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Title: Exploring Birth Trauma Experiences in South Asian Women: An Interpretative Phenomenological Analysis

Short title: *BIRTH TRAUMA IN SOUTH ASIAN WOMEN*

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Author Contributions
Aditi contributed to the conceptualisation, data curation, methodology, analysis, and the writing of the original draft. Vyv and Emma contributed to the supervision, validation of themes and the review and editing of the research.

Abstract:

Aims/ Background

South Asian women may be more likely to experience distress following childbirth and risks linked with birth trauma. Additionally, South Asian women have shown to be less likely to receive subsequent support, compared to White women. Therefore, this study explored how South Asian women make sense of birth trauma and seek support.

Design / Methods

This study employed a qualitative design with interpretative phenomenological analysis. Public and participant involvement, reflexivity and trauma-informed approaches guided research processes. Recruitment was conducted using purposive and snowball sampling methods. The study was advertised through third sector organisations, specialist postnatal research groups and social media. Eight participants with birth trauma experiences completed a semi-structured interview.

Results

Interpretative phenomenological analysis developed four themes 'the power of maternity/obstetric healthcare professionals,' 'loss of connection,' 'disentangling discrimination' and 'pervasive cultural stigma in motherhood.' Findings highlighted the power differentials between maternity healthcare professionals and discriminatory interactions. The birthing experience represented a multitude of losses for South Asian women which underpinned longstanding distress. Formal support seeking was limited by cultural stigma and mistrust with the National Health Service.

Conclusions

This research identified the complex interplay of negative experiences and mistreatment during childbirth contributing to birth trauma in South Asian women. Clinical implications include improving the relational experience and wellbeing of South Asian women during childbirth. Research implications include continuing to situate South Asian women's voices in maternal/perinatal research and service developments.

Keywords:
Birth trauma; maternal mental health; South Asian; qualitative

Word count – **24**1

Introduction

Health inequalities are avoidable, unfair, and systematic differences in healthcare between different groups of people (The King’s Fund, 2022). Within the context of maternal ethnic health inequalities women from Black and South Asian (SA) ethnicities are at increased risk of complications, stillbirths, and preterm births, compared to White women (Jardine et al., 2021). Black women are more likely to die from pregnancy complications with Asian women twice as likely to die or suffer injury, compared to White women (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries, 2024). From women who died during childbirth, nearly half were ethnic minority women, of which were predominantly Asian women (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries, 2024). Maternity care disparities increase the risk of ethnic minority women developing postnatal mental health problems (Watson et al., 2019).

Birth trauma (BT) can underpin maternal mental health difficulties, impacting about 1 in 3 births and 4% of these women reaching a clinical threshold (Alcorn et al., 2010; Ayers et al., 2024; Baxter, 2020). BT can trigger anxiety, fear of childbirth (tokophobia), bonding difficulties, relationship issues and post-traumatic stress disorder (PTSD) (Watson et al., 2021).

BT is not an established clinical diagnosis and lacks a consistent definition due to BT-related research being primarily atheoretical (Beck, 2015; Elmir et al., 2010; McKenzie-McHarg et al., 2015). Existing conceptual frameworks such as the Diathesis-Stress Model and Cognitive Model of PTSD highlight the vulnerabilities, risks and maintain factors linked with the developed of childbirth-related PTSD. Whilst, these have been applied to birth trauma, there is focus on the aftermath rather than the trauma itself, lacking specific considerations for ethnic and cultural differences (Ayers, 2004; Beck, 2004; Ehlers & Clark, 2000; Ford et al., 2010; King et al., 2017).

