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# The effect of respectful maternity care on the perception of traumatic birth among mothers in southern Türkiye

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## Abstract

**Background** Respectful maternity care is a universal right for all reproductive women. The relationship between women and maternity care providers is crucial throughout pregnancy, birth, and postpartum. Qualitative studies suggest that care quality and interactions with healthcare professionals impact women more than medical interventions. This study examines the effect of respectful maternity care on the perception of traumatic birth.

**Methods** The study was conducted with 540 mothers who had a healthy birth in a public hospital in southern Türkiye between May and August 2024. The data collection process was carried out in two stages. In the first stage, mothers who completed the 24-h postpartum period filled out the Personal Information Form and the Women's Perception of Respectful Maternity Care Scale, and their contact information was obtained. In the second stage, one week after birth, the Birth-Related Trauma Perception Scale was completed through phone interviews with the mothers.

**Results** Mothers'perceptions of birth-related trauma and respectful maternal care were found to have significant relationships with many sociodemographic and obstetric variables ($p < 0.05$). The participants'mean respectful maternal care score and mean trauma perception score were 68.55 ± 9.30 and 120.80 ± 14.53, respectively. In addition, a high level of negative correlation was found between birth trauma and respectful maternal care ($r = -0.864$; $p < 0.001$).

**Conclusions** The study revealed that women exhibited a high perception of psychological trauma and a moderate perception of respectful maternity care. The findings indicate that sociodemographic and obstetric factors play a significant role in shaping women's experiences of both respectful care and birth trauma. Notably, a strong negative correlation was identified between respectful maternity care and the perception of birth trauma.

**Keywords** Birth trauma, Maternity care, Postpartum posttraumatic stress disorder, Risk factors, Respectful maternity care

## Introduction

Care in obstetrics should respect women's and maternal rights in line with ethical principles and be scientifically based and woman-centered [1]. Respectful maternal care (RMC) includes the right of any childbearing woman to universal care, whenever possible, including respect for her autonomy, dignity, feelings, choices and preferences, choice of attendant at birth, and cultural rituals [2]. RMC during childbirth is a fundamental human right, and

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accordingly, the ethical, psychological, social, and cultural dimensions of childbirth must be considered in this process [1, 3]. The World Health Organization (WHO) recommends a respectful approach to maternity care for all women. While promoting safe, effective, and personalized care, this approach removes unnecessary health outcomes and inappropriate or unnecessary medical interventions [3–5]. Childbirth is a transitional period in a woman's life characterized by significant physiological changes. As women will be sensitive and exposed, this period is also marked with vulnerability. It was reported that women in labor were exposed to varied degrees of mistreatment and neglect worldwide, especially in developing countries and in countries with higher gender inequality [6, 7]. Certain behaviors, including abuse and neglect, can have adverse physical and emotional effects on maternal health [8]. Nevertheless, many women are unaware of the abuse or neglect they are subject to or perceive it as a usual part of the birth process [9, 10]. This is considered a violation of human rights. At the same time, based on human rights principles, RMC aims to ensure that every woman receives dignified, fair care without coercion or discrimination, including preferences for care during childbirth to promote positive experiences [11]. WHO suggests via its recommendations on intrapartum care for a positive birth experience that respectful birth care is compatible with human rights-based approaches to maternity care and can improve women's birth experiences and reduce health-related inequalities [3]. WHO insists that"every woman has the right to the highest attainable standard of health, including the right to dignified and respectful health care"[2]. Nevertheless, women's experience of maternity care in healthcare facilities, particularly in low- and middle-income countries, is characterized by discrimination, inadequate psychosocial support, and healthcare professionals with a condescending attitude toward women. A woman's birth experience can leave life-changing psychological marks. Previous studies suggested that one-third of women described their experience of giving birth as traumatic. The above psychological distress during childbirth renders women exposed to unfamiliar environments, care providers, and environmental factors, including medical procedures [12]. While respectful birth care ensures that women feel safe and supported during the birth process, lack or inadequacy of this care can cause birth to be perceived as a traumatic experience. Traumatic childbirth is characterized as an event during labor and delivery that poses a real or perceived threat of severe injury or death to the physical or emotional well-being of the mother or infant. Women who have experienced a traumatic birth often describe it as a moment of helplessness, loss of control, intense fear, and distress [13]. Traumatic birth experience has been associated with postpartum mental health problems, including depression and posttraumatic stress disorder (PTSD) [13, 14]. Poor mental health during the postpartum period can alter a woman's sense of self and disrupt family relationships. Challenges during the early mother-infant attachment can have an adverse effect on a child's social, emotional, and intellectual development [14]. Furthermore, traumatic birth experiences can also have an adverse effect on women's future decisions about where, how, and with whom to give birth [15, 16]. Women, for example, may prefer to give birth at home to avoid repeating a traumatic hospital experience [17]. Jackson et al. (2012) reported that the decision to give birth at home (giving birth without a professional care provider) might be influenced by a previous birth trauma [18]. Therefore, the outcomes of traumatic birth experiences can be serious and far-reaching for women and their families. Previous qualitative studies, which investigated women's traumatic birth experiences, identified women's interactions with health professionals as a more important factor compared to the type of medical intervention or delivery. For example, a perceived lack of control and involvement in decision-making may contribute to women's experience of trauma [19, 20]. Accordingly, the birth care provided by healthcare professionals can affect the health of the mother, baby, family, and society in general. Therefore, it is necessary to investigate and understand the effect of the mother's perception of received care during the birth process on the woman's perception of childbirth. This study aimed to investigate the effect of RMC on the perception of traumatic birth.

