Agora: Red Deer Polytechnic Undergraduate Journal
Volume 15:1 2024 Agora Conference Proceedings

An Exploration of Subjective Traumatic Births and the Influence of Childhood Trauma and Low Maternal Confidence[1]

Shree Aiyer

Motherhood can be a pivotal part of some women's life, and it is usually a stage she looks forward to from a young age. A predominant phase in this progress is the perinatal period, which is defined as a short period of time before labour to a few weeks after having given birth (Vogels-Broeke et al., 2021). Evidently, the event of childbirth is very definitive in this milestone, but a woman's perinatal period is far more than just childbirth and the events of care involved before, during, and post-birth. Although the concept of mother-centered care related to the birth and the postpartum period has become more widespread in the past couple decades, transitioning to motherhood is influenced by various dynamic physical, psychological, and social characteristics that actively shape the mother's experience throughout the peripartum period (Larkin et al., 2009; Prinds et al., 2014; Seefat-van Teeffelen et al., 2011; Vogels-Broeke et al., 2021).

The perinatal period and the transition to motherhood also features many neurobiological, psychological, and social changes, as well as stressors that may be influential in the mother and child's wellbeing (Cárdenas et al., 2020). Environmental and psychosocial stressors that the mother experiences can be damaging to the overall pregnancy and labour, as well as the health of the mother and fetus. The dangers of psychological, social, and physical impacts can be detrimental to both mother and child; thus, there is basis to suggest that maternal stress during the prenatal period can be consequential for current and future generations (Coussons-Read, 2013). Women who are affected by psychological, emotional, and/or physical stressors specifically during labour can be traumatized by childbirth. This is generally referred to as birth trauma (Watson et al., 2021). Some known stressors are the fear of childbirth, medical interventions, interactions with healthcare professionals, as well as the experience of childhood trauma (Atzl et al., 2019; Bhatia & Jhannjee, 2012; Elmir et al., 2010; Reed et al., 2017).

During pregnancy, an individual may recall experiences of childhood trauma; this can potentially trigger certain psychological symptomology in those susceptible to developing

[1] This research was funded by SSHRC. This is an executive summary. For the complete thesis, please see the digital publication in the RDP Library Repository

psychopathology (Atzl et al., 2019). The emotional, physical, psychological, and cognitive stressors involved in pregnancy can be heightened by the experience of childhood trauma, since these memories arise as women reminisce about their entire childhood experience as they prepare themselves for motherhood (Atzl et al., 2019; Narayan et al., 2017). There were strong links found between the occurrence of childhood trauma and perinatal psychological disorders such as post-traumatic stress disorder (PTSD) and depression (Choi & Sikkema, 2016). Atzl and colleagues (2017) researched the influence of childhood adversity and age on pregnancy related mental health issues. It was found that when childhood maltreatment was experienced at an early age (0 to 5 years), it was significantly predictive of a perinatal-related PTSD diagnosis. There was no relationship found between middle or adolescent age childhood trauma and birth trauma-related PTSD or depression. This finding is significant, because it highlights the critical nature of the early childhood period in shaping future outcomes in the stress response system and mental health, specifically during the peripartum period.

Mothers who have a traumatic birth experience are more likely to develop psychosocial difficulties during the postnatal period. Their mental health may be in a deteriorating state, making them more susceptible to face issues with anxiety, PTSD, and obsessive-compulsive disorder (OCD) (Ionio & DiBlasio, 2014; Molloy et al., 2021). Further negative impacts of birth trauma include extreme emotional responses, difficulty in communication, formation of maladaptive attachment styles, self-doubt, and low maternal confidence (Elmir et al., 2010; Molloy et al., 2021; Schwartz et al., 2015). The experience shapes how a mother views her capabilities in parenting and whether she views herself as a "good mother" (Molloy et al., 2021). Some mothers have noted that they feel that self-perception and self-knowledge of their own bodies and experiences are put into question or even dismissed during the labour experience by healthcare professionals (Molloy et al., 2021); these negative interactions can plant seeds of doubt in the mother's mind about her parenting abilities, which can consequently influence the mother's experience with parenting and the attachment she forms with the child. Furthermore, self-efficacy in general is developed predominantly in childhood and plays a role in overall psychological well-being (Orth & Robins, 2014). Thus, the experience of a traumatic childhood can lead to a decrease in self-esteem, confidence, and self-efficacy (Walter et al., 2010), which can negatively impact their resilience as well (Beutel et al., 2017).