Within the literature, sometimes BT is defined as the physical trauma or injury experienced due to obstetric interventions during childbirth (Greenfield et al., 2016). However, it is recognised that adverse maternity care experiences are associated with BT (Watson et al., 2021). More recently, mistreatment of women during birth, which represents abusive, discriminatory and non-consensual practices during childbirth, describes BT (Ayers et al., 2024). This study aligns with the construct that BT reflects distressing experiences as a direct result from the events, injury and/or care received from childbirth and its aftereffects (Elmir et al., 2010; Greenfield et al., 2016; Leinweber et al., 2022). This study advocates the importance of subjective appraisal of BT especially as Black and SA women with BT are likely to avoid their distress and seldom seek support (Conneely et al., 2023; Slade et al., 2021).

Most research exploring ethnic minority women’s experiences of maternal mental health typically incorporates Black, Asian, and other minority ethnic women as a homogenous group, without detailed consideration for differences in experiences (Aspinall, 2021; John et al., 2021; Watson et al., 2021). SA communities are underrepresented in research and the most prominent ethnic minority group in England and Wales (Quay et al., 2017; Office for National Statistics, 2022). SA typically refers to people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives (Minority Rights Group International, 2022). Individuals with SA ethnicity hold commonalities across cultural beliefs, norms, and values, although inevitably diversity exists (Anand & Cochrane, 2005; Onozawa et al., 2003). During the antenatal and perinatal periods, SA women may include following a particular diet, restricting activities, religious ceremonies and using Ayurvedic approaches (George et al., 2022). Such cultural practices may intersect with BT if the quality of relationships with Maternity/Obstetric Health Professionals (MHPs) are poor and insensitive to SA women's cultural identity (Sharma et al., 2025).

Additionally, SA women may experience unique risks and vulnerabilities during pregnancy and childbirth. For instance, gestational diabetes is highly prevalent in SA women compared to other ethnicities and can result in adverse outcomes for the mother and baby, which may underpin a traumatic birth experience (Ejaz et al., 2023; Greenhalgh et al., 2015). Physical birth injuries can increase the experience of BT, SA women experience a higher rate of obstetrical anal sphincter injury compared to White individuals (Park et al., 2024). Additionally, there are higher emergency caesarean section rates, operative deliveries and higher risk of postpartum haemorrhage in SA women compared to their White counterparts (Briley et al., 2021; Reddy et al., 2017; Yunas et al., 2025). Reflecting on these unique risks and wider health inequalities may signify how SA women may be vulnerable to BT.

In terms of support, compared to White British women, Indian and Pakistani women are twice as likely to experience distress during pregnancy and the year after childbirth, whilst less likely to receive psychological intervention (Moore et al., 2019). Although this finding was not specific to BT, increased psychological distress after childbirth can stem from a traumatic birth experience and subsequently reach the threshold for post-traumatic stress disorder (Ertan et al., 2021).

This study aims to explore how South Asian women make sense of BT and seek support in order to provide an in-depth and rich understanding of their experiences.

Materials & Methods

Ethical approval was granted by the University of Sheffield (reference number: 045276). Trauma-informed approaches informed the entire research process (Isobel, 2021).

Design

A qualitative design informed by interpretative phenomenological analysis (IPA) (Hammarberg et al., 2016; Smith et al., 2022). IPA aimed to explore the individual's lived experiences of BT whilst developing an analysis identifying commonalities between experiences (Shinebourne, 2011; Smith et al., 2022).

Participants

Purposive sampling complimented with snowball sampling methods were employed to recruit a relatively homogenous sample of eight SA women with BT.

Participants met the inclusion criteria if they (a) were a UK resident, (b) aged 18 years or above with capacity to consent, (c) identified as SA, (d) experienced BT between six months and five years ago in the UK, (e) identified as experiencing BT as informed by a checklist based on Greenfield's et al., (2016)'s description of BT (Table 1). Also, participants were required to access the telephone or internet, willing to be interviewed in English and willing to talk about the impact of traumatic birth experiences. Participants were excluded if the BT resulted in the death of an infant to support homogeneity for IPA.