## Methods

### Study design and setting

This study was designed as descriptive and cross-sectional research. It was conducted in the delivery room of a state hospital in southern Türkiye between May and September 2024. A State Hospital is a healthcare institution that services individuals from all socio-economic backgrounds. The hospital's maternity ward operates with a total of nine delivery rooms. The healthcare personnel in the maternity ward include 9 doctors and 23 midwives. During the data collection process, the number of pregnant women admitted to the maternity ward was determined to be 875, with the study sample comprising approximately 62% of this total.

### Participants

The study population consisted of mothers who applied to the delivery room and gave birth to a healthy newborn. The inclusion and exclusion criteria for participant selection were as follows:

***Mothers who met the following criteria were included in the study***

- Minimum of a primary school education
- Open to communication
- Gave birth vaginally
- Those who volunteered to participate in the study

***Mothers who met any of the following criteria were excluded from the study***

- Experienced complications during childbirth (e.g., severe postpartum hemorrhage, emergency interventions)
- Gave birth via cesarean section
- Had a stillbirth or neonatal complications requiring intensive care

***Mothers with the following criteria do not meet the eligibility criteria of the study***

- Had a high-risk pregnancy (e.g., preeclampsia, gestational diabetes with complications)
- Had a diagnosed psychiatric disorder affecting perception and communication
- Were non-Turkish speakers and unable to communicate effectively
- Declined to participate in the study

**Sample size calculation**

The study population consisted of mothers who applied to the delivery room and gave birth to a healthy newborn. To determine the minimum sample size required for the study, we used the Epi Info StatCalc program, which is widely utilized for epidemiological and statistical calculations. The sample size was calculated based on the following parameters: confidence level: 95% margin of error (alpha level): 5%. Expected prevalence: Since no prior study provided an exact prevalence rate for our study population, we assumed the most conservative prevalence of 50% to ensure the largest possible sample size, which would maximize the statistical power. Using these inputs, the minimum required sample size was determined to be 385 mothers. However, to account for potential non-response, incomplete data, or other unforeseen losses, we increased the sample size by approximately 40% and aimed to recruit additional participants. As a result, the study was completed with a total of 540 mothers, ensuring robust and reliable findings.

**Data collection**

The study data was collected using the Personal Information Form, the Women's Perception of Respectful Maternity Care (WP-RMC) Scale, and the Birth-Related Psychological Trauma Perception Scale (BRPTPS). The data collection process was conducted in two stages:

- The Personal Information Form and WP-RMC Scale were completed, and contact information was obtained from mothers who had completed the 24-h postpartum period.
- BRPTPS was completed via phone calls one week after delivery.