Unfortunately, the subjective nature of birth trauma creates an obstacle in identification, diagnosis, and treatment (Beck, 2004). There is a significant lack of acknowledgement and comprehension about birth trauma in society, which leads to the inability to fully recognize women's situations, provide consistent support, aid in recovery, and reform care and practice associated with the peripartum period (Watson et al., 2021).

When looking at the previous research in this field, as far as is known, there are has not yet been a study that considers both childhood trauma and maternal confidence in relation to the experience of birth trauma, particularly in the Canadian context. Thus, we aim to uncover how these three factors influence and interact with one another. Through this research, we will be able to provide insight into some of the broad patterns that underlie birth trauma and gain a better understanding of their predictive factors and negative impacts. In essence, the goal is to strengthen and add to the literature in the field to improve the perinatal period and enhance wellbeing for the mother and the child.

Method

Hypotheses

Derived from the literature in the field, the study is testing three hypotheses. First, childhood trauma is predictive of subjective birth trauma. Second, lower parenting self-efficacy or maternal confidence has a significant relationship with birth trauma. Lastly, childhood trauma has a significant relationship with lower maternal confidence/ parenting self-efficacy.

As described previously, the literature in the field supports the connections between one variable and the other. However, there has not yet been, as far as is known, a study regarding the intersection off all three variables. The primary goal of the study is to look at general tends between birth trauma, childhood trauma, and maternal confidence through an exploratory lens.

Design

The current study utilized descriptive statistics, correlational analyses, and a linear regression to comprehend the self-report data from the survey participants. The aim of this research is to understand predictive and risk factors relating to birth trauma while considering childhood

trauma and maternal self-efficacy, as well as socioeconomic, geographic, and demographic characteristics.

Participants

The sample ($N = 84$) of participants consisted of 83 females and one demi-woman with a mean age of 31.19 years ($SD = 5.873$, range = 22 – 45). The participants consisted of the following ethnicities: 3.6% Asian, 32.1% Black, 57.1% European/Caucasian, 2.4% Hispanic, 1,2% Indigenous, and 3.6% mixed). All of the participants were Alberta residents at the time of participation, with 63.1% having given birth in a large urban population centre with a population of 100,000 and over. The majority of the participants (60.7%) had described experiences with their first child, 42.9% of which reported about their first pregnancy. When considering the type of birth, 41.7% had an emergency c-section, 14.3% had an elective c-section, 17.9% had assisted vaginal births, 25.0% had normal vaginal births, and 1.2% did not answer. Participants' household income varied minimally with 8.3% making under $20,000 and 22.6% making $100,001 or over. Approximately half of the participants (45.1%) reported that their child had spent time in NICU, of which the average was 14.56 days.

Materials

Participants were given self-report scales and questionnaires and asked open-ended questions to assess and understand their retrospective accounts of birth trauma, childhood trauma, maternal confidence, and social support (refer to Appendix A for complete survey).

City Birth Trauma Scale.

The City Birth Trauma Scale was used to understand the subjective traumatic birth experience of their most recent birth (Ayers et al., 2018). It assesses childbirth related PTSD according to criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for traumatic events during or immediately after the childbirth. The self-report scale consisted of 29 questions with four subscales: symptoms of re-experiencing, negative cognitions and mood, and hyperarousal. A higher score indicates more PTSD symptoms being present, which will represent a subjectively traumatic birth. This scale and its subscales have shown good internal consistency, with $\alpha = 0.92$ for the total scale.