Currently, there is no universal trauma screening tool within the maternal population (Grisbrook & Letourneau, 2021). Therefore, a checklist informed by the literature and consultation with an Expert-by-Experience was developed, shown in

Table 1. This checklist aimed to support participants to self-identify relevant experiences of BT and describe the sample.

Table 1

Birth trauma checklist

- At the time of birth did you have feelings of intense fear, helplessness, or horror?
- After your childbirth did you feel shocked, guilty, or numb?
- Did you (the mother) and/or the baby experience physical injury that resulted in longstanding distress?
- Did you experience fear of physical injury or death to you (the mother) or the baby and experience longstanding distress?
- Did you experience a lack of care (perceived as discrimination, unsupportive or inhumane) during childbirth which caused longstanding distress?

Recruitment

Recruitment was through online third sector organisations, specialist postnatal research groups and social media (Facebook, Instagram, and Twitter). Recruitment was conducted between July and September 2022.

Procedures

Following ethical approval, invitation posters were advertised on social media. Participants who responded were emailed the information sheet and the primary researcher's contact details (AS). After contact was made, the researcher confirmed eligibility, documented signed informed consent and scheduled the interview. At the time of interview, verbal consent to be interviewed, audio recorded using an approved device and transcribed, was confirmed. Also, the researcher confirmed the participant felt comfortable to talk about BT which was checked throughout the interview. A debrief sheet included the researcher's contact details and signposted to organisations that provide support. Participants were reimbursed with a £10 voucher.

Data Collection

Demographic information is presented in Table 2. Pseudonyms were used to preserve anonymity. Participants’ age when they experienced BT (or if experienced multiple BT, age when they experienced their first BT) ranged between 24-40 years (average age was 37.63 years). No participants discontinued or withdrew from the study.

Table 2

Participant Demographics

Participant	Ethnicity	Immigration Generation	Method of birth associated with birth trauma	Time since birth trauma	No. of children at interview
Ameerah	British Pakistani	First	Induction and caesarean section; Planned caesarean section	< 4 years < 5 years	2
Maya	Pakistani	Immigrant	Vaginal birth	< 5 years	2
Nadiya	British Bangladeshi	Third	Emergency caesarean section with general anaesthetic	< 5 years	2
Deepika	South Asian	Third	Vaginal with episiotomy; Vaginal birth	< 2 years < 5 years	2
Bhavna	Indian	First	Forceps delivery	< 1 year	1
Misha	Indian	First	Emergency caesarean section	< 5 years	1
Naseema	Afghan	First	Forceps delivery	< 2 years	1
Mahira	British Pakistani	First	Caesarean section	< 3 years	1

Semi-Structured Interview

Interviews were conducted by the primary researcher (AS) via telephone or Google Meets, depending on the participant's preference. A topic guide ensured continuity between participants and structure, whilst enabling flexibility for follow-up questions and clarifications (Busetto et al., 2020) (Appendices). The eight interviews ranged between 37-87 min (average interview was 61 min). No participants were known by the researcher.

Public and Participant Involvement

There were two avenues for public and participant involvement to invite feedback on the participant-facing research documents. Firstly, consultation with a group of experts-by-experience comprising of five White British women and one Iranian women with experience(s) of BT. Secondly, consultation with an Expert-by-Experience, a SA woman with experience of BT more than five years ago. Public and participant involvement resulted in minor changes namely, around clarity.

Data Analysis

Philosophical Underpinning

The research was situated from a critical realist stance, that knowledge is historically, socially, and culturally situated and underpinned by theories that help us get closer to an individual's reality, but does not determine their reality (Bhaskar, 2010; Fletcher, 2017). A hermeneutic phenomenological approach aimed to make sense and interpret lived experiences of BT (Laverty, 2003).

Coding and Analysis

The interview data was analysed by the primary researcher (AS), employing the seven flexible stages for analysis by Smith et al., (2022). The interviews were transcribed between the researcher and a university-approved transcriber. The researcher was immersed in the interview transcripts by transcribing and (re-)reading the data. Exploratory noting and coding at the descriptive, linguistic, and conceptual level were completed. Codes were discussed in research supervision. Developing group experiential themes was a dynamic and iterative process. A finalised table of group experiential themes was created with agreement from the research team.