***Personal information form***

The Personal Information Form was developed by the authors and consisted of items intended to inquire about descriptive characteristics of women (age, education level, employment status, income status, gestational week, number of pregnancies, number of births, number of living children, and planned pregnancy status).

***Women's Perception of Respectful Maternity Care (WP-RMC) Scale***

The WP-RMC questionnaire was developed by Ayoubi et al. (2020) in Iran [21]. A reliability and validity study for the Turkish language was conducted by Çamlıbel et al. (2022). This questionnaire consists of 19 items and 3 subdomains and is scored between 1 and 5 points. Items 15, 16, 17, and 19 are reverse-scored. The minimum score is 19, and the maximum score is 95. Higher scores indicate a more positive perception of respectful maternal care. The questionnaire includes the following subdomains: the providing comfort subdomain; items 1–7, participatory care subdomain; items 8–14, and mistreatment subdomain; items 15–19. The Cronbach's alpha coefficient of the scale is 0.96. The Cronbach's alpha values of the scale subdomains vary between 0.88 and 0.95 [22]. In this study, the overall Cronbach's alpha coefficient was 0.86. The Cronbach's alpha values of the subdomains were 0.82, 0.81, and 0.77, respectively.

***Birth-Related Psychological Trauma Perception Scale (BRPTPS)***

BRPTPS was developed by Mucuk and Özkan (2020) to assess mothers'perceptions of psychological trauma related to vaginal delivery and can be used as a valid and reliable measurement tool across Turkey [23, 24]. This scale can be used from the first week to 1 year after

birth. It was considered that this scale would allow identification of women who were sensitive to birth trauma, evaluation of women in terms of trauma symptoms in the process, and provision of required individualized midwifery care in a more qualified manner. It was designed as a 5-point Likert-type scale. The scale has one subdomain. There are 11 items (4, 5, 11, 13, 15, 17, 28, 29, 30, 31, and 36) that need to be reverse-scored in calculating the overall scale score. The overall scale scores range between 39 and 195. The higher the score on the scale, the higher the woman's perception of trauma. The Cronbach's alpha coefficient of the scale is 0.92. In this study, the Cronbach's alpha coefficient was 0.89.

### Data analysis

In this cross-sectional study, the dependent variable is the perception of traumatic birth (measured using the Birth-Related Psychological Trauma Perception Scale).

The independent variables include: The perception of respectful maternity care (measured using the Women's Perception of RMC Scale), age, education level, employment status, social security status, income level, duration of marriage, number of births, number of children, and prenatal care status are socio-demographic and obstetric factors.

The Statistical Package for the Social Sciences (IBM SPSS Statistics) version 25.0 was used to analyze study data. Demographics and clinical characteristics of the participants were expressed in frequency (percentage) or mean ± standard deviation (SD). Number, percentage calculation, and average (minimum, maximum) criteria were used to evaluate the data. Skewness–Kurtosis values were used to test the normal distribution hypothesis for the study data. For the data that met the parameter conditions, a t-test or one-way analysis of variance (ONE A Way) test was used for two independent groups or more than two independent groups, respectively. Since parametric conditions were met, the Pearson correlation was calculated for correlation analysis. A $p$-value of $<0.05$ was considered statistically significant.

### Ethical considerations

For the conduct of the study, ethics committee approval (Decision No: 2024/36–04/22/2024) was obtained from Tarsus University Ethics Committee, along with permission for data collection from the institution where the research would be conducted. Additionally, the necessary permissions were obtained from the relevant authors for the scales used in the study. Participants were informed about the purpose and methodology of the study, and verbal and written informed consent was obtained from those who agreed to participate. The study was conducted in accordance with the principles of the Declaration of Helsinki.

