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Exploring women's experiences in a midwifery continuity of care model following a traumatic birth

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ABSTRACT

Problem: Over one third of women report their birth experience as psychologically traumatic. Psychological birth trauma has been associated with perinatal mental illness and post-traumatic stress disorder.
Background: Midwifery continuity of care provides improved outcomes for mothers and babies as well as increased birth satisfaction. Some women who have experienced psychological birth trauma will seek out midwifery continuity of care in their next pregnancy. The aim of this study was to explore women's experiences of midwifery continuity of care following a previous traumatic birth experience in Australia.
Methods: A qualitative descriptive approach was undertaken. Eight multiparous women who self-identified as having psychological birth trauma were interviewed. Data were analysed using thematic analysis to discover how participants subsequently experienced care in a midwifery continuity of care model.
Findings: Seven out of eight participants had care from a private midwife following birth trauma. Four themes were discovered. *The nightmare lives on:* despite a positive and/or healing experience in midwifery continuity of care, women still carry their traumatic birth experiences with them. *Determination to find better care:* Women sought midwifery continuity of care following a previous traumatic birth in their desire to prevent a similar experience. *A broken maternity system:* women described difficulties accessing these models including financial barriers and lack of availability. *The power of continuity:* All reported a positive experience birthing in a midwifery continuity of care model and some reported that this had a healing effect.
Conclusion: Offering midwifery continuity of care models to women with a history of psychological birth trauma can be beneficial. More research is necessary to confirm the findings of this small study, and on ways women who have psychological birth trauma can be prioritised for midwifery continuity of care models in Australia.

Statement of Significance

Problem or Issue

One third of Australian women report their birth experience as traumatic.

What is Already Known

Midwifery continuity of care can increase women's satisfaction with their maternity care.

What this Paper Adds

Midwifery continuity of care models may be beneficial to women with a history of psychological birth trauma. There are barriers when accessing midwifery continuity of care models such as financial barriers and lack of availability.

1. Background

Psychological birth trauma is a serious issue for many women and their families. Up to one third of Australian women describe their birth experiences as traumatic [1] and 15.7% of women suffer from birth-related Post-Traumatic Stress Disorder worldwide (PTSD) [2]. Birth trauma is often a result of actions and interactions with care providers, such as using lies and threats to gain compliance, bodily violation, prioritising their own agendas and disregarding women's embodied knowledge [3]. Women have described their traumatic birth as dehumanising, having their dignity stripped from them, as well as

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reporting non-consensual procedures and feeling as though they were raped [4]. There are profound long-term consequences of birth trauma impacting bonding and attachment with their infant, sexual dysfunction, and difficulties breastfeeding [5–7]. For some women who perceived their previous birth experiences as traumatising, choosing to birth outside the system was a desirable choice to prevent recurrence of a traumatic birth [8].

The overarching intention of this study is to help improve the psychological safety for women who give birth in Australia. Midwifery continuity of care is supported by high level evidence of satisfaction, safety, clinical and cost effectiveness for women and their babies without risks in the perinatal period [9–11]. Midwifery continuity of care has been defined as care in which the midwife is the lead professional in the planning, organisation and delivery of care given to a woman from the initial booking, through pregnancy the birth and into the postnatal period [9]. Women are more satisfied with this model as they report a relationship of trust and that their known midwife exceeded their expectations of care [10]. Existing evidence gives insight into midwifery continuity of care as a more psychologically safe model, however it is unclear whether women who access these models report fewer incidences of birth trauma. The aim of this study was to conduct a preliminary investigation exploring women's experiences of midwifery continuity of care following previous birth trauma.

Within the 11 identified models of maternity care in Australia, there are three that aim to provide midwifery continuity of care during the perinatal period. Midwifery group practice caseload care is a publicly funded model where the known primary midwife provides perinatal care with secondary backup from a midwife/midwives to cover leave and days off [12]. Care is collaborative with obstetric doctors when risk factors are identified. Care is usually provided in the hospital, community and home with some models offering publicly funded homebirth. Similarly, team midwifery care, also known as midwifery group practice (MGP), is where midwives work in teams (no more than 8 midwives) to provide antenatal, intrapartum and postnatal care [12]. Lastly, private midwifery care is when antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives usually in the home. Private midwives also collaborate with doctors when risk factors are identified [12]. These models vary from public hospital maternity care where midwives work shifts in different areas of maternity care (E.g., birthing unit, antenatal clinic). This care is often described as fragmented as women may have a different midwife for each antenatal appointment and may have an unknown midwife caring for them at birth [12].

