCPs within Aotearoa (Midwifery Council, 2021; New Zealand Nurses Organisation, 2019; The Royal Australian and New Zealand College of Obstetricans and Gynaecologist, 2023). Partnership is one of the five principles

that provides a foundation for health equity; women's experiences however continue to voice a lack of autonomy and was specifically present for wāhine Māori participants. One has to question terms such as 'women's centred maternity care' and upholding the 'Code of Ethics and Standards of Practice' within HCP practice. This has further implications for legal and ethical considerations with regards to women's rights, indigenous rights and the Human Rights Act 1993 (New Zealand Legislation, 2024).

Within 3 studies women felt sexually abused/violated that contributed to the experience of birth trauma. According to the Thomson and Downe (2008) research, there are links and commonalities between experiences of abuse/violation within traumatic births to victim's accounts of violence or abusive criminal offences. More recently, Keedle et al. (2022) state obstetric violence is gendered violence which impacts on experiences of childbirth resulting in loss of autonomy, confusion and disempowerment for birthing women. The confusion for women is present due to societal conditioning that causes a power imbalance, that impacts this experience as women often trust in HCP knowledge and authority. While within the study there was one history reported of sexual assault, currently the 2021 New Zealand Crime and Victims survey (New Zealand Government, 2022), found 35 percent of females experienced sexual assault within their lifetime and 18 percent of adults aged between 15-19 years, had already experienced sexual assault, with only eight percent of sexual assault being reported to police. This emphasises the need for HCP to respond sensitively to women and whānau given the probability that women have experienced some form of previous trauma prior to birthing, therefore would benefit from trauma-informed care.

Limitations

The qualitative research was limited to people who identify as women and therefore not inclusive of all birthing people (e.g. transgender, gender diverse or intersex). There were minimal studies by Māori for Māori with regards to experiencing a traumatic birth, as well as other ethnic minority groups of people. There was also limited research on birth trauma in Aotearoa. The research did not explore HCP experiences of working within an institutional ethos based on a patriarchal and hierarchical medical dominated system. It is important to acknowledge that within the research, cultural differences within maternity care in Aotearoa with regards to independent midwives as Lead Maternity Careers (LMC) was limited, due to other maternity care settings having different structures of care globally.

Recommendations for Future Research

Further research is needed on women's experience of birth trauma within Aotearoa that focuses on gaining a diverse sample of participants in terms of ethnicity, age and under the care of different lead maternity carers. In order to gain a wider understanding of the cultural context of birth trauma within Aotearoa. This may lead to a framework that would aid HCP to acknowledge and validate women's individual experiences of birth trauma.

Implications for Counselling

Counsellors needs to be aware of how common birth trauma is and the multifaceted contributions to women's experiences of traumatic birth and how this impacts women's sense of self. It is important that counsellors who work with mothers understand that relationship dynamics and power imbalances between HCPs and women contribute to feelings of powerlessness, violation, and discrimination. Given the link between experiences of birth trauma have commonalities to experiences of victims of abuse, it should be understood that birth may also re-trigger preexisting traumas. This study draws attention to the overarching systemic influence of the hierarchal hegemonic bio-medical model. It also acknowledges the importance of establishing trust and mutual understanding as essential within the therapeutic relationship. Findings of this research highlight the relationship between birth trauma and the micro, miso and macro environments that exist in the socio-ecological system that influences experiences of trauma. Also highlighted are the socially constructed discourses of birth and the institutional injustices that influence gendered violence and discrimination related to gender, age, and ethnicity. A recommendation for HCPs could be that medical training requires growth from reflective practice into reflexive practice in order to encompass cultural humility within HCPs.

Conclusion

This systematic review highlights the multifaceted impacts that a traumatic birth has on a woman's sense of self. Feeling connected and seen during labour and birth, through values and beliefs being understood and respected, providing space for women to feel heard and

therefore working in partnership with HCPs. When this was not present, women felt powerless, invisible, and suppressed through their autonomy being undermined often due to actions of HCPs that did not involve or include women in decision making. Moreover, the institutionalised maternity care system enables the exposure of women to experiences of birth trauma, through the disempowered position women are placed in, even when maternity care systems state they are providing 'women centred care'. It is important to recognise the intersection of different oppressions that exist through discrimination, especially for Māori and minority groups within Aotearoa and globally, in order to address birth trauma. This requires a multi-level approach across health disciplines and a societal shift in awareness of birth trauma. HCPs are humans too, and may also feel powerless within the hierarchal structure that exists within maternity care systems. HCPs role could be to acknowledge women's experiences as being valid and true to them. We could also provide support by knowing and recommending local services that can provide in counselling.

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