Trauma and Distress Scale.

Childhood trauma was assessed using the Trauma and Distress Scale (TADS; Patterson et al., 2002). It is a 43 question self-report scale which is used to measure childhood adversities in five different domains: emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse. There are 4 to 5 questions per domain, and all questions take age categories into account (0–6, 7–12, and 13–18 years). The TADS is a 5-point Likert Scale: 0 = never, 1 = rarely, 2 = sometimes, 3 = often, and 4 = almost always. The total score, which represents the complete burden of childhood adversities, is calculated as the combination of the scores from all five domains.

Perceived Maternal Parenting Self-Efficacy Scale.

Maternal self-efficacy was assessed using the Perceived Maternal Parenting Self-Efficacy scale (PMP-S-E; Barnes & Adamson-Macedo, 2007). The questionnaire examines a mother's beliefs about their ability to be successful as a maternal figure and in their parenting role. This scale has 20 items as a 4-point Likert scale (1 – Strongly disagree, 2 Disagree, 3 – Agree, 4 – Strongly agree) with four subscales: care taking procedures, evoking behaviour(s), reading behaviour(s) or signalling, and situational beliefs. The scale has strong internal consistency reliability and external reliability ($\alpha = 0.91$, $\alpha = 0.96$), as well as good validity.

Maternal Confidence Questionnaire.

Lastly, maternal confidence was measured with the Maternal Confidence Questionnaire (MCQ; Parker & Zahr, 1985). This 14 item 5-point Likert scale (1 – Never, 2 – Seldom, 3 – Some, 4 – Often, 5 – A great deal) quantifies maternal confidence in parenting skills and the ability to recognize their infant's needs. The questionnaire has also been shown to have good flexibility, reliability, and validity.

Procedure

The sample for the study was chosen through self-selection, where Alberta residents over 18 years of age subjectively identified themselves as having experienced a traumatic birth in the past five years. The self-report survey was sent to various community resources where participants had access, such as women's clinics. The incentive for participation was a $15 online gift card. The research was approved by the Red Deer Polytechnic Research Ethics Board (REB) (Red Deer

Polytechnic, 2024). Participants were provided a consent form at the outset of the survey, which provided information on the survey. Due to the sensitive topic, participants were provided with a list of community resources within the consent form. Participants then completed demographic questions, which asked about socioeconomic and geographic factors, then completed the scales. Responses from the participants were anonymous and collected through Simple Survey. For data analysis, IBM SPSS, a statistics software, was used.

Results

Descriptives

Of the 84 participating women, 72.7% reported experiencing complications during pregnancy, 35.7% were diagnosed with at least one psychological disorder related to the birth, and 26.2% were diagnosed with at least one psychological disorder unrelated to the birth. It was found that 30% of the participants were found to have high levels of birth trauma related PTSD and 44% had moderate symptomology.

Regression Analyses

In order to test the first hypothesis of the study, a Pearson's correlation was conducted between the Birth trauma-related PTSD subscale in the City Birth Trauma scale and the total childhood trauma subscale in the TADS. A significant positive correlation was found, $r = .342$, $p < .001$. Further analyses showed that birth trauma related PTSD was significantly correlated with childhood emotional abuse ($r = .397$, $p < .001$), childhood physical abuse ($r = .323$, $p < .003$), and childhood sexual abuse ($r = .299$, $p < .006$). A linear regression was conducted with total childhood trauma as the predictor and the analysis yielded a significant regression, $b = .162$, $t(83) = 3.30$, $p = .001$, meaning that childhood trauma was predictive of birth trauma. It also accounted for significant variance in birth trauma related PTSD, $R^2 = .117$, $F(1, 82) = 10.89$, $p = .001$.