Research Quality

To ensure research quality principles for evaluating the validity of qualitative research criteria was followed: sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance (Yardley, 2015; Yardley, 2017). An independent audit and evaluation of research processes was completed, supporting transparency (Elman & Kapiszewski, 2014; Tracy, 2010). The Consolidated Criteria for Reporting Qualitative Studies checklist guided the write-up to ensure quality reporting (Tong et al., 2007). Regular research supervision (VH and EW) was utilised to reflect on the research processes.

The researcher inevitably influences the qualitative research processes (Yardley, 2015). The primary researcher (AS) was a cisgender woman, Trainee Clinical Psychologist. AS identified with SA ethnicity and familiar with some SA cultural values and norms, which may have influenced participants' willingness to engage with the research.

Results

IPA analysis developed four group experiential themes, detailed in Table 3. Each group experiential theme was illustrated by participant quotes with analytic interpretations. Quotes were chosen to ensure participant representation across the sample.

Table 3

Summary of Themes

Group Experiential Themes	Sub-Theme
1.0 The power of maternity/obstetric healthcare professionals	1.1 Coerced and violated 1.2 Ignored and dismissed 1.3 Intolerable disappointment by the NHS
2.0 Loss of connection	2.1 Loss of reality 2.2 Loss of bonding experiences
3.0 Disentangling discrimination	-
4.0 Pervasive cultural stigma in motherhood	4.1 Keeping up the illusion of coping 4.2 The shame of needing emotional support

1.0 The Power of MHPs

Power struggles were characterised between participants and MHPs with participants left suffering with a sense of persistent threat.

1.1 Coerced and Violated

Participants perceived feeling coerced to MHP’s clinical instructions which manifested distress and feelings of powerlessness. The discussions around consent and choices appeared to be absent. Naseema internalised an overwhelming lack of agency and a threat to mortality.

> "I felt like I was being kind of forced, you know, doing something that I didn't want, and I felt like just, just very scared, I think that's what I felt. I was scared that I was not gonna make it, baby was gonna pass away or what" (Naseema).

Participants experienced invasive intrusions of their body. Nadiya shared deep shock when stripped of dignity, privacy and a disregard of bodily autonomy.

> "You've decided that you're going to wash me without taking into consideration consent or even asking whether I want you to do that, literally whilst my mum is stood there, spread my legs open, start washing me and cleaning me, and I'm just thinking 'I don't want to be washed there and cleaned'" (Nadiya).

Bhavna spoke of feeling overpowered and a violation of her body, resembling sexual trauma.

> "I remember saying to him, 'I just want you to stop touching me,' like 'I want you to stop now' and like 'enough,' and he was like 'but you don't feel pain,' I remember him like flicking my vagina, like 'you don't feel pain though,' like flicking, like to prove it" (Bhavna).

Ameerah described how power was exercised through judgement and the blame of the poor outcome for the baby was located onto the mother, framing her as negligent "she saw me and she said, 'it's because of women like you that your children end up in intensive unit because you don't do as what you're told'" (Ameerah).

1.2 Ignored and Dismissed

The BT experience comprised of the mother and baby's needs being ignored and dismissed. The impact of being ignored manifested a sense of inferiority which was detrimental to maternal wellbeing and sense of self, as Deepika described being "made to feel like an idiot" (Deepika).

Participants shared dehumanising and invalidating interactions during childbirth. Misha perceived MHPs to blatantly reject her expressed needs and actively devalued.

> "I called the Nurse, and she came in and I said, 'I'm in so much pain, there is something seriously wrong,' and she looked at me, she looked me in the eyes, and she said, 'what do you expect me to do about it?'" (Misha).

