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A multidisciplinary evaluation, exploration, and advancement of the concept of a traumatic birth experience

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ABSTRACT

Background: Understanding a woman's traumatic birth experience benefits from an approach that considers perspectives from various fields of healthcare and social sciences.
Aim: To evaluate and explore the multidisciplinary perspectives surrounding a traumatic birth experience to form a theory and to capture its structure.
Methods: A multidisciplinary advanced principle-based concept analysis was conducted, including the following systematic steps: literature review, assessment of concept maturity, principle-based evaluation, concept exploration and advancement, and formulating a multidisciplinary concept theory. We drew on knowledge from midwifery, psychology, childbirth education, bioethics, obstetric & gender violence, sociology, perinatal psychiatry, and anthropology.
Results: Our evaluation included 60 records which were considered as 'mature'. Maturity was determined by the reported concept definition, attributes, antecedents, outcomes, and boundaries. The four broad principles of the philosophy of science epistemology, pragmatics, linguistics, and logic illustrated that women live in a political, and cultural world that includes social, perceptual, and practical features. The conceptual components

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antecedents, attributes, outcomes, and boundaries demonstrated that a traumatic birth experience is not an isolated event, but its existence is enabled by social structures that perpetuate the diminished and disempowered position of women in medical and institutionalised healthcare regulation and management.
Conclusion: The traumatic childbirth experience is a distinctive experience that can only occur within a socio-ecological system of micro-, meso-, and macro-level aspects that accepts and allows its existence and therefore its sustainability - with the traumatic experience of the birthing woman as the central construct.

Statement of significance

Problem or issue

In healthcare, the topic of traumatic birth experience is predominantly represented by the midwifery and psychology domain but needs to be viewed from a wider healthcare and social sciences lens.

What is already known

The experience of birth trauma is a global phenomenon and represents a complex concept.

What this paper adds

Through integrating different domains and synthesising the different knowledge bases, the traumatic birth experience has shifted from a personal to a socioecological aspect. Traumatic birth must be conceived as a societal concern and responsibility. Socioecological factors create the conditions for a traumatic birth experience and trivialise and perpetuate women's experiences.

1. Introduction

Childbirth is a major life-event and becoming a mother is regarded as a liminal experience, with the birth functioning as the key transition momentum [1]. Women can experience birth with feelings varying from great happiness, strengthening and healing [2,3] to suffering and trauma [4]. Birth can be thus both powerful and vulnerable [5,6]. Evidence highlights that women experience childbirth as a negative or traumatic event, with a worldwide prevalence of 5–50% [7–13].

Being in labour and giving birth is a human, bodily, intuitive, epistemological, biophysical, bioethical, obstetric, technocratic, cultural, psychological, spiritual, and social tapestry [5,14–19]. Birth is regarded as a life-event captured in everyday life of women being a part of the world and of human existence [20,21] - where bodily, social, environmental, and historical features interplay.

Given the multifaceted perspectives of reality, this means that the woman's traumatic birth experience does not exist in isolation from underlying values and opinions that determine the perspective on traumatic birth as a concept [22]. All these health-related, psychological, sociological, cultural, political, ethical and behavioural domains form a multifaceted collection of individual agents with individual viewpoints and different skills sets, that may not be visible to the other – though collectively these domains offer different horizons to bolster a mutual perspective [23].

The experience of birth trauma is a global phenomenon [24]. In the 1960 s and 70 s, the women's liberation movement and concurrent feminist activism drew attention to women's reproductive experiences. Due to the view that birth is natural and routine for most women, women's attestations of profound suffering went unheard [25]. Key campaigns, such as the #metoo and #break the silence, emerged after 2000 [26–28], recognising a traumatic birth as a profoundly distressing experience, coined through extreme terminology such as 'birth rape' and 'obstetric violence' [29]. In the early twenty-first century, trauma became a topic of research in midwifery and psychology, where midwifery started to apply this diagnostic lens to birth experiences [25]. Traumatic birth has since become an established research topic [30]. Trauma as a psychological category has a long and complex history that has gradually led towards our present understanding, evident in the language that people use [27]. Post-Traumatic Stress Disorder (PTSD) only became an official psychiatric diagnosis when it was included in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) [31]. It then took a further twenty years before PTSD was recognised as being potentially relevant to the experience of childbirth [27].

Traumatic birth experiences have an everyday meaning and understanding but also represent a complex, multifaceted concept which is commonly used in multiple domains in healthcare and social sciences, consisting of multiple theoretical and instrumental knowledge, understanding, and meaning [22]. The aim of this study is therefore to evaluate and explore the multidisciplinary perspectives surrounding a traumatic birth experience to form a coherent useful theory and to capture the structure of the experience [32]. In this paper, we present an advanced principle-based concept analysis of the concept 'traumatic birth experience' as it appears in records from various multidisciplinary domains [33–35]. This paper integrates multiple domains and sources to diversify knowledge and understanding of the constitution and concept of a traumatic birth experience. We stressed the importance of looking beyond individual domains to determine all uses of women's traumatic birth experiences.

2. Methods

2.1. Procedure

This work was undertaken as part of the EU COST Action "Perinatal mental health and birth-related trauma: Maximizing best practice and optimal outcomes" (www.cost.eu/actions/CA18211), consisting of researchers and clinicians from across Europe, Israel, and Australia. A project group of academics and practitioners was formed to focus on the topic and methodology of study and to represent different domains that are (in)directly involved with women with traumatic birth experiences, to benefit from the interrogation by those with different cultural, professional, and political backgrounds. Eight different domains were included in the project group: psychology, midwifery, sociology, anthropology, bioethics, obstetric & gender violence, childbirth education and perinatal psychiatry. Each domain was represented by two project members. Based on their expertise, some group members participated in two domains.

2.2. Advanced principle-based concept analysis

We used a principle-based concept analysis for this study as described by Morse and colleagues [33,36,37], advanced by Fontein-Kuipers and colleagues [38] to: (1) determine the multidisciplinary state of the science surrounding the concept of traumatic birth experience, (2) to understand the multidisciplinary perspective of the concept, and (3) to move the concept towards a higher level of clarity [34]. Advanced principle-based concept analysis consists of five steps [38] with the evidence of the sequence of activities recorded in an audit log.