For the second hypothesis, two Pearson's correlations were computed comparing birth trauma related PTSD with maternal confidence and parenting self-efficacy. Neither correlation was significant since birth trauma related PTSD and maternal confidence yielded $r = .012$, $p = .917$ and birth trauma related PTSD and parenting self-efficacy yielded $r = .142$, $p = .198$, which shows that there were no correlational relationships between the variables. It is important to note that the correlation between maternal confidence questionnaire and parenting self-efficacy was $r = .762$, p

< .001. Thus, linear regression analyses with these variables were computed as a total of MCQ and PMP-S-E scores. A significant regression was not found when considering total confidence/self-efficacy from birth trauma related PTSD, $b = .164$, $t(83) = .791$, $p = .431$; therefore, birth trauma is not predictive of maternal confidence or self-efficacy. Birth trauma related PTSD did not account for any variance in total maternal confidence and self-efficacy $R^2 = .008$, $F(1, 82) = 0.63$, $p = .431$.

When testing the third hypothesis, two Pearson's correlations were computed. Both yielded significantly negative correlations between maternal self-confidence and total childhood trauma ($r = -.509$, $p < .001$) and between parenting self-efficacy and total childhood trauma ($r = -.297$, $p < .006$). Furthermore, a linear regression with total childhood trauma as the predictor of total confidence/self-efficacy was computed, which found $b = -0.374$, $t(83) = -4.20$, $p < .001$; Thus, total childhood trauma is significantly predictive of maternal confidence and self-efficacy.

Total childhood trauma also accounts for significant variance in total maternal confidence and self-efficacy, $R^2 = .177$, $F(1, 82) = 17.64$, $p < .001$. Notably, total childhood trauma accounts for more variance when predicting maternal confidence/self-efficacy than birth trauma related PTSD.

Discussion

The purpose of this study was to improve the general understanding of birth trauma. Specifically, the aim was to comprehend the relationships that underlie birth trauma, childhood trauma, and post-natal maternal confidence. Among the study participants, it was found that 30% experienced severe birth trauma related PTSD and 44% experienced a moderate level, which matches consistent reports that 30% of women globally have a traumatic birth experience (Soet et al., 2003). In fact, this is more than the 9.3% prevalence rate that Smarandache et al. (2016) had found among Canadian women; hence, the data further supports the need for increased awareness surrounding this phenomenon.

The first hypothesis was established showing that if a woman had experienced traumatic experiences in her childhood, then she had an increased likelihood of experiencing a traumatic birth as well, which is supported by vast research in the field. Experiences of trauma, regardless of the domain, have been shown to decrease resilience and heighten sensitivity to triggering situations (Atzl et al., 2019; Beutel et al., 2017). Furthermore, women are likely to recall traumatic

memories from their childhood during the labour period, making them more susceptible to experience trauma. These factors come into play during labour, which is a very demanding situation, causing women to feel more distressed and, eventually, leading to PTSD symptomology (Choi & Sikkema, 2016). The results of the study do, however, slightly contradict the research presented by Porthan and colleagues (2023), which states that emotional abuse and emotional neglect have the strongest relationship with birth trauma as opposed to our findings that rather showed that emotional, physical, and sexual abuse are correlational. Clearly, emotional abuse is a critical component and may be more influential than any other domain of childhood trauma, since it, in most cases, underlies the other domains of trauma (Dye, 2022; Hart et al., 1996). However, there is minimal focus on the five domains of childhood trauma separately in relation to birth trauma; perhaps, further research can shed light on the details regarding this phenomenon.