Experiences of being ignored by MHPs, escalated to psychological and physical distress perpetuating a threat to the self. Nadiya expressed "I was really cross because I wasn't listened to, I wasn't heard, I was in agony, my, my pain wasn't addressed, I'd been left alone all of the night feeling like I was going to die" (Nadiya).

The repeated efforts of being ignored reflected a pattern of neglect and a silencing of women's needs. "I have rung the bell so much they're not coming, and I felt really helpless, and a few hours pass, and I called her, and she pretended not to see me, and I saw her turn her head away" (Ameerah).

1.3 Intolerable disappointment by the NHS

Nearly all participants experienced intolerable disappointment and helplessness, often developing deep distrust and resentment with the NHS. The poor treatment of care posed a threat and doubted the safety of Ameerah's baby. "I said to them 'you haven't taken care of us while we're in the hospital why should I believe that you will look after my child now?'" (Ameerah).

Misha described how the NHS failed her, however, internalised her experience as acute self-blame. "One thing that I was left with was that my body had failed me. Not that the health care system had failed me, which it had. It had 100%, it failed." (Misha).

Participants experienced abandonment by the NHS and subsequently had to "seek out private care" (Bhavna) to resolve physical difficulties as a direct result of childbirth. Bhavna described suffering with "a gaping wound for four and a half months because the NHS said, 'we're not going to do anything about it'" (Bhavna). Participants described coping with their childbirth experiences by actively avoiding the NHS after mistreatment. Naseema described attempts to avoid the NHS for a future birth. "I've lost all my trust and it was give and take, next time I would go privately, just to make sure that I don't have to go through what I just went through" (Naseema).

2.0 Loss of Connection

Participants described struggling with a multitude of losses specifically, losing sense of reality during birth and bonding experiences just after birth.

2.1 Loss of Reality

A loss of reality was reflected in over half of the participants feeling "really out of it" (Mahira), "a real disconnect" (Nadiya), "like a dead body" (Naseema), and "out of this world" (Deepika).

Intense feelings of shock and disorientation followed childbirth which altered expectations and transition into motherhood. As Naseema described:

> "I was literally shocked. I didn't know, you know when you, I initially thought that it would be such a beautiful time enjoying my baby after delivery, but it was just very painful, and I was just in shock of what the hell just happened. I was literally frozen" (Naseema).

Nadiya shared attempts to recalibrate to her physical presence during childbirth.

> "I'd woken up, I was in a quiet room with the blue curtains, surgical curtains tied, absolute quiet, couldn't hear ANYTHING at all with like a light shining down onto my face, I had no baby bump, I couldn't feel pain. I didn't feel sick so, either I'd died or he died and I couldn't work which one it was" (Nadiya).

Deepika described feeling disconnected with childbirth and subsequent incongruous interactions with MHPs resembled passive habits rather than authenticity. "I felt really weird because I was like in the theatre bit with the first one and like everyone was like saying 'congratulations' to me, and I was like 'that's a weird thing to say'" (Deepika).

2.2 Loss of Bonding Experiences

Participants highly valued immediate bonding time and Naseema described "I won't ever get that time back" (Naseema). Some participants directed blame towards MHPs such as the midwives and obstetricians. Misha described a tokenistic gesture "They gave me a little bit of time with her and then they took her away and this is another one of the traumas that they created" (Misha). This was echoed by Ameerah's heartbreak and confusion.

> "It was like a loss, it was so heart wrenching cos I just wanted to be near my baby, and I think it was like a really maternal instinct, it was like 'I want to be with my baby now like why are you keeping us apart?'" (Ameerah).

The immediate maternal attachment opportunities were interrupted by medical procedures which undermined the quality of bonding experiences..

> "I had no skin-to-skin, for a few minutes, had to give the baby to my boyfriend and I couldn't even enjoy that moment cos I was being stitched and I, I couldn't feel pain, but I could feel every tug, like I could see like, blood spraying off of the string" (Bhavna).