## Results

Five hundred and forty mothers who gave normal births participated in the study It was determined that mothers in the 18–24 age group had the highest all of women perception of trauma with a score of 125.41 ± 13.64, while those with a university-level or higher education had the lowest perception of trauma with a score of 118.78 ± 13.13. Unemployed mothers perceived their childbirth experiences as more traumatic, with a score of 121.61 ± 14.97. Additionally, the trauma perception score of 54 mothers who had been married for one year was found to be higher (124.67 ± 13.06) compared to those with a longer duration of marriage. It was also determined that as the number of births and children increased, the perceived level of birth trauma decreased. In addition to all these findings, mothers who received prenatal care had significantly lower psychological birth trauma perception scores compared to those who did not receive prenatal care. There was a significant relationship between mothers'perceptions of trauma related to childbirth and age, education, employment status, duration of marriage, number of births, number of children, and receiving prenatal care (Table 1).

Among the participants, 82 mothers (≥ 35 age) had the highest RMC perception score, with an average of 70.36 ± 8.85. Mothers with a primary school education had the lowest RMC score, at 65.81 ± 8.59. Employed mothers had a higher RMC score (70.09 ± 9.68). Additionally, mothers with social security and those whose income exceeded their expenses had higher RMC scores than those without social security and those with a lower perceived income (69.07 ± 9.24; 69.50 ± 8.74, respectively; $p< 0.05$). Mothers who had been married for 10 years or more had an average RMC score of 70.79 ± 8.52 ($p< 0.001$), while those who had given birth three or more times and had three or more children had average RMC scores of 70.56 ± 8.46 ($p< 0.001$) and 70.57 ± 8.41 ($p< 0.001$), respectively. In addition, mothers who received prenatal care had a significantly higher average RMC score than those who did not (69.65 ± 9.30 vs. 66.87 ± 9.08; $p< 0.001$). Moreover, there was a statistically significant difference in mothers'perceptions of RMC based on age, education, employment status, social security status, income status, duration of marriage, number of births, number of children, and prenatal care (Table 1).

The participants'mean perception of RMC score, mean comfort provision score, mean participant care, mean mistreatment score, and mean BRPTPS were (68.55 ± 9.30), (23.87 ± 4.83), (22.65 ± 4.99), (22.03