This study is focusing on psychological birth trauma and the term will be referred to as *birth trauma*. This is not to be confused with the term that is also used to describe physical trauma as a result of childbirth (e.g., perineal or labial tearing, pelvic floor muscle damage).

2. Ethics

Appropriate ethical approval was obtained from the [blinded] Human Research Ethics Committee (HREC approval number ETH20–5100).

3. Methods

A qualitative descriptive methodology was selected for this study to provide insight on women's experiences and perspectives of birth trauma and midwifery continuity of care [13,14]. A qualitative approach was most useful for this study as it honours the concept that the experience of birth trauma is in the eye of the beholder. Each woman is unique and therefore have different views of the world creating a multitude of realities. The qualitative approach allowed for deep exploration of their individualised traumatic birth experiences.

Included in the study were women who self-identified with a previous experience of birth trauma. To be eligible for the study, women needed to have received care from a midwife in a midwifery continuity model of care following their traumatic birth experience. Other criteria included being over 18 years of age and being between 6 and 18 months after their last birth to prevent recall bias. Women were included from any geographical location in Australia, as long as they received their maternity care in Australia. Women who did not speak fluent English were excluded from the study. Women who identified as experiencing birth trauma in a midwifery continuity of care model were not excluded from this study, however no women identified.

Considering Covid-19 restrictions at the time of data collection, participants were primarily recruited through online convenience sampling. Following ethical approval an online flyer was posted into both public and private groups that pertained to maternity care in Australia on the social media platform Facebook. Virtual snowball sampling was utilised to recruit participants. This meant that the online flyer was able to be shared on social media by participants to others who might have been interested in participating. The proposed sample size for this study was 8–15 participants. Having this number of participants was likely to result in adequate data saturation based on similar qualitative studies using in-depth interviews as their method of data collection [7,15].

Potential participants emailed the researcher to express their interest in the study. They were then emailed the participant information sheet, the interview questions (Box 1) and the safety and support guide which included referral services for participants if they needed further support following the interview. A convenient meeting time and date was then arranged. Considering the COVID-19 restrictions at the time of data collection, all interviews were conducted online via Zoom. This was an effective strategy to access a wider range of participants nationwide and convenient for both the researcher and participant as this excluded travel time. Participation was voluntary and informed verbal consent was obtained after participants had received their information pack on the study. Participants were aware they could cease the interview recording and leave the study at any time. All interviews were conducted by the researcher and audio recorded with consent from all participants. A point of data saturation had been reached at eight interviews. De-identified data were transcribed by the researcher. Participants and any other names mentioned were allocated pseudonyms to protect their privacy. Data were stored safely through a university-based secure data management system.

Prior to the interview, participants were asked if they had a mental health condition such as anxiety, depression or Post Traumatic Stress Disorder (PTSD). They were then offered the PCL-5 screening tool, as participation in the study may have not been appropriate due to the risk of distress. The PCL-5 screening tool is a 20-item self-reported measure that assesses the presence and severity of PTSD symptoms in the past month and a total score of 31–33 or higher suggests that the participant may benefit from professional PTSD treatment [16]. Out of the eight participants six scored below 31, one declined to be screened and one scored 32, however consented to continue to participate in the study as they already had appropriate support services in place. A distress protocol was also developed if distress were to occur throughout the interview.

The semi-structured in-depth interviews aimed to explore women's experiences in a midwifery continuity of care model following their experience of a traumatic birth. Simple demographic data was also collected. Using open-ended questions meant participants were not provided with a set of predetermined answers to choose from, allowing participants to respond with more options and opinions, giving the data set more diversity [17]. The use of a semi-structured question "tell me about your traumatic birth experience" kept the participant on track, as the researcher was also mindful of the length of each interview. Due to the short timeframe of the honours degree for which this study was part, member checks were not conducted to verify accuracy of transcripts. The following questions (Box 1) guided the interviews:

Box 1
Semi structured interview questions.