Nadiya described the initial difficulties with bonding and providing care as a mother's duty hindered by lasting pain experiences. "At the beginning I found it really difficult to connect cos I couldn't hold him, I was in agony, I wasn't doing the feeds, I wasn't changing his nappy, obviously you know, I was in pain," (Nadiya).

3.0 Disentangling Discrimination

Nearly all participants described experiences of discrimination within the context of sexism and/or racism. However, participants identified discrimination with variable degrees of certainty. Deepika searched for reasons for poor maternity care experiences which led her to contemplate racism, recognising the care received extended beyond a single MHPs' prejudice and suggestive of systemic racism. "It's when you look back you think if it was a White person would they have done that?" (Deepika). This was similarly echoed by Misha caught in an internal conflict, attributing poor maternity experiences directly to her Indian identity.

> "It's awful because was it, 'because we were Indian and we're people of colour?' There's a part of you that thinks 'did this happen to me because I am

> Brown?' and you don't have anybody to ask, so your brain is whirling, thinking 'what, because I was Brown, was I treated this badly, because I was Brown?'" (Misha).

Mahira reflected certainty and confidence of her care being due to racism. "I'm just going to say it how it is to be honest, had this have been a White, British woman that wouldn't have happened" (Mahira). There was a recognition of unequal standards of maternity care and a recognition of injustice, suggesting being SA perpetuated inferiority.

Nadiya described a position of gendered power imbalance with substandard maternity care being recognised as a current norm rather than cultural discrimination or racism.

> "I know that there is a lot of conversations at the moment with women in general and you know women's birth experiences being denied, pain medications with invasive procedures, I think I fit into that category of, the care women generally receive during um you know birth, is a conversation that's being had at the moment, and I think that I fit into that" (Nadiya).

Although Nadiya wondered whether being "Westernised" (Nadiya) was supportive, due to the integration of British and SA cultures. This was also reflected by Misha who perceived her experiences of being part of a mixed-race couple (with a White counterpart) was protective from discrimination. "This is gonna sound awful, but I think because I have a White husband, I didn't get it nearly as bad, which is an awful, awful thing to say" (Misha). It represented how she perceived her White husband to reduce the intensity of racism and exposing the tension between recognising privilege of her husband’s Whiteness and awareness of her own ethnic inequalities.

4.0 Pervasive Cultural Stigma in Motherhood

Participants expressed expectations to uphold cultural norms and standards as a SA mother. Most participants denied seeking support for BT. The illusion of coping sometimes worked, and the shame of needing emotional support was salient.

4.1 Keeping up the Illusion of Coping

Participants experienced pressures to uphold the cultural standards to be a self-reliant mother and conceal struggles. Ameerah described the cultural expectation of self-sacrificing and silencing of maternal emotional difficulties in order to prioritise the baby, thus devaluing the importance of maternal wellbeing.

> “we don’t accept help, so we don’t, we’re expected to look after ourselves and deal with it, um and that makes it a lot harder, it’s like if you’re like you’re told you’ve had a hard time you’re very much told well actually ‘look you’ve got this beautiful baby focus on the baby why are you thinking about all the horrible things that you went through’” (Ameerah).

Mahira described valuing an outward appearance of resilience and denial of the true extent of the distress.

> “It was definitely helpful for them to ask these questions, but I think I also wanted to, I wanted to show that I was coping I guess, so maybe that’s why I minimised it. I didn’t want to, maybe I didn’t, at the time, I didn’t think it was a problem” (Mahira).

For Misha the experiences of receiving cultural messages supporting the value of self-reliance seemed to be internalised and suppressed difficult feelings to keep them private. “I find that I just end up going ‘just deal with it, just deal with it, you can sort it out afterwards, you can fix it afterwards’” (Misha). The discouragement from talking about traumatic birth experiences was echoed by Naseema “You always have to keep it ‘hush’ going through what you did” (Naseema).