The current study did not find any significant relationship between birth trauma related PTSD and maternal confidence or parenting self-efficacy; it was neither correlational nor predictive. This contradicts past research which has found that when mothers experience a traumatic birth experience, particularly when linked to negative interactions with healthcare professionals, they have shown increased self-doubt and doubted their knowledge about parenting, resulting in lower maternal confidence (Molloy et al., 2021). Raudasoja et al. (2022) also demonstrated that it was possible to predict maternal self-efficacy from birth trauma; however, it can yield mixed results. Specifically, the predictive relationship only holds true in extreme case such as a very positive or very negative birth experience. Furthermore, the researchers concluded that there were other factors that influenced maternal confidence, not just birth trauma. Taking that into light with the current study, it is important to consider that there were relatively low reports of low maternal confidence or parenting self-efficacy. Furthermore, there may have been an influence of social desirability bias. Since the scales focused on parenting skills and confidence/ self-efficacy, there may have been a difficulty in admitting shortcomings in fear of being considered a “bad mother”, resulting in such high numbers.

The third hypothesis was supported: experiencing childhood trauma decreased the confidence or self-efficacy that mothers felt after giving birth. As mentioned, the experience of childhood trauma can have detrimental effects on one’s resilience, confidence, and self-efficacy (Walter et al., 2010; Beutel et al., 2017). These feelings are escalated during the stressful

postpartum period, possibly leading to low maternal confidence, particularly for first time mothers (Garon-Bissonnette et al., 2022). Low maternal confidence can influence parenting outcomes and result in complications when bonding with the child and in forming a secure attachment (Goto et al., 2010; Huang et al., 2022; Kojra et al., 2012). Traumatic childhood experiences of the mother were able to predict higher levels of maladaptive socioemotional behaviour in the child (McDonnell & Valentino, 2016); this may possibly result in intergenerational trauma since the level of trauma in mothers was linked to similar levels of trauma in the child. It is important to consider this relationship very carefully in terms of parenting because it has the potential to perpetuate continuously.

Next Steps

Building on these findings, this research will have subsequent phases.

Phase 2

The next step of this project will be conducting focus groups with participants from the survey. We are expecting around 30 participants to provide experiences of their labour and shed light on connections to childhood trauma and maternal confidence. A qualitative approach will provide more insight into individual experiences of birth trauma, as well as demonstrate a full picture into what women feel in regards to the perinatal period.

Phase 3

The data found from the current study (Phase 1) and phase 2 will help to design preventative care and eventually implement a perinatal psychoeducation program to be launched in Central Alberta. The findings help to highlight optimal methods in providing support to expectant mothers to decrease the likelihood and negative impacts of birth trauma.

Considerations

Due to the focus of the study, there are some factors to be aware of. This study focused on the birth experiences of cis women in order to control for certain extraneous variables such as sense of belonging, sense of identity, and social support that may influence the validity of the findings. However, the survey did contain gender-neutral and inclusive language, allowing replication of this study while studying different gender demographics. Furthermore, since the

findings were from Central Alberta, there is limited generalizability among populations. Due to vast differences in healthcare, economy, and lifestyle, experiences of women around the world and even Canada may differ substantially.

Conclusion

This study provides insight into the broad patterns surrounding birth trauma when considering the mother's childhood trauma and her confidence in motherhood. It is evident that the predictive nature of traumatic childhood experiences plays a critical role in peripartum experiences, influencing both birth trauma and maternal confidence, meaning that it would be an ideal target for preventative care in order to enhance the wellbeing of the mother and child.

References

Atzl, V. M., Narayan, A. J., Rivera, L. M., & Lieberman, A. F. (2019). Adverse childhood experiences and prenatal mental health: Type of aces and age of maltreatment onset. *Journal of Family Psychology, 33*(3), 304–314. https://doi.org/10.1037/fam0000510

Ayers, S., Wright, D. B., & Thornton, A. (2018). Development of a measure of postpartum PTSD: The City Birth Trauma Scale. *Frontiers in Psychiatry*, *9*, 409. https://doi.org/10.3389/fpsyt.2018.00409

Barnes, C. R., & Adamson-Macedo, E. N. (2007). Perceived Maternal Parenting Self-Efficacy (PMP S-E) tool: development and validation with mothers of hospitalized preterm neonates. *Journal of Advanced Nursing, 60*(5), 550–560. https://doi.org/10.1111/j.1365-2648.2007.04445.x