2.2.1. Literature review

The first step was to select the literature following searches of

bibliographic databases. To establish the breadth of the different perspectives, we performed preliminary literature searches per domain, showing that *traumatic, negative, birth* and *experience* were shared topic-specific terms between the domains and therefore most suitable as conceptual key terms. As a group, we agreed on the search terms: (traumatic) OR (negative) AND (birth) AND (experience) AND (domain specific terms, determined by the domain experts). Quantitative and qualitative research studies and records published in English or in the languages spoken by the researchers (Spanish, Portuguese, Dutch, German, Icelandic, Slovak), original research and relevant grey literature were considered eligible. There was no restriction for publication date or country. Per domain, two researchers independently searched the literature in domain relevant databases/sources, and selected records based on title and abstract. Per domain and as a group, the searches and selections were compared and discussed. If experts thought a paper did not represent their domain, as a group we discussed if a paper better fitted another domain.

2.2.2. Assessment of concept maturity

Maturity was used as a criterion to include papers that best estimate the probable truth of the concept, but not as an evaluation of the quality of the concept [39]. Records had to contain at least four of the following five aspects: (1) definition or description of the traumatic birth experience, (2) attributes, (3) antecedents, (4) outcomes, and (5) boundaries of the traumatic birth experience. These criteria define the level of maturity of the concept studied in each individual paper [33,38,40]; the levels categorised as 'immature' (criteria inadequate, confusing and/or competing), 'emerging' (criteria partially operationalised) and 'mature' (criteria theoretically used and operationalised). As a group we first calibrated the criteria that defined the level of maturity to maintain accuracy and standardisation of concept maturity. Per domain, two researchers independently assessed the selected papers for their level of maturity, subsequently discussing findings and reaching consensus on selection. A third author was consulted if consensus could not be reached. The texts of the included papers served as data for our assessment [32,33,35,38,40]. The records classified as 'mature' were included in the subsequent principle-based evaluation. Per study, we recorded details such as type of document, aim (of study), country, and participants.

2.2.3. Principle-based evaluation

Per domain and per record, four broad principles of the philosophy of science: epistemological, pragmatic, linguistic and logic were evaluated [32]. The epistemological principle concerns the scientific knowledge that defined the traumatic birth experience in the literature. The pragmatical principle examined the concept's usefulness and applicableness. The linguistic principle guided an in-depth evaluation of the consistency of use and meaning of the concept in language. The logical principle directed a precise examination of the concept's interrelatedness with other concepts without losing its own boundaries [32,33,35,40]. The texts of the included records served as data for the principle-based evaluation [32,33,35,40]. Per domain, two project members independently extracted citations, quotes and/ or segments of text and subsequently discussed and summarised the key elements of the data in tabular format using MS Excel or a Word table.

2.2.4. Concept exploration and advancement

In the process of concept advancement, it is assumed that unanswered questions remain [33,38,40]. Per domain and as a group, we reflected on pervasive issues that emerged during the principle-based evaluation. The issues were collapsed and combined to formulate a critical question [38]. The group members then returned to their records and analysed each domain's treatment of the critical inquiry according to the conceptual components: antecedents, attributes, outcomes, and boundaries [33,34,40]. This critical inquiry was rooted in the team's expertise and knowledge and transcended the artificial boundaries created by the various domains, enabling a broader interdisciplinary understanding of the scientific concept and to determine congruence among the disciplinary perspectives [35]. The conceptual components findings of each domain were integrated by the group to answer the critical inquiry.

2.2.5. Theoretical definition

The principle-based evaluation and further concept exploration and advancement led to a (provisional) consensual conceptual theory being formulated that incorporated the multidisciplinary meaning of the concept of traumatic birth experiences in which conceptual components are more clearly explicated [38].

3. Results

3.1. Search strategy and study selection of domain-specific literature

Searches were carried out between June and November 2022 using the electronic databases Pubmed, Web of Science, Medline, EBSCO (PsychINFO, PsychArticles), SCOPUS, JSTOR and CINAHL. Grey literature was searched using Google Scholar, COST Action CA18211 publications (https://www.ca18211.eu/research-outputs/), UPFinder and LSE Monographs on Social Anthropology. The initial search identified 4932 records. After screening titles and abstracts for a clear relevance to traumatic childbirth experience within the context of the eight domains and after removal of the duplicates, the selection was narrowed down to 422 articles that were scrutinised in full text for eligibility and 133 eligible records emerged (Fig. 1).

3.2. Assessment of concept maturity

Of the 133 records, 60 (45%) were included as at least four of the concept's criteria were identified and the paper was classified as 'mature' (Appendix A), 27 (20%) records showed 'emerging maturity' and 46 (35%) were classified as 'immature' [33,38,40]. MS Excel was used to help organise the data according to the concept criteria, showing missing information regarding definitions (n = 3), antecedents (n = 3), attributes (n = 1) and boundaries (n = 8) (Appendix A). The records were published between 2001 and 2022 and included 14 quantitative studies, 25 qualitative studies, five mixed-methods studies, four reviews, three discussion papers, four case reports/series, two study protocols, one theoretical paper, one editorial report, and one book. The 60 records originated from 28 countries, predominantly situated in northern and western Europe but also in western Asia, Africa, Australia, and the United States. The records comprised self-reports of a total of 9546 pregnant (17–32 weeks' gestation) and postpartum (<6 years) women and an additional number of 1036 women with explicitly (self)identified traumatic births (reported <20 h to >10 years postpartum). The records also included 426 reports of women without children, of 61 partners of women with a traumatic childbirth experience, and of 1300 health care professionals (predominantly midwives). In addition, 73 reports synthesising women's traumatic childbirth experiences and synopses of 1311 social media messages about traumatic childbirth experiences were included. The records' details, definitions, conceptual components, and references are shown in Appendix A. The domains of psychology (n = 18) and midwifery (n = 15) showed the highest number of included records and sociology (n = 3) and anthropology (n = 1) the lowest number. Despite differences in the quantity of records per domain, the research group considered the included papers to adequate represent the concept's metaparadigm.

3.3. Principle-based evaluation of women's traumatic birth experiences

The domain specific epistemological, pragmatic, linguistic and logical perspectives for the 60 mature domain-specific records are shown in Table 1.