Tell me about your traumatic birth experience:
- What model of care were you in?
- What was supportive within this model of care?
- What was not supportive in this model of care?

Why did you choose a midwifery continuity of care model for your next birth, what influenced this decision?
- What was different about this model of care?
- What was supportive within this model of care?
- What was not supportive in this model of care?

What model would you choose for your next birth?

3.1. Reflexivity

The researcher was transparent about their own biases, goals and weaknesses during the study, whilst being aware that qualitative research cannot be completely objective [18]. She had a passion for midwifery continuity of care and this carried a risk of bias. Through acknowledging this she remained objective and did not make assumptions that women felt the same way she did. The use of a reflexive journal served to remind the author of their initial thoughts around the topic to understand their own biases.

3.2. Data analysis

Thematic analysis was undertaken as it provided a detailed insight into the perspectives of participants and a complex analysis of the data through emerging themes [19,20]. To demonstrate trustworthiness in this study the Lincoln and Guba (1985) criteria of credibility, transferability, dependability and confirmability was considered throughout each of the six distinct analytic steps [19]. The first author familiarised themselves with the raw data to generate initial codes. These codes were cross checked with the interviews and co-authors. The author and co-authors then analysed the data into themes and sub themes and generated the report.

4. Findings

This study focused on exploring women's birth experiences in a midwifery continuity of care model following a traumatic birth experience. Each interview was transcribed from the audio recording by the lead author. Interview length ranged from 22 min to 1.14 h with a mean length of 48.1 min. The average age was 31.6 years, ranging from 26 to 39 years old. Half of the participants lived in urban areas and half lived in regional areas, and most were educated to a tertiary level. Seven of the eight participants were cared for by PPMs following their traumatic birth experiences. Demographic data is described in Table 1.

Four main themes were developed: 'The nightmare lives on', 'Determination to find better care', 'A broken maternity system', and 'The power of continuity'. The four themes represent women's birth journeys and is a chronology of their experiences and perceptions. Table 2 summarises the themes and sub-themes.

5. The nightmare lives on

In the first theme 'the nightmare lives on', women described their experiences of a previous traumatic birth similar to a recurring nightmare. Even after a subsequent positive healing birth experience, women still carried their traumatic memories. For example, Helen felt as though she wanted to run away from the hospital where she had given birth. She said:

Table 1
Demographics.

Age	Area of residence	Highest Educational attainment	Employment	Parity	Model of maternity care for each pregnancy
29	Urban	Bachelors	Maternity leave (previously permanent part time)	2	1. Public hospital/doctors clinic 2. Private midwife homebirth
33	Regional	Diploma	Maternity leave (previously part-time)	2	1. GP shared care 2. Private midwife hospital birth
39	Regional	Bachelors	Full time mother	2	1. Public hospital standard 2. Private midwife homebirth
38	Urban	Masters	Part-time	2	1. Private obstetrician 2. Private midwife homebirth
29	Urban	Diploma	Full time mother	2	1. GP until 20 weeks, then public hospital 2. Midwifery Group Practice
26	Regional	Certificate 3	Unemployed	2	1. Public hospital doctors clinic 2. Private midwife homebirth
28	Regional	Diploma	Prefer not to say	2	1. Public hospital doctors high risk clinic 2. Private midwife homebirth
31	Urban	Bachelor	Medical pension	3	1. Private obstetrician 2. Private midwife homebirth 3. Private midwife homebirth

Table 2
Themes and sub-themes.

Theme	Sub-Themes
	Lack of informed consent and choice
	Treated worse than a dog
The nightmare lives on	*Out of body birth*
Determination to find better care	
A broken maternity system	
	Restoring control to the birthing woman
The power of continuity	*That's how it should be*

I couldn't run, but I was basically running, I had everything packed and I was like, get me, get me out. Never, ever want to come back here (hospital) ever. (Helen)

The sub themes within this theme were 'Lack of informed consent and choice', 'Treated worse than a dog' and 'Out of body birth'. Women described their feelings related to their traumatic birth in detail.