**Table 1** Sociodemographic characteristics of participants and differences in variables ($n = 540$)

| Variables | | Birth-Related Psychological Trauma Perception Scale | | | Respectful Maternity Care Perception Scale | | |
|---|---|---|---|---|---|---|---|
| | N (%) | X ± Standard Deviation (SD) | Test | *p* | X ± SD | Test | *p* |
| **Age** | | | | | | | |
| **18–24** | 144 (26.7) | 125.41 ± 13.64 | F = 8.132* | **0.001*** ** | 66.19 ± 8.98 | F = 5.574* | **< 0.001*** ** |
| **25–29** | 160 (29.6) | 120.31 ± 15.20 | | | 68.34 ± 9.63 | | |
| **30–34** | 154 (28.5) | 120.04 ± 13.99 | | | 69.67 ± 9.29 | | |
| **≥ 35** | 82 (15.2) | 117.38 ± 13.92 | | | 70.36 ± 8.85 | | |
| **Education** | | | | | | | |
| **Primary school** | 111 (20.6) | 123.53 ± 15.58 | F = 3.849* | **0.022*** ** | 65.81 ± 8.59 | F = 6.803* | **0.001*** ** |
| **High school** | 242 (44.8) | 121.09 ± 14.88 | | | 68.81 ± 9.43 | | |
| **University or above** | 187 (34.6) | 118.78 ± 13.13 | | | 69.82 ± 9.25 | | |
| **Employment status** | | | | | | | |
| **Employed** | 145 (26.9) | 118.59 ± 13.05 | t = 2.142** | **0.033*** ** | 70.09 ± 9.68 | t = − 2.345** | **0.019*** ** |
| **Unemployed** | 395 (73.1) | 121.61 ± 14.97 | | | 67.98 ± 9.11 | | |
| **Social security** | | | | | | | |
| **Yes** | 445 (82.4) | 120.30 ± 13.86 | t = − 1.709** | 0.088 | 69.07 ± 9.24 | t = 2.872** | **0.004*** ** |
| **No** | 95 (17.6) | 123.11 ± 17.20 | | | 66.07 ± 9.27 | | |
| **Perception of income** | | | | | | | |
| **Income below expenses** | 138 (25.6) | 122.14 ± 18.57 | F = 1.370* | 0.255 | 66.78 ± 10.16 | F = 3.478* | **0.032*** ** |
| **Income equals to expenses** | 283 (52.4) | 120.84 ± 13.11 | | | 69.00 ± 9.00 | | |
| **Income above expenses** | 119 (22.0) | 119.13 ± 12.17 | | | 69.50 ± 8.74 | | |
| **Duration of marriage (years)** | | | | | | | |
| **1 year** | 54 (10.0) | 124.67 ± 13.06 | F = 10.058* | **< 0.001*** ** | 66.56 ± 9.46 | F = 6.269* | **< 0.001*** ** |
| **2–4 years** | 190 (35.2) | 123.78 ± 14.19 | | | 66.82 ± 9.51 | | |
| **5–9 years** | 156 (28.9) | 117.88 ± 15.99 | | | 69.33 ± 9.21 | | |
| **≥ 10 years** | 140 (25.9) | 117.64 ± 13.45 | | | 70.79 ± 8.52 | | |
| **Number of births** | | | | | | | |
| **1** | 245 (45.4) | 123.90 ± 14.30 | F = 11.001* | **< 0.001*** ** | 66.84 ± 9.64 | F = 8.329* | **< 0.001*** ** |
| **2** | 156 (28.9) | 118.92 ± 15.14 | | | 69.44 ± 9.06 | | |
| **≥ 3** | 139 (25.7) | 117.43 ± 13.15 | | | 70.56 ± 8.46 | | |
| **Number of children** | | | | | | | |
| **1** | 249 (46.1) | 123.79 ± 14.69 | F = 10.486* | **< 0.001*** ** | 66.80 ± 9.63 | F = 8.736* | **< 0.001*** ** |
| **2** | 161 (29.8) | 118.84 ± 14.55 | | | 69.61 ± 9.03 | | |
| **≥ 3** | 130 (24.1) | 117.48 ± 13.09 | | | 70.57 ± 8.41 | | |
| **Prenatal care status** | | | | | | | |
| **Received** | 326 (60.4) | 118.75 ± 13.18 | t = − 4.089** | **< 0.001*** ** | 69.65 ± 9.30 | t = 3.427** | **< 0.001*** ** |
| **Not received** | 214 (39.6) | 123.90 ± 15.90 | | | 66.87 ± 9.08 | | |

* One-way Analysis of variance; **t-test; ***$p < 0.05$

± 1.18), and (120.80 ± 14.53), respectively. The detailed descriptive results are given in Table 2.

There was a very strong negative correlation between participants'RMC scores and BRPTPS. Furthermore, BRPTPS had a very strong negative correlation with the variables of providing comfort and participant care (Table 3).

## Discussion

RMC is not considered a luxury but a human right with the potential to improve maternal and infant health outcomes worldwide [25]. In its 2015 declaration,"The prevention and elimination of disrespect and abuse during facility-based childbirth,"the WHO warned that many women were treated with disrespect and aggression

**Table 2** Mean and standard deviation values of variables

| Variables | Minimum | Maximum | Mean | Percentiles | | |
|---|---|---|---|---|---|---|
| | | | | 25 | 50 | 75 |
| **Perception of Respectful maternity care/Women's Perception of Respectful Maternity Care** | 41.00 | 86.00 | 68.55 ± 9.30 | 63.00 | 68.00 | 76.00 |
| ***Providing Comfort*** | 11.00 | 35.00 | 23.87 ± 4.83 | 21.00 | 23.00 | 28.00 |
| ***Participatory Care*** | 11.00 | 34.00 | 22.65 ± 4.99 | 19.00 | 23.00 | 26.00 |
| ***Mistreatment/Mistreatment*** | 19.00 | 25.00 | 22.03 ± 1.18 | 21.00 | 22.00 | 23.00 |
| **Birth-Related Psychological Trauma Perception Scale** | 69.00 | 169.00 | 120.80 ± 14.53 | 111.00 | 121.00 | 131.00 |