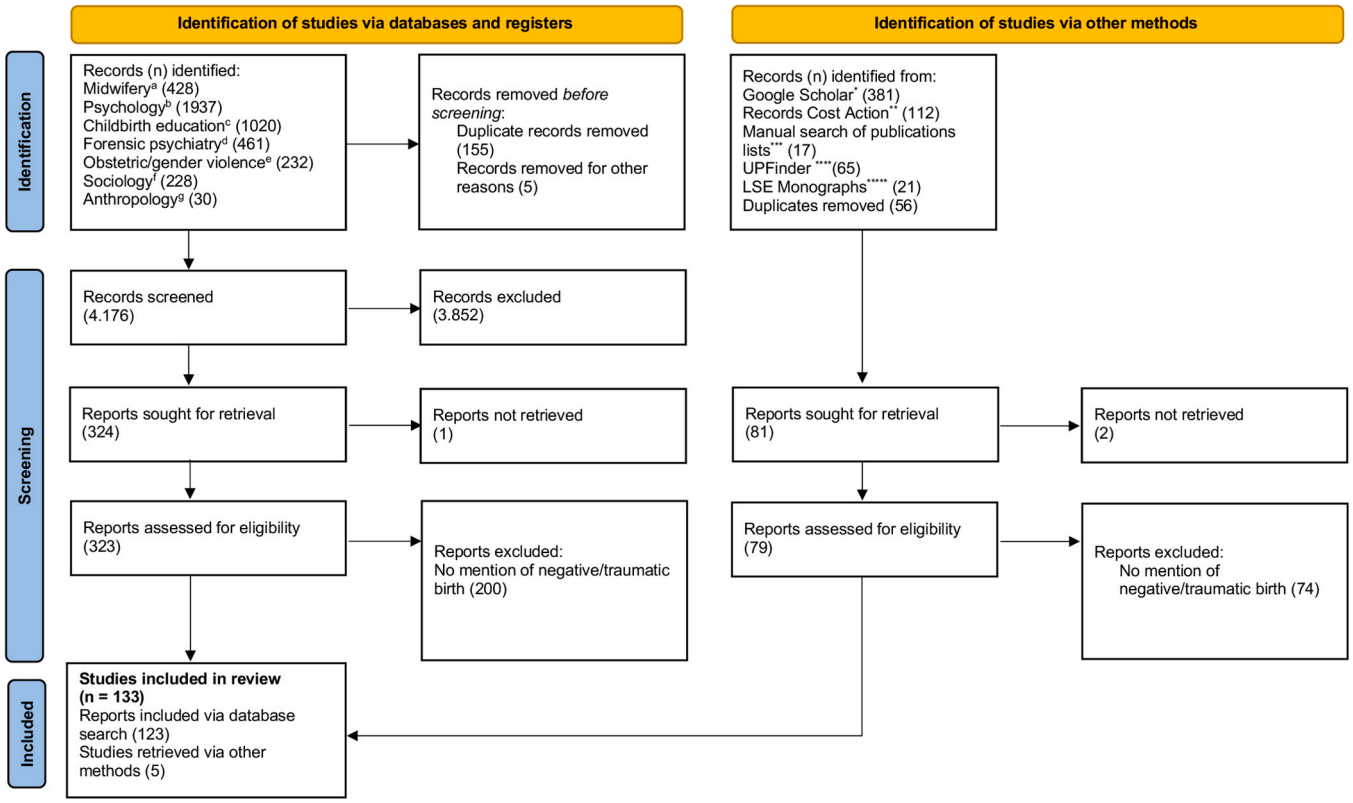

Fig. 1. PRISMA 2020 flow diagram including searches of databases registers and other sources.

3.3.1. Epistemological evaluation of the concept's definition

Midwifery, psychology, and sociology included definitions articulating the traumatic birth experience to be subjective and to be self-defined by the woman. Psychology also included the (objective) DSM-IV diagnostic criterion for PTSD in their definition - acknowledging both subjective and objective reports as eligible defining traumatic birth experience. There was a commonality between the definitions and descriptions provided by sociology, bioethics and obstetric & gender violence as these definitions represented an embodied experience grounded in the structure of the (care) institution - power dynamics and injustice being the common denominators. The common characteristics of traumatic childbirth experiences among domains of midwifery, bioethics, obstetric & gender violence and psychology included physical, psychological, and social harm. The concept's descriptions from childbirth education, psychology, and perinatal psychiatry, were inferred from behaviour-based dysfunctional (coping) strategies during and after the birth. In sociology, anthropology, bioethics and obstetric & gender violence domains the definitions centred traumatic birth in the cultural and societal state of being a mother and entering motherhood. All eight domains showed a common denominator: the birth being the perfect storm of societal, cultural, obstetric, physical, emotional, behavioural, and interpersonal components.

3.3.2. Pragmatical evaluation of the concept's applicability and its usefulness to the domain

In midwifery, the concept was operationalised through the woman's very distressing experience of childbirth, and not necessarily one that included interventions or complications. Childbirth education operationalised the concept through women-disempowering discourses about birth. Sociology, anthropology, bioethics and obstetric & gender violence demonstrated clear conceptual development, binding the concept to the woman's diminished position and reproductive function and role in society. In all domains, the concept was inextricably linked to the interpersonal woman-care provider interaction but midwifery, bioethics and obstetric & gender violence also included a wider reference to the medical and technocratic model of care, and institutional rules and boundaries. In perinatal psychiatry and psychology, the concept was predominantly bound on the intrapersonal level. However, in psychology as well as midwifery, the traumatic experience was not only bound to the woman: neonates, healthcare professionals and birth partners who witnessed or who were involved in the woman's traumatic event of the birth were also positioned as casualties of traumatic experiences. The concept is recognised to be associated with birth itself, with disempowerment of women and the subordinate role of reproduction, through rules and policies and the societal, medical, and institutional perceptions of and the interaction of the woman with others.

3.3.3. Linguistic evaluation of consistent and appropriate use of the concept in the domain context

Psychology and midwifery described the subjectivity and objectivity of emotional pain, internal belief systems, sense of capacity, and fight-flight-freeze that signpost the disturbed homeostasis of the sympathetic nervous system, of emotions and of cognition. Childbirth education used the concept in the context of the woman being a passive and disempowered participant of the birth event. Sociology described the concept to highlight the vulnerable position of women in society while anthropology described women as victims of power dynamics in society. According to sociology, bioethics and anthropology, the woman's victimised and disempowered position during birth is invisible, whereas perinatal psychiatry depicted a traumatic birth as sudden and completely unexpected – women are ill-prepared. Regarding linguistic properties to describe the meaning of the traumatic birth experience, perinatal psychiatry, obstetric & gender violence, bioethics, childbirth education and anthropology, used words such as *evil, drama, horror, terror, crisis, abuse, violence, harshness, frightening, harm,* and *pain*. Psychology and childbirth education use metaphors (*e.g.*, the woman being a *spare wheel* or an *outsider*) to describe the concept – all linguistically highly negative and anxiety provoking.