Beck C. T. (2004). Post-traumatic stress disorder due to childbirth: the aftermath. *Nursing Research*, *53*(4), 216–224. https://doi.org/10.1097/00006199-200407000-00004

Beutel, M. E., Tibubos, A. N., Klein, E. M., Schmutzer, G., Reiner, I., Kocalevent, R. D., & Brähler, E. (2017). Childhood adversities and distress - The role of resilience in a representative sample. *PloS one*, *12*(3), e0173826. https://doi.org/10.1371/journal.pone.0173826

Bhatia, M. S., & Jhanjee, A. (2012). Tokophobia: A dread of pregnancy. *Industrial Psychiatry Journal*, *21*(2), 158–159. https://doi.org/10.4103/0972-6748.119649

Choi, K. W., & Sikkema, K. J. (2016). Childhood maltreatment and perinatal mood and anxiety disorders: A systematic review. *Trauma, Violence, & Abuse*, 17, 427– 453. http://dx.doi.org/10.1177/15248380.15584369

Coussons-Read M. E. (2013). Effects of prenatal stress on pregnancy and human development: mechanisms and pathways. *Obstetric Medicine*, *6*(2), 52–57. https://doi.org/10.1177/1753495X12473751

Dye, H. L. (2019). Is Emotional Abuse As Harmful as Physical and/or Sexual Abuse?. *Journal of child & adolescent trauma*, *13*(4), 399–407. https://doi.org/10.1007/s40653-019-00292-y

Garon-Bissonnette, J., Bolduc, M. G., Lemieux, R., & Berthelot, N. (2022). Cumulative childhood trauma and complex psychiatric symptoms in pregnant women and expecting

men. *BMC Pregnancy and Childbirth*, *22*(1), 10. https://doi.org/10.1186/s12884-021-04327-x

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing*, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Goto, A., Nguyen, Q. V., Nguyen, T. T., Pham, N. M., Chung, T. M., Trinh, H. P., Yabe, J., Sasaki, H., & Yasumura, S. (2010). Associations of psychosocial factors with maternal confidence among Japanese and Vietnamese mothers. *Journal of Child and Family Studies*, *19*(1), 118–127. https://doi.org/10.1007/s10826-009-9291-9

Hart, S. N., Brassard, M. R., & Karlson, H. C. (1996). Psychological maltreatment. In J. Brier, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC Handbook on Child Maltreatment* (pp. 72-89). Thousand Oaks: Sage Publications Inc.

Huang, H. H., Lee, T. Y., Lin, X. T., & Duan, H. Y. (2022). Maternal Confidence and Parenting Stress of First-Time Mothers in Taiwan: The Impact of Sources and Types of Social Support. *Healthcare (Basel, Switzerland)*, *10*(5), 878. https://doi.org/10.3390/healthcare10050878

Ionio, C., & Di Blasio, P. (2014). Post-traumatic stress symptoms after childbirth and early mother–child interactions: An exploratory study. *Journal of Reproductive and Infant Psychology, 32*(2), 163–181. https://doi.org/10.1080/02646838.2013.841880

Korja, R., Latva, R., & Lehtonen, L. (2012). The effects of preterm birth on mother-infant interaction and attachment during the infant's first two years. *Acta Obstetricia et Gynecologica Scandinavica*, *91*(2), 164–173. https://doi.org/10.1111/j.1600-0412.2011.01304.x

Larkin, P., Begley, C. M., & Devane, D. (2009). Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, *25*(2), e49–e59. https://doi.org/10.1016/j.midw.2007.07.010

McDonnell, C. G., & Valentino, K. (2016). Intergenerational Effects of Childhood Trauma: Evaluating Pathways Among Maternal ACEs, Perinatal Depressive Symptoms, and Infant Outcomes. *Child Maltreatment*, *21*(4), 317–326. https://doi.org/10.1177/1077559516659556

Molloy, E., Biggerstaff, D. L., & Sidebotham, P. (2021). A phenomenological exploration of parenting after birth trauma: Mothers perceptions of the first year. *Women and Birth: Journal of the Australian College of Midwives*, *34*(3), 278–287. https://doi.org/10.1016/j.wombi.2020.03.004

Narayan, A. J., Bucio, G. O., Rivera, L. M., & Lieberman, A. F. (2016). Making sense of the past creates space for the baby: Perinatal childparent psychotherapy for pregnant women with childhood trauma. *Zero to Three Journal*, *36*(5), 22–28.