However, Deepika experienced the unrealistic expectations of adhering to SA norms of motherhood and navigated overcoming intergenerational transmission of cultural norms to seek support for her mental health. “I’m breaking barriers [laughing]. I’m, we need to stop that, that’s stupid, all of that, any cultural stuff saying that we shouldn’t [seek help]” (Deepika).

4.2 The Shame of Needing Emotional Support

Due to the lack of open dialogue around mental health, participants experienced challenges when subsequently disclosing accessing support for BT. For Misha, accessing support represented a shameful act whilst offering insult towards her parents, exposing some of the intergenerational cultural differences. “You can’t talk to Indian parents about therapy. Well, I couldn’t, I felt bad about it because everything is taken so personally, you know, if you seek therapy it’s ‘what did I do wrong as a parent?’ (Misha). Nonetheless, Misha reported to engage with NHS psychological therapy and navigated the accompanying experiences of shame. “I was so ashamed for getting healthcare, for getting therapy in the first place but it was the best thing” (Misha).

Whereas Bhavna appeared unashamed of engaging in therapy and sought timely access to therapy independent to the NHS. “Within three days obviously got um given the, the therapist who I’m still working with, she, she helped me obviously with the EMDR therapy for that particular incidence [childbirth]” (Bhavna).

Ameerah reflected a sense of self-preservation and valuing stoicism around managing the impact of the BT. “I don’t need to revisit it for counselling purposes or for help, I don’t think that’s who I am, I’m quite a resilient person, I’ve dealt with it, I’ve moved on” (Ameerah).

For Maya it was a revelation that formal support for BT existed, suggesting awareness may have conflicted social norms and mental health being stigmatised. “Because in our countries, I’ve never heard anybody going through like for their mental treatment unless they are crazy” (Maya).

Discussion

This study provides a unique exploration of SA women’s experiences of BT in the UK. SA women voiced experiences of inferiority and dehumanisation through childbirth underpinned by a deep sense of mistreatment from MHPs. SA women spoke of the shock and out of body experiences after childbirth. Profound grief was expressed regarding separation from their baby immediately after birth. SA women attempted to formulate poor maternity care experiences within the context of discrimination and spoke on discriminative experiences with varying degrees of certainty due to the nuances with recognising systemic discrimination. SA women were unlikely to seek support for BT due to mistrust in the NHS. Cultural stigma and norms perpetuated avoidance and minimising struggles from the birth experience, whilst promoting a cultural standard to strive to cope.

This study highlighted perceptions of MHPs abusing their position of power which was echoed by a meta-synthesis reporting similar experiences generalised to ethnic minority women (MacLellan et al., 2022). Some participants felt MHPs disregarded consent, which reflected mistreatment from MHPs (Ayers et al., 2024). Such experiences are likely to influence negative appraisals of maternity care during childbirth which may contribute to the development of PTSD (Ehlers and Clark, 2000).

Racial discrimination during childbirth is a significant risk factor for adverse birth outcomes (Alhusen et al., 2016; Janevic et al., 2020). From professionals' perspectives, MHPs may normalise their routine care as mistreatment, particularly with regards to ethnic minority women (Salter et al., 2023). These experiences may be underpinned by unconscious bias and racism (Aquino et al., 2015; Bowler, 1993; Chitongo et al., 2022; Lyons et al., 2008; Puthussery et al., 2008).

Participants experienced disconnection which may have reflected disengagement, a coping mechanism during childbirth. Women's experiences have reflected the disengagement with childbirth to cope and resulted in the loss of self (Bateman et al., 2017; Byrne et al., 2017; Nijenhuis & van der Hart, 2011). These experiences may be interpreted as dissociation, shown to predict childbirth-related PTSD, therefore, warrants further exploration with relation to SA women (Harris & Ayers, 2012).