Table 1
Overview studies and principle-based evaluation of negative/traumatic childbirth experiences per domain.

Author (s) (year of publication)*	*Epistemological perspective*	*Pragmatical perspective*	*Linguistical perspective*	*Logical perspective*
Midwifery (15 studies)				
Byrne et al. (2017)	Symptoms of PTSD - not necessarily meeting the diagnostic criteria for PTSD	A maternity system not accepting/catering for individual differences Tension between the individual experience of the mother and the ethos of the maternity system	The woman is undermined, dismissed, detached, dehumanized and passive and excluded Distant mother A fight	Humanisation
de Klerk et al. (2018)	Negative experience	Protocols and guidelines, including practice about vaginal examination	Disturbing, invasive and embarrassing	Obstetric & Gender violence
Koster et al. (2019)	A psychological distressing event	Unilateral care management. Woman-midwife interaction	In the eye of the beholder	Humanisation
Kuipers et al. (2022)	Psychological injury	Sensory sensations related to the birth environment form part of the traumatic memory and birth recollections Super value of risk Super value of (institutional) rules	Cultural and individual meaning and value	Sociology Anthropology Obstetric & Gender violence
Kurz et al. (2017)	Negative transformation through childbirth and into motherhood	De-establishment of life after birth	Birth is not just to produce a baby Disturbed birthing rites of passage	Sociology Anthropology
Lundgren (2005)	Childbirth is something entirely negative; a situation without return, and without the opportunity to determine or assert prior control	Influenced by the approach towards and expectations of birth	To be avoided, and it should be as easy and painless as possible Victim of the process of childbirth Helplessness	
Minooee et al. (2020)	An event which involves unexpected physical, emotional, or psychological distress for the mother or the midwife who perceive the mother/new-born to be at risk of serious physical or emotional injury or death	Experiences reported by women and by midwives Women and/or midwives are (extremely) upset	No dignity Fear, helplessness, and horror Suboptimality Abusiveness Unexpectedness and unpreparedness	Secondary trauma Obstetric & Gender violence
Perdok et al. (2018)	Psychological distress during labour	Lack of quality of care	-	Medicalisation
Priddis et al. (2018)	Physically or psychologically traumatic vaginal birth	Chasm between idealised birth/motherhood and reality	"Trauma through a Thousand Cuts"	Psychology
Rönnerhag et al. (2018)	An unexpected emotional distressing problem termed an adverse event or near miss, arising from a health-care encounter	From the perspective of women An unsafe birth	False sense of security Feelings of being, invisible and ignored Feelings of being abandoned. Lack of trust and losing control	Humanisation Psychology
Rice & Warland (2013)	Stress from witnessing and working with traumatised women	Work within an apposition of the medical model of care and a midwifery model of care Working between two philosophies of care Working in a hospital-based environment	A personal cost for midwives (responsible, guilt, self-blame)	Secondary trauma Medicalisation
Schrøder et al. (2016)	When the infant or the mother suffers severe and possibly fatal injuries related to the birth	Midwives feeling upset in the aftermath of an adverse event Human and systematic errors	A personal cost for midwives (responsible, self-blame, shame, worry, psychological burden)	Secondary trauma
Simpson & Catling (2016)	A subjective judgement of a woman's global birth experience, characterized by peri-birth traumatic 'hotspots'	While the birth experience may appear uncomplicated to care providers, such as doctors and midwives, women may still find the event traumatic Indication of the birth process and the outcome of birth	Being in the eye of the beholder, not in the eye of the midwife	
Taheri et al. (2020)	Mental distress caused by actual or threatened injury to mother or her new-born that may occur during labour or birth	Protocolised, standardised, universal, routine care	Subjectivity	Obstetric & Gender violence
Westergren et al. (2021)	Being mistreated, not taken seriously, not being seen, listened to, believed, or respected, not receiving proper support or adequate information	Norms and expectations based on gender affiliation Patriarchal and hierarchical care context	Normative	Sociology Medicalisation Feminism
Psychology (18 studies)				
Ayers (2007)	Responding with fear, horror, or helplessness to a birth that is associated with perceived threat or physical harm to self or baby	Intrapartum signs of excessive fear, panic, mental defeat, or dissociation, and frustration, irritability, and anger Postpartum intrusive and painful memories of birth	Intrusion Lack of control Wanting labour to end (stop it).	Perinatal psychology/ psychiatry
Ayers (2017)	A traumatic event when women perceive their life and/or the life of their baby to be in danger	Poor or maladaptive coping after birth.	Resilience/ posttraumatic growth	Perinatal psychology/ psychiatry

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Table 1 (*continued*)