5.1. Lack of informed consent and choice

Women described having a lack of informed consent and choice during their traumatic birth experience. The recount of the treatment they received from the health care providers during their previous labour/birth that was not via midwifery continuity of care was detailed. Women described that in order to be treated with respect they had to comply with hospital policies and/or what was more convenient for the health care provider. One woman said:

I refused induction. But I see that I say this, "I had to" go in for monitoring and that makes me angry because it goes into my psyche, that "I had" to do these things, that I didn't have a choice. I felt like I didn't have a choice. If I wanted to be treated respectfully I had certain things that I couldn't do. (Olivia)

Furthermore, this woman described how she felt coerced to consent to certain procedures and threatened by care providers in regard to her baby's wellbeing;.

They got my consent, but none of it was informed. It was all very 'do it or your baby's going to die'. And every person had a different opinion on what I should be doing and made it very well known that I should be doing only what they were saying. (Helen)

Women described a lack of communication from their health care providers and poor information-sharing resulting in a coerced 'consent'. Women often identified that their choices were not supported, therefore 'giving up' and complying with the health care providers. This woman described how her views were not heard:

The thing that I found not supportive was the constant intervening, the forceful behaviour and not accepting no as an answer, not respecting my rights or accepting me saying no, like my consent didn't matter. (Nicky)

5.2. Treated worse than a dog

Every woman reported some form of distrust between themselves and their careers that led one participant to describe that she felt she was treated "worse than a dog". Two women described poor depersonalised and dehumanised care:

And anyone reading a discharge summary would be like, oh, what an amazing birth on paper. But in terms of how I was made to feel, worse than a dog, I was treated so poorly. (Lucy)

I went to a couple of those diabetes clinics, which I felt were dehumanizing. I felt like I was part of a cattle yard, like with these other women. Like we would literally be lining up in the corridor with our little pee jars to go into a room to test our own urine samples. Dehumanizing is how I would put it. (Olivia)

Furthermore, the following women described being physically assaulted by care providers. They reported feeling hopeless, helpless and vulnerable, with no one advocating for them.

He asked me to take my clothes off, for a breast exam followed by a pelvic exam. And that was my first experience of rape. Obviously, as you know, it's unnecessary for a 24 year old to have either of those exams.And so I was completely taken advantage of with that pelvic exam and that breast exam. (Lucy)

She actually physically grabbed my right leg and rolled me over onto my back, forcing me to be on my back and putting my legs in the stirrups. And I just felt hopeless at that time and helpless. And like, I didn't have anyone there to advocate. (Nicky)

Women described how they initially thought that the system would have their best interests at heart, but after reflection they felt that the system was unsafe and set them up for failure. This woman said:

It was a false sense of safety I had in my first birth that anything provided by the hospital would be a good model of care and that would keep me safe and now I realise it's more common because the more you talk to women the more stories you hear of people's 'not so great' experiences, that fragmented model wasn't safe, it wasn't safe for me. (Gemma)

5.3. Out of body birth

Women reported PTSD symptoms when recounting their traumatic birth experiences. These were defined as having an 'out of body' experience, feeling dissociated and having delusional thoughts. One woman's description was:

Do you know when you're in a traumatic situation and people say it was having like an out of body experience? That's what I felt like at the end, I felt like I was looking down at myself, like not myself, but this was just happening to someone else. I was just looking down, watching the situation and I couldn't hear them actually talking to me anymore because they had pushed me so far that I didn't want to be listening to them. (Nicky)

6. Determination to find better care

The second theme follows the journey of participants as they were determined to find better care for their next birth. For some women this meant finding a privately practising midwife and accessing care outside of the hospital system. Most women described searching extensively for information through joining social media groups and listening to podcasts.