The World Health Organisation recommends immediate skin-to-skin contact between a mother and baby after birth (World Health Organisation, 2017). Skin-to-skin contact has shown to be protective to BT experiences (Mehler et al., 2020). Participants' experiences were generalisable to other women's experiences who have experienced a sense of disconnection when involuntarily separated from their baby, which worsened maternal suffering (Palmquist et al., 2020; Stevens et al., 2019).

Cultural stigma and adhering to SA cultural norms sometimes inhibited help-seeking for BT. SA women have been less likely to disclose difficulties and offered opportunities to understand the events around their birth, supportive for processing BT (Niles et al., 2021; Sigurðardóttir et al., 2019). Increased mental health stigma, a reluctance to disclose difficulties and seek support in the perinatal period, may be exacerbated by SA values around family honour and reputation (Amoah, 2021; Eylem et al., 2020; Shariff, 2009). Cultural stigma and keeping up the illusion of coping may suggest that SA women's BT memories were left unprocessed, thus vulnerable to developing PTSD (Ehlers & Clark, 2000; Ozer et al., 2003). Unprocessed and unresolved trauma may have an intergenerational impact and result in maladaptive coping strategies thus should be explored further in SA women (Bowers & Yehuda, 2016; Fenech & Thomson, 2014).

Strengths, Limitations and Research Implications

This study explored in-depth BT experiences from SA women. The successful online recruitment reflected that SA women may use online platforms to support their sense-making of BT. It would be pertinent to explore how SA women use online platforms and its acceptability to help-seeking, as this can be a private experience and potentially mitigate associated support-seeking stigma.

Although the study aimed for a homogenous sample, there were some key differences between participants. For instance, some participants experienced BT during the COVID-19 pandemic, which represented women's experiences more widely (John et al., 2021; Sanders & Blaylock, 2021). Financial privilege was reflected in some participants' narratives when seeking support from private services. Whilst socioeconomic status data was not collected, it would be beneficial to explore the intersectionality of SA ethnicity and socioeconomic backgrounds, especially as women from lower socioeconomic backgrounds have described uncompassionate and impersonal care leading them to feel unsafe during childbirth (Vedeler et al., 2023). Furthermore, the intersectionality of gender, ethnicity, religion and generational differences within BT should be considered in prospective research, Abrams et al., (2020) has proposed guidance for this.

Clinical Implications

MHPs and maternity services are recommended to integrate trauma-informed care principles to better seek to understand SA women's lived experiences. Trauma-informed care offers a systemic approach to prevent (re-)traumatisation and prioritises women's safety, trust, choice and empowerment throughout their care. Additionally, supporting cultural safety advocates for MHPs and services to be self-critical of power imbalances and reduce intentional or unintentional bias, to achieve maternity care equity and reduce the risk to experience BT (Curtis et al., 2019; Leinweber & Stramrood, 2024).

Maternity and Maternal Mental Health services have a role to increase access and acceptability for SA women to safely disclose and make sense of BT experiences. Better understanding SA women's lived experiences of BT can support with preventing the development of further psychological distress and support with challenging cultural stigma. Specialist Psychologists could assist MHPs and systems with supporting culturally sensitive trauma-informed training, clinical supervision, and consultation across the system. Utilising a formulation-led approach, psychologists can also offer culturally adapted psychological intervention for BT (McKenzie-McHarg et al., 2015; The British Psychological Society, 2016; Williamson et al., 2021). Effective cultural adaptations for trauma interventions have included socio-cultural integrations, cultural matching, psychoeducation, addressing cultural stigma and practical considerations which should be further considered within the context of BT (Benjamin et al., 2025).

Conclusion

This research highlighted the power differentials between MHPs and discriminatory interactions contributing to BT in SA women. The birthing experience represented a multitude of losses for SA women. Formal support seeking was limited by cultural stigma and mistrust in the NHS.

Word count: 4,982 – (Total including tables= 5,255 words - Table 1 89 words - Table 2 119 words - Table 3 67 words)

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The participants of this study did not provide consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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