Author (s) (year of publication)*	*Epistemological perspective*	*Pragmatical perspective*	*Linguistical perspective*	*Logical perspective*
			versus vulnerability to PTSD	
Daniels et al. (2020)	Physical and emotional suffering during birth that resulted from either complications, physical injury or negative reactions during the birthing experience	Sudden changes, emergencies, complications during the birth	Merely a passenger, a spare wheel, and an outsider Not involved or presence not acknowledged Not being the birthing woman. Being useless Being treated as the enemy	Childbirth education Secondary trauma Sociology
DeGroot & Tennley (2017)	Psychosocial or symbolic loss	Diminishment of the individual experience	The grief that individuals experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported	Sociology
Dikmen-Yildiz et al. (2018)	Childbirth that meets diagnostic criteria for a traumatic event, if women perceived loss of control, threat or physical harm to self or baby, even if the birth is seemingly normal	It differs from other potentially traumatic events in that it is predictable and generally entered into voluntarily PTSD Maladaptive coping	Resilient and non-resilient responses	Perinatal psychology/ psychiatry
Ford & Ayers (2011)	An event associated with perceived threat or physical harm to self or baby	An interplay between obstetric complications, women's perceptions and emotions during birth and support mechanisms Responses of fear, horror, helplessness, PTSD	Low self-efficacy, locus of control, disbelief of control and/or power	Perinatal psychology/ psychiatry
Garthus-Niegel et al. (2013)	DSM-IV	A combination of objective and subjective birth experiences where the subjective experiences influence the development of PTSD	Fear of birth, anxiety, depression	Perinatal psychology/ psychiatry
Garthus-Niegel et al. (2014)	Exposure to actual or threatened death or severe injury of self or baby during birth	Mismatch between the women's expectations or preferences of birth PTSD	Importance of the subjective perception is stressed out	Childbirth education
Garthus-Niegel et al. (2018)	Exposure to actual or threatened death or severe injury of self or baby during birth	Affected or low couple relationship satisfaction	Depressed and anxious	Perinatal psychology/ psychiatry
Gökçe Isbir et al. (2021)	An event associated with perceived threat or physical harm to self or significant other	Retrospective emotion-focused approach to the birth	-	Childbirth education
Harris & Ayers (2012)	A person perceiving that their own or another person's life or physical integrity is threatened, responding with intense fear, helplessness, or horror	Extreme distress	Inhumane, ignored, unsupported, abandoned, out of control, fear, stressed out	Perinatal psychology/ psychiatry
Ketley et al. (2022)	An event that occurs during any phase of the childbearing process that involves actual/ threatened serious injury or death to the mother or her infant	Expectations and assumptions about the birth and how to cope differ from reality Not being prepared (by others) for the immediate traumatic experience	Shock and betrayal	Childbirth education
Murphy & Strong (2018)	Classifying the birth itself as having a significant negative impact on life	Mismatches in expectations and reality	Feeling invisible and out of control Nightmare 'Not just an ordinary bad birth' Strong intentions to improve maternity services/ make it better	Birth activism
Roberts et al. (2021)	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 results in psychological distress of an enduring nature	The experience has the ability lead to emotional trauma or to (personal) growth	Disbelief Emotional Sensitive Feeling misunderstood Guilt Growth	Childbirth education
Sandoz et al. (2019)	Childbirth that meets diagnostic criteria for a traumatic event if women perceived threat or physical harm to self or baby and feel frightened and a loss of control during the birth	Psychological stress responses and regulation PTSD	Danger, frightened, helpless Vulnerability Sensitivity	Perinatal psychology/ psychiatry
Thomson & Downe (2008)	A psychically destructive experience of externally imposed incomprehensible dehumanising treatment, regardless of the clinical method of delivery	The experience estranged women from their birth, and from societal normality	Violence, torture and abuse	Sociology Obstetric & Gender violence
Thomson et al. (2021)	The emergence of a baby from its mother in a way that involves events or care that cause deep distress or	Not formally integrated or mandated in care provision	Lack and uncertainty	Midwifery

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Table 1 (*continued*)

Author (s) (year of publication)*	*Epistemological perspective*	*Pragmatical perspective*	*Linguistical perspective*	*Logical perspective*
	psychological disturbance, which may or may not involve physical injury, but results in psychological distress of an enduring nature			
Wenzel & Stuart (2011)	An event associated with perceived threat or physical harm to self or baby, and the person responds with fear, horror, or helplessness	Poor coping during and after labour Subsyndromal posttraumatic stress symptoms	Using of expressive language and metaphors ('bodies are being torn apart during birth') Perceptions of uncontrollability	Perinatal psychology/ psychiatry
Childbirth education (7 studies)				
Cutjar et al. (2020)	Subconscious non-volitional negative changes in the woman's perception, mood, and behaviour during labour	Nocebo effect Information provision and storytelling (vivid descriptions) that are potentially unhelpful and implying a scary message, include negative statements and negative suggestions, with warnings and references to painful and unpleasant sensations with the potential to influence negative perceptions	Negative statements about birth ('crowning and burning, 'burning and stinging') Direct commands or instructions Negative birth stories associate birth with suffering, risk, and fear Warnings and references to painful and unpleasant sensations, causing anxiety, distress, and pain Metaphors used to describe or explain physical changes that occurred during labour, becoming a shared common language from which discussion is stimulated	Midwifery
Fisher et al. (2012)	A birth happening to women, rather than with them being involved	A horrible and a very painful experience while losing control over the birth process	Being told what to do Doing whatever the doctor says Doing whatever	Obstetric & Gender violence
Fenwick et al. (2013)	Intense fear of labour and birth that is dysfunctional or disabling	Inappropriate decisions and distorted thinking during birth	Oblique defeatist statements	
Hotelling (2013)	Highly stressful situation decreasing women's confidence and ability to give birth	Preparing women that something will go wrong during birth	Nocebo effect Risk communication Disempowering communication	Psychology
Hulsbosch et al. (2021)	Childbirth being a very stressful or even psychologically traumatic event	Catastrophising information and stories about the event of birth	Dissociation Depression Worrying	Psychology
Kay et al. (2017)	Frightening and dramatic experience	Negative stories Misinformation	Domination (by others, birth)	
Miller & Danoy-Monet (2021)	Childbirth fear	Negative stories	Manipulation	
Obstetric / gender-based violence (6 studies)				
Aktaş & Aydın (2018)	Poor birthing experience An experience comparable to rape	Physical and psychological abuse during childbirth Seeing the birthing woman as a lesser being	Healthcare violation Abuse of authority Carelessness Invisible violence Patriarchal hierarchy Power	Medicalisation Humanisation
Annborn & Finnbogadóttir (2022)	The very complex phenomena of negative experiences during childbirth	Care in childbirth is based more on care professionals' attitudes than on scientific evidence	Destructive Inhuman Abuse Threats of violence	Humanisation Psychology
Bellón Sánchez (2015)	An event characterised by the woman's loss of autonomy and ability to decide freely about her body and sexuality dictated by medical institutions	Impacts on quality of life after birth	Obedience and submission Abuse of authority/ authoritative knowledge Sexism Exploitation Dictation	Humanisation Medicalisation Feminism

(*continued on next page*)

Table 1 (*continued*)