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science*, 23(5), 381–387. https://doi.org/10.1177/0963721414547414

Parker, S., & Zahr, L.K. (1985). The Maternal Confidence Questionnaire. Boston, MA: Boston City Hospital.

Patterson, P., Skeate, A., Schultze-Lutter, F., Graf von Reventlow, H., Wieneke, A., Ruhrmann, S., & Salokangas, R. (2002). The Trauma and Distress Scale. Birmingham, UK: University of Birmingham.

Porthan, E., Lindberg, M., Härkönen, J., Scheinin, N. M., Karlsson, L., Karlsson, H., & Ekholm, E. (2023). Childhood trauma and fear of childbirth: findings from a birth cohort study. *Archives of Women's Mental Health*, *26*(4), 523–529. https://doi.org/10.1007/s00737-023-01328-x

Prinds, C., Hvidt, N. C., Mogensen, O., & Buus, N. (2014). Making existential meaning in transition to motherhood--a scoping review. *Midwifery*, *30*(6), 733–741. https://doi.org/10.1016/j.midw.2013.06.021

Raudasoja, M., Vehviläinen-Julkunen, K., & Tolvanen, A. (2022). Passing the test of motherhood? Self-esteem development and birth experience in the transition to motherhood: A longitudinal mixed methods study in Finland. *Journal of Advanced Nursing*, *78*(12), 4246–4260. https://doi.org/10.1111/jan.15468

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth*, *17*(1), 21. https://doi.org/10.1186/s12884-016-1197-0

Schwartz, L., Toohill, J., Creedy, D. K., Baird, K., Gamble, J., & Fenwick, J. (2015). Factors associated with childbirth self-efficacy in Australian childbearing women. *BMC Pregnancy and Childbirth*, *15*, 29. https://doi.org/10.1186/s12884-015-0465-8

Seefat-van Teeffelen, A., Nieuwenhuijze, M., & Korstjens, I. (2011). Women want proactive psychosocial support from midwives during transition to motherhood: a qualitative study. *Midwifery*, *27*(1), e122–e127. https://doi.org/10.1016/j.midw.2009.09.006

Smarandache, A., Kim, T. H., Bohr, Y., & Tamim, H. (2016). Predictors of a negative labour and birth experience based on a national survey of Canadian women. *BMC Pregnancy and Childbirth*, *16*(1), 114. https://doi.org/10.1186/s12884-016-0903-2

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth (Berkeley, Calif.)*, *30*(1), 36–46. https://doi.org/10.1046/j.1523-536x.2003.00215.x

Vogels-Broeke, M.P. R., & Nieuwenhuijze, M. (2021). Validating a framework of women's experience of the perinatal period; a scoping review. *Midwifery*, *92*, 102866. https://doi.org/10.1016/j.midw.2020.102866

Walter, K. H., Horsey, K. J., Palmieri, P. A., & Hobfoll, S. E. (2010). The role of protective self-cognitions in the relationship between childhood trauma and later resource loss. *Journal of Traumatic Stress*, *23*(2), 264–273. https://doi.org/10.1002/jts.20504

Watson, K., White, C., Hall, H., & Hewitt, A. (2021). Women's experiences of birth trauma: A scoping review. *Women and Birth: Journal of the Australian College of Midwives*, *34*(5), 417–424. https://doi.org/10.1016/j.wombi.2020.09.016