So, knowing that I didn't want that to happen again and then knowing I wanted a VBAC and through the process of researching why everything happened for the first one, I came across papers and then podcasts and then people online. (Taylor)

Once women discovered the midwifery-led care model, they had a strong determination to find this for their next pregnancy/birth. The following described how one woman sought trust in her relationship with her caregivers:

I just wanted to be able to trust myself, trust my body and have a care provider that would be able to trust me as well and not be operating through fear. (Zoe)

7. A broken maternity system

The next theme, 'A broken maternity system', focused on the barriers that each woman faced when trying to access midwifery continuity of care models. The expense of engaging a PPM was described by this woman:

> The cost for a home birth was prohibitively expensive for us. So basically we just can't afford it. I feel it's really silly of our government and Medicare (Medicare is Australia's universal healthcare insurance scheme funded by Australian tax-payers) not to fund homebirth (Billie)

A further geographical barrier was described by this woman who even considered free birthing (giving birth without a healthcare professional present) due to the difficulty of engaging and affording a PPM:

> I wanted to do the continuity of care, but I wasn't in the catchment area because I'm so far away. So then I actually considered freebirth at one point because private midwifery is extremely expensive. (Nicky)

One woman described having to lie to 'fit' a local maternity system's catchment areas and access the care model she chose:

> I might have fibbed a few times. Again, women shouldn't have to fib, but I'm willing to stoop that low in order to get the birth that I want and need. (Lucy)

The themes demonstrated that women reported positive birth experiences in a midwifery continuity of care model. However, women also reported difficulties accessing and affording this care.

8. The power of continuity

The final theme encompasses the power of continuity. Women compared their experiences of care within this model to their previous traumatic birth. Majority of the participants received care from a privately practising midwife and all women reported a positive experience and said they would choose this model again for their next birth.

8.1. Restoring control to the birthing woman

The care was described as individualised; they were provided with informed consent and women were in control of all decisions. Women described the lack of informed consent they had experienced that contributed to their previous traumatic birth experiences. They described how their relationship with the midwife in the subsequent continuity model made them feel more informed, empowered and engendered a trust in their bodies to have a physiological birth. One woman stated her birth in a midwifery continuity model was the "single most transformative day of her life" *(Gemma)*.

The following woman described in detail how her midwife helped to restore her personal control:

> She just made sure I was fully informed and that I could consent or not consent to absolutely anything, she said, even if she's giving me the information, she said, I'll support you. No matter what you do, you can do what with my recommendations or you cannot, it doesn't matter. I'm still going to provide the care for you. And that just made all the difference, knowing that they trusted my judgment in my own body, but were also there to give me all the support and the information that I needed. (Helen)

8.2. That's how it should be

Women's experiences in a midwifery continuity of care model after previous birth trauma was the catalyst of their realisation of how birth should be. Women felt that their positive birth experience helped them to heal following their previous traumatic birth and that their continuity of care midwife assisted them in this process to move forward as described here by two women;.

> It was healing to have that, it was healing of the first experience for sure. (Olivia)

> I was able to process trauma from first birth and move forward. I felt empowered, informed, trusted and well prepared for birth. (Billie)

The following woman described her realisation of how birth should be, their emotional 'release' and the transformation they experienced:

> I was completely in this unravelled state, she completely got me in a point where I was completely unravelled, my life was changed, oh my goodness, I'm seeing a whole new world with completely new eyes because I've just experienced this. The amazing phenomenon of childbirth, I'm completely a new person. (Gemma)

Furthermore, women also described emerging from their birth experience in a midwifery continuity of care model with a stronger emotional well-being compared to after their traumatic experience. For example, this woman said:

> It was just the best experience to not be in hospital and having anxiety and all of that separation anxiety from my baby, like I got to just be with her instead of her getting taken away straight away. It was just completely different from my first daughter and I had no anxiety or depression afterwards. (Nicky)

9. Discussion

The results from this study support existing literature suggesting that a strong relationship with a known midwife results in increased trust, more personalised and respectful care and better information sharing [10,11,21]. In the theme 'The power of continuity', care from their private midwife was described as individualised and consensual, where participants were in control of decision making, informed and empowered. No participant reported a traumatic experience in a midwifery continuity model of care suggesting this model is more psychologically safe. We also acknowledge that the positive experience was likely to have come about from both continuity of care that was received, but also from the participants being more experienced and informed. For example, one woman describes not being in hospital as a mechanism for reduced anxiety, hence her wish for a homebirth setting was more about the institution, rather than the model of care.