**Table 3** Pearson's correlations (*p*-values) between variables ($n = 540$)

| Variables | Birth-Related Psychological Trauma Perception Scale | |
|---|---|---|
| | r | *p* |
| **Perception of Respectful Maternity Care/Women's Perception of Respectful Maternity Care** | − 0.864[a] | **< 0.001** |
| ***Providing Comfort*** | − 0.817[a] | **< 0.001** |
| ***Participatory Care*** | −.805[a] | **< 0.001** |
| ***Mistreatment/Mistreatment*** | − 0.065 | 0.130 |

[a] Correlation was significant at the 0.01 level (2-tailed)

during birth care [2, 26]. WHO promotes RMC so that women can have a positive experience. In this new context, certain terms, including obstetric violence, mistreatment, and disrespect, emerged and acquired visibility. WHO links these terms to maternity care [27]. It is important to consider the connection between respective maternal care and postpartum trauma because, during traumatic births, the caregivers can cause the development of PTSD in mothers during the postpartum period (i.e., they could be convinced that they or the baby were in danger of serious injury or death). Events in which people feel that their dignity has been violated and experience intense fear, helplessness, loss of control, and/or terror can cause postpartum PTSD [25]. The main aim of this study was to investigate the effect of RMC on the perception of traumatic birth in Turkish mothers.

Previous studies reported that sociodemographic and obstetric reasons generally had inconsistent effects on birth trauma [28–33]. The fact that trauma is a multifactorial concept might have counted for the above results. It was found that the participant mothers'perceived trauma decreased as their age increased and their level of education increased. A systematic review suggested that women's age and educational status affected the perception of childbirth [34]. A study by Aktaş (2018) reported that there was a negative correlation between age and birth trauma and that trauma decreased as age increased [35]. Similarly, Grekin and O'Hara (2014) reported that postpartum PTSD decreased with increased age [32]. The results of the present study are consistent with those of previous studies. Similar to the results of the present study, Aksoy Derya et al. (2024) and Koç and Özkan (2022) suggested that the perception of traumatic birth decreased as the level of education increased [36, 37]. Döner and Uçtu (2024) reported that the perception of traumatic birth was higher in participants who held a university degree and above [38]. On the other hand, a study by Işık and Demirgöz Bal (2022), which investigated the effect of spousal support on the level of posttraumatic stress symptoms during the postpartum period, reported that there was no significant difference in the level of education [39]. In a study by Çankaya and Ocaktan (2022), there was no significant difference between women's education level and perception of traumatic birth [40]. These contradictory results in comparing the level of education and the mother's postpartum psychology might be due to the use of different measurement tools and the mothers'personality traits.

In the present study, the level of perceived trauma of unemployed mothers was higher, consistent with the previous studies. Similar to studies by Koç and Özkan (2022) and Şahin and Bingöl (2021), there was a significant difference in perception of traumatic birth by employment status [37, 41]. A study by Çelik (2018) reported that employed mothers had lower mean PTSD scores [42]. In light of the results of the present study, with the increase in the financial power and education level of women, their ability to meet the needs of themselves and their babies increased; in other words, mother's economic status may positively affect their psychological well-being and help them with better coping with postpartum stressors.

There was a significant relationship in the participants'perceptions of trauma by the duration

of marriage, number of births, number of children, and prenatal care. A study by Koç and Özkan (2022) reported that perceived trauma was lower in participants with a marriage duration of ≥10 years, with ≥3 births and children, and who received prenatal care [37]. Döner and Uçtu (2024) suggested that birth trauma scores of multiparous women were lower, while there was no relationship between prenatal care and trauma perception [38]. Aktaş (2018) reported that perceived birth trauma in women decreased as the number of children and duration of marriage increased [35]. This might have led the mothers in question to perceive the birth as less traumatizing, as their ability to cope with and manage stress might have improved with experience.

Respectful maternal care focuses on improving interpersonal interactions between women and health