Author (s) (year of publication)*	*Epistemological perspective*	*Pragmatical perspective*	*Linguistical perspective*	*Logical perspective*
Cifre (2019)	Negative experiences with reproduction healthcare (processes)	A disproportionate and inexorably medicalised intervention of the natural process of childbirth	Hierarchical treatment	Humanisation Medicalisation Feminism
Henriksen et al. (2017)	A subjective experience of pain and lack of control during birth	The joy of becoming a mother is overshadowed	Dramatic Unexpected	Midwifery
Van der Pijl et al. (2022)	A birth experience implicitly conveyed an experience of sexual abuse	Not the intervention but rather the context in which the intervention takes place Interventions are vulnerable moments	Violent care	Birth activism Humanisation Midwifery
Bioethics (4)				
Bradley et al. (2016)	Women's negative views, perceptions and experiences of labour and birth where there is a focus on the technical birth whilst the woman's interpersonal, emotional and biosocial aspects are neglected	Over-medicalisation and disrespectful care within a broader framework of structural inequality and violence against women Power dynamics Situating birth as a purely medical event	Disrespect Abuse Control Harshness	Sociology Obstetric & gender violence Medicalisation
Buchanan et al. (2022)	A disempowering experience characterised by lack of beneficence and non-maleficence	Mistreatment and abuse at the systems level and interpersonal level	Sensitivity Abuse Disrespect Disempower	Obstetric & gender violence Humanisation Midwifery
Karakoç & Kul Uçtu (2021)	Experiencing upsetting and troubling problems during birth	The act of delivery is regarded as a moment of separation from the child	Anxiety Separation Guilt Responsible	Psychology
Martin-Badia et al. (2021)	Women having bad experiences when autonomy is being removed from them during birth, being a problem of social justice towards women	Medicalisation of childbirth is a violent act and an exercise of non-legitimate power	Subjective Depersonalisation Abuse Victim	Obstetric & gender violence Sociology Midwifery Medicalisation
Sociology (3 studies)				
Chadwick (2019)	Embodiment of poor quality of care while giving birth and becoming a mother	Driver of emotional and relational mother-child difficulties	Vulnerable corporeality of labour/birth	Psychology
Fielding-Singh & Dmowska (2022)	An actual or threatened serious injury or death to a mother or to her infant, or mothers' feelings of dismissal and neglect even in the absence of serious complications	Women as non-autonomous, capable individuals No informed consent	Feeling pressured Invisible, out of control, and ignored	Obstetric & Gender violence
Hresanová (2014)	A negative and unpleasant incident during birth generating negative emotions	Women's disillusionment with (care during) birth	Paternalism Infantilising Subordinate Indignity	Humanisation Bioethics Anthropology
Perinatal psychiatry (6 studies)				
Bonnet (2021)	Disorganised behaviour occurring during the birth delivery process and afterwards	Confusion, dissociation, ambivalence towards the newborn and violent impulses to harm the newborn No recollection of the contractions or birth Total refusal of any sensory contact (hear, smell, feel) because of violent impulses to kill the baby Violent impulses must be considered Neonaticide	The birth process is labelled as 'unthinkable' Reports of having been surprised by the sudden expulsion of the infant because of misinterpreting or dismissing all signs of pregnancy, as well as early signs of labour	Bioethics Forensics
Murphy-Tighe & Lalor (2019)	A fearful, life-defining experience which does not end with birth of baby	Paralysing fear Crisis in pregnancy Avoidant coping strategies such as concealing the pregnancy Subsequent traumatic event in life	Horrible Shocking	Sociology Anthropology
Nesca & Dalby (2011)	Trauma symptoms (dream-like state, amnesia, panic, avoidance of stimuli related to birth and disorganised behaviour) occurring during and immediately after the birth process, which can occur even in uncomplicated births	Trauma is indicated in recalled feeling dazed, confused and oddly detached, seemingly emotionless and patchy memory Neonaticide	The birth is reported as extremely painful and terrifying and with isolation, helplessness, and fear of dying 'Nightmare'	Bioethics Forensics
Şar et al. (2017)	An acute dissociative reaction to a spontaneous birth which followed a denied/concealed pregnancy. A dissociative state of confused, transient stupor with intermittent states of panic	The failure to perceive the state of pregnancy by the social network Panic during birth	Accounts by bystanders described the woman in an acute state of distress as 'looking like crazy', 'screaming' and 'shocked'	Forensics
Spinelli (2001)	Depersonalisation, intermittent amnesia, and dissociative hallucinations, which occurred during and immediately after the typically unassisted birth	Acute stress Dissociation	Bizarre	Bioethics Forensics
Wille et al. (2003)	Overwhelming birth	Paralogical reasoning	Surprised, perplexed, and disorganised	Anthropology

(*continued on next page*)

Table 1 (*continued*)

Author (s) (year of publication)*	*Epistemological perspective*	*Pragmatical perspective*	*Linguistical perspective*	*Logical perspective*
Anthropology (1)				
Barata in Fradique and Lacerda (2022)	A difficult birth experience mediating stress A complex and confusing sensorial experience	The problem is not birth itself, but rather the obstetrical model of assistance enforced at the hospital	Horror movie Evil Technocratic birth Victims (women)	Obstetric & Gender violence Medicalisation

* References in Appendix A

3.3.4. Logical evaluation of the concept's boundaries when integrated with or related to other concepts

There were reciprocal meanings between psychology and obstetric & gender violence, psychology and midwifery, psychology, and sociology and between midwifery and obstetric & gender violence. This reciprocity seems to recognise mechanisms during birth that paralyse and destruct women, rendering them passive and barely able to face and fight against this violence but instead need to come to terms with this afterwards. The high degree of overlap shows the collective interrelated nature of the concept, emphasizing that the concept of traumatic birth experience 'hold its own' as a distinct concept: a perfect storm with the woman as the central victim or sufferer. Records within all domains, apart from childbirth education, referred to other domains that were not included in this study, being: secondary trauma, medicalisation, humanisation, feminism, birth activism and forensics.

3.4. Concept advancement: using the literature as data

To explore the concept further, we critically reflected on the outcomes of the principle-based evaluation. Our evaluation showed that women, as conscious human beings, live in a social, political, and cultural world including individual, social, perceptual, and practical experiences - a so-called lifeworld [20,21]. When we discussed this phenomenon as a group, the individual domains could not fully explain its mechanism. We queried if the birth is the epic centre of a traumatic experience or whether the traumatic birth experience is an inevitable seismic event? Or might it be a cascade or perfect storm of events and if so, which ingredients are essential for it to occur? Or is 'the whole is more than the sum of the parts' with maybe a (chronological) tipping point for the traumatic experience to occur or develop? Our queries were collapsed and combined to derive commonalities across the conceptualisation of the traumatic childbirth experience found in each domain. As a result, we developed the following question: *How can the domains collectively explain the existence of the lived traumatic childbirth experience in the woman's lifeworld?* This question was answered by returning to the 60 studies, executing our critical enquiry to determine congruence among perspectives within the domain's conceptual components: antecedents, attributes, outcomes, and boundaries [33,34,38].