The findings from this study have affirmed that women's experiences of birth trauma were directly influenced by the actions and interactions with healthcare providers in standard models of maternity care. Due to the fragmented model of care, women did not have a relationship of trust with their care provider and described being treated 'worse than a dog'. Results from this study echo existing literature that confirms birth trauma can occur when women are disrespected, unheard, dismissed, bullied and coerced by hospital staff [1,3,7]. Women in this study reported that in order to be treated with respect they had to comply with hospital policies and/or what was more convenient for the healthcare provider in the standard model of care. With seven out of the eight participants in this study choosing a private midwife following their birth trauma and six of those birthing a home, this study also suggests that women choose to birth out of the hospital system to avoid a recurrence of birth trauma. Participants explained that their traumatic birth in a standard model of maternity care was the catalyst for their journey to find a safer model and prevent a recurrence of birth trauma. This determination was similar to women who sought a homebirth following a previous caesarean section to avoid hospital policies and the risk of early induction, the cascade of intervention and repeat caesarean section [15].

In this study a lack of access to hospital MGP models is why women

may have chosen a PPM. In Australia, a lack of midwifery continuity of care models has been well established, with only 15% of models (MGP/caseload) reported nationwide [22], despite numerous past government reports recommending widespread implementation [23–25]. Geographical barriers and limited spots in these models due to high popularity left some participants with no option but to engage a PPM as they desired continuity of care. However, the lack of rebates from Medicare made this option very expensive (fees range from around $4–6000). Due to these barriers, one participant in this study considered freebirth to avoid a recurrence of birth trauma. Similar findings have been reported where women choose to freebirth over midwife-attended homebirth due to a lack of access to homebirth midwives, financial barriers and having a previous traumatic birth [8].

Women report safer experiences in midwifery continuity of care models, suggesting the need for universal access to these models and Medicare for homebirth so less Australian women experience birth trauma. This study found that women were greatly satisfied being cared for in a midwifery continuity of care model and some found that it helped to heal their previous birth trauma, however all reported barriers when trying to access these models, suggesting systemic change is needed.

10. Recommendations for practice

There are many ways to make positive systemic change to the Australian maternity system and increasing midwifery continuity of care models is one of them, with 'how to' guides readily available [26]. Identifying the economic benefits of midwifery continuity of care can be helpful to show health policy-makers that providing continuity of care is not costly. For example, Callander et al. [27] showed publicly funded MGP caseload costs 22% less than other models of maternity care. They also found that only continuing to offer other models of care costs public hospital funders $4823 more per woman compared to if publicly funded MGP caseload care was offered [27].

Another way to facilitate staffing of continuity models is to enable new graduates to work this way [28]. This, together with ensuring a collaborative model with open communication between management, midwives and obstetricians, can assist with the implementation and scale up of midwifery continuity of care [29,30]. Providing widespread access to midwifery continuity of care in Australia may decrease the rates of traumatic birth such as those experienced by the women in this study.

11. Limitations and recommendations for future research

This was a small qualitative study of eight participants. None of the women in this study identified as Aboriginal or Torres Strait Islander, therefore there is limited insight into of First Nations women's experiences of midwifery continuity of care following a previous traumatic birth. Only English-speaking women were participants in this study, and it is likely that those women whose first language is not English have higher rates of birth trauma due to communication/cultural difficulties. Virtual snowball sampling was utilised for convenience, which would have excluded those experiencing digital poverty. Majority of the participants in this study received care from PPMs which represents less than 1% of the birthing population in Australia [31] so the sample is not representative of all women receiving care from midwifery continuity of care models. However, this could also be seen as a strength of this study through the homogeneity of women's chosen model of care. More research is necessary to confirm if women would have had a positive birth experience in a continuity of care model situated in the public system following birth trauma. It is also important to note that women who are able to access a PPM are often highly educated and financially resourced [1], therefore women from different socioeconomic backgrounds, and those with vulnerabilities are not represented in this study.

12. Conclusion

Women sought midwifery continuity of care following a previous traumatic birth as they desired a relationship of trust with their midwife to prevent a reoccurrence of a traumatic experience. All women reported a positive experience birthing in a midwifery continuity of care model and some reported this care as healing. All described the difficulties accessing midwifery continuity of care including financial barriers and lack of availability. The psychological safety of birthing women in Australia is an important topic that requires further examination. Research findings need to be integrated into future maternity care strategies, to reinforce existing evidence around the value of midwifery continuity of care(r).

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.01.006.

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