3.4.1. Antecedents

According to anthropology, bioethics and obstetric & gender violence, certain *a priori* societal macro-level aspects that shape society enable traumatic birth experiences to occur. These aspects are present in the woman's lifeworld and reflect women's subordinate position in society when compared to men and comprise gender discrimination, unformalized woman's rights, racial and educational social stigma, lack of political acts of respectful care and societal acceptance and normalisation of disrespect and abuse in general and to women in specific. Midwifery, childbirth education, anthropology, bioethics and obstetric & gender violence identified societal negative perceptions of labour (pain) and of birth as *a priori* factors as well as sociocultural expectations that 'motherhood is the woman's destiny and her principal source of accomplishment and joy' [41]. The micro societal *a priori* perceptions fail to acknowledge that traumatic birth experiences exist, which sets the conditions for the 'invisible' trauma to proliferate. Midwifery, bioethics, obstetric & gender violence, sociology and anthropology appointed *a priori* meso-level aspects concerning the acceptance of the patriarchal and hierarchical (over)medical hegemonic and techno-medical dominant ethos of the maternity community that exercises power over the birthing woman. This ethos is embodied in reproductive health and hospital protocols, policies, rules, and guidelines and in the dynamics of medicalisation and ignoring international and/or governmental recommendations about human and respectful care at an organisational or institutional level. This ethos also underpins the behaviour and attitudes of healthcare professionals during birth. In addition, women often seem to be unaware of their (reproductive) rights. The bioethics and sociology domains also highlight micro-level insights into how midwives, usually women, are at the lower end of the medical hierarchy and act as subordinate to obstetricians within medical institutions where abuse of authority and sexism exists. Midwifery, psychology, childbirth education, bioethics and perinatal psychiatry domains also recognised further micro-level antecedents from a woman's perspective such as: expectations of or internalised beliefs about birth, fear of birth including medical procedures/interventions, previous birth experiences, previous other non-birth related trauma, a negative or insecure self-concept, a history of (antenatal) psychological problems, as well as (relational) abuse or violence, stillbirth/neonatal death, premature birth, threatened miscarriage, infertility problems and/or a complicated pregnancy.

3.4.2. Attributes

For traumatic birth experiences to exist, certain peri-traumatic hotspots were identified in all our eight domains' instances or contexts in which this occurs. Our domains showed that the chasm between women's personal and social expectations and reality, the poor and harmful and invasive practices, interaction, and communication - including notions of dominance, power, authority, and control - all attributed to a woman's traumatic childbirth experience. The attributes represented a complexity of social and system deficiencies and insensitivities - deriving from a lack of human rights and substandard or lack of quality of care and - not accommodating, ignoring, or devaluing the woman as an individual human being.

3.4.3. Outcomes

The outcomes of traumatic childbirth experiences were polarised as positive or negative. The negative outcomes were reported by all domains while positive outcomes were only reported by psychology, being women's personal growth and post-traumatic growth. The negative outcomes included suffering and burden from affected and reduced emotional well-being and psychological health, diminished quality of life, dysfunction, and maladaptation, negative impacts on relationships with partners and/or child and women feeling estranged from normal societal representations of motherhood. While most of the domains assumed that psychological/psychiatric morbidity, including PTSD or suicide, represented the extreme negative end of the continuum of outcomes, in the domain of perinatal psychiatry, however, this related to neonaticide. Another additional outcome that emerged from the evaluation of the midwifery, bioethics, anthropology, obstetric & gender violence and psychology domains, is that society and the maternal health community have a 'blind spot' for the existence of traumatic experiences. This blind spot deprives and disallows women from openly

acknowledging and/or publicly voicing their experiences - helping to perpetuate invisibility and continuation. The childbirth education, psychology and midwifery domains reported women feeling betrayed and not socially supported – emphasizing that a healthy baby is more important than a positive birth experience. Ironically, the midwifery domain also reported how women with traumatic birth experiences were understanding and sympathetic to the midwives and their working conditions, in which the birth event occurred.

3.4.4. Boundaries

Although our concept was used interchangeably with related concepts such as perinatal or obstetric trauma or posttraumatic trauma (disorder), predominantly in the psychology and midwifery domains, our evaluation showed that the event of a traumatic childbirth experience is a distinct type of trauma within the woman's lifeworld. According to bioethics, childbirth education, obstetric & gender violence, midwifery, anthropology and sociology, the concept exists within the boundaries of sociocultural internalised (normative) behaviour and androcentric and paternalistic approaches in (healthcare) politics and in the institutionalised maternity services and its work culture. The attributes demonstrated an overlap with medical care overuse and inhumane care while the outcomes showed an overlap with psychology. Perinatal psychiatry showed an overlap with criminal law while obstetric & gender violence and bioethics showed an overlap with governmental and/or international policies. The authors interpretated the concept as unique and noticed that it seems to follow the tenets of the 'Russian doll model' in which the human system micro-culture is nested within macro culture manifestation in the order of individual, group, organisation, and society. The experience of the birthing woman as the central construct affected by the social transference of androcentric, paternalistic, institutionalised, and regulatory forces [42].

3.5. Multidisciplinary theory

Traumatic childbirth is a lived experience that is emotionally and motivationally loaded. In the event of childbirth, the antecedents and attributes set the process in motion. The actors in the woman's lifeworld, including those in the childbirth environment, are nested in the same ecological system, sustaining the process and its outcomes. For the event of birth to be or to become a traumatic experience, a perfect storm of factors exist that simultaneously enable the woman's experience to arise, to simultaneously deny or trivialise its existence and to perpetuate its occurrence. A traumatic birth experience has its roots and is enabled within an ecological system of social, political, and cultural features and human behaviour.

4. Discussion

By conducting this multidisciplinary principle-concept exploration and advancement of women's traumatic birth experiences, we systematically and transparently assessed and evaluated the multidisciplinary state of the science surrounding the concept to understand its interdisciplinary perspective, according to the domains of midwifery, psychology, childbirth education, bioethics, obstetric & gender violence, sociology, perinatal psychiatry, and anthropology. The concept has been advanced by shifting the focus from it being a situational and contextual event to being situated and understood as a societal problem. We believe this multidisciplinary advanced principle-based concept analysis is a novel area of inquiry in proposing that the experience of traumatic birth is embedded and enabled within an ecological system of the woman's historical, political, and cultural factors including individual, social, perceptual, and practical experiences [20,21]. The integration of the different domains in this study supports care providers to better understand the individual woman and her birth experience as part of childbirth practices, belief systems and values and social and political forces surrounding childbirth [43].

Women with traumatic birth experiences tend to conceive their experiences mostly at a micro- and meso level [24] rather than a macrosystem that enables these experiences to occur and exist [44]. Following the birth, women can feel expected to be happy with having a healthy baby [45] but if the primary focus of birth is on the risk of mortality and morbidity, ignoring or subordinating the woman's experience [38] and avoiding critiquing the ecological system in which the concept is rooted, traumatic birth experiences will continue. In practical terms, the pragmatic and linguistic evaluation and the conceptual components antecedents, attributes and outcomes (Appendix A) provide useful information about the predisposing and contributing factors, characteristics, and consequences of a woman's traumatic birth experience. This information is valuable in the prevention of the described negative outcomes, and for the assessment, identification, and recognition of women's traumatic birth experiences - information of merit for the education and professional development of care providers directly involved with childbearing women. The pragmatic and linguistic perspectives and conceptual components include a variety of words that women use to express the experience, originating from studies among women. This vocabulary offers explicit words and language to be used in the communication with women about their prospective and retrospective perceptions of birth. The pragmatic and linguistic perspectives and conceptual components also include examples of positive language which can be empowering and respectful and examples of poor language, phrases that are anxiety-provoking, violent, insensitive, and disempowering [46].

Raising awareness that traumatic birth is rooted in society might help to reduce women's self-blaming coping strategies and feelings of failure [47,48]. A society that is blind to the systematic errors enabling and facilitating traumatic birth experiences, denying its existence, and minimising and marginalising women' experiences illustrate the vicious circle of embracing inauthenticity and constrains of women's social roles and norms [49]. As in the principle-based evaluation feminism was identified as a bordering domain, it would be of interest to explore how choice, autonomy, control, and empowerment are perceived from a feministic point of view within the woman's ecological system as described in this study. The epistemological and logical perspectives, antecedents and attributes offer food for thought for care providers to reflect on their personal thoughts about the woman's role and position in society, the role and function of reproduction, the women's reproductive rights and how these are embodied in the institution they work.

One of the antecedents of a traumatic birth experiences, is midwives being at the lower end of the medical hierarchy and subordinate to obstetricians within medical institutions. Midwives - who are often women with a similar lifeworld as birthing women – might regard themselves as being oppressed because of androcentric, systematic, and unconscious biases [44,50]. Androcentric bias is believed to be deeply embedded in working environments in maternity services and the unwritten, hidden, and unofficial rules and cultural perspectives that undermine women's values and rights, continue to exist in maternity services [44]. The current culture of (self) blaming midwives [51] is not justified and allows the public, commentators, and policymakers not to change their discourse or attitudes, thereby paralysing care practitioners and arguably propagating the subordination of women. Traumatic birth as the topic of study, turned out to be a societal issue of systematic injustice and concern providing a much more nuanced perspective on the midwife's role – highlighting the midwife is neither the problem of, nor the solution to the systematic societal errors that affect reproductive care. While further work is needed to understand the various processes and mechanisms that facilitate and underpin a traumatic birth experience, and in different contexts, potential solutions to challenge the workforce culture could be *via* adopting a trauma and compassionate-informed approach [52,53]. Compassionate leaders and humane and human-right focussed care professionals, are ones who strive to protect the freedom of choice, autonomy, authenticity and self-determination of childbearing women, might be the determined

individuals to challenge the workforce culture [54,55].

4.1. Strengths and limitations

This is the first study to determine the multidisciplinary state of the science surrounding and the perspectives of the concept of traumatic birth experience, undertaken by ten international experts, representing eight different domains. Although the search strings were domain specific according to domain experts and the key terms used consistently in the searches of the different domains, it is recognised that some records may have been missed. We included records based on their level of maturity to include papers that best estimated the truth of the concept of traumatic birth experience [39] and believe to have adequately represented the concept's metaparadigm from the eight included domains. However, it may be that excluding records and domains might have affected the current state of the concept as presented in this study. The excluded immature and emerging records likely included relevant information that could have added to the concept evaluation and advancement. Additionally, the logical evaluation of the concept's boundaries when integrated with or related to other concepts showed that there are other domains that we did not include in this multidisciplinary principle-based concept analysis. A future update of this principle-based concept analysis is recommended to extend and expand the concept, including the identified missing domains such as medicalisation, humanisation, feminism, birth activism and forensics. Additionally, our included mature records were largely represented by midwifery and psychology, due to these domains being the first to study the concept [25,27]. However, care was taken to ensure that all insights were represented in the concept evaluation and advancement by the triangulation of methods and investigator triangulation [39]. This work was designed and conducted by academics and practitioners lacking patient or public input, potentially underrepresenting women's views on the study findings.

5. Conclusion

This work has led to an in-depth multidisciplinary understanding and a broad conceptual foundation of a traumatic childbirth experience has evolved. The concept has advanced by shifting the focus of its existence from the situational and contextual event of birth to an experience that occurs within a socioecological system of macro- and meso- and micro level aspects that initiate and reinforce the woman's subordinate position in society and are fuelled by system deficiencies and insensitive practices. This socioecological system creates the perfect storm that allows the concept to occur, denies or trivialises its existence, while disabling women's rights to have a positive birth experience *and* a healthy baby, both of which are important and meaningful for the health of society. A trauma and compassionate informed whole system change that operates at each level of the socioecological system is needed. Our results highlight that if the childbearing woman continues to be the *Cinderella* of society, politics, and health services, and when a traumatic birth experience is only perceived as a female fault, then changes to alter women's birth experiences are unlikely to occur. For traumatic childbirth experiences to cease, large-scale structural changes and societal changes are needed. Traumatic birth experiences need to be a central concern of the political health agenda of every nation.

Ethical approval statement

Ethical approval was not needed for this concept analysis.

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Ethical statement

N/A.

CRediT authorship contribution statement

Yvonne Kuipers: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Resources, Writing – original draft, Supervision. **Gill Thomson:** Validation, Formal analysis, Investigation, Resources, Writing – original draft, Writing – review & editing. **Zuzana Škodová:** Formal analysis, Investigation, Resources, Writing – review & editing. **Ina Bozic:** Formal analysis, Investigation, Resources, Writing – review & editing. **Valgerður Lísa Sigurðardóttir:** Formal analysis, Investigation, Resources, Writing – review & editing. **Josefina Goberna-Tricas:** Formal analysis, Investigation, Resources, Writing – review & editing. **Alba Zurera:** Formal analysis, Investigation, Resources, Writing – review & editing. **Dulce Morgado Neves:** Formal analysis, Investigation, Resources, Writing – review & editing. **Catarina Barata:** Formal analysis, Investigation, Resources, Writing – review & editing. **Claudia Klier:** Validation, Formal analysis, Investigation, Resources, Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Conflict of interest

None.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.08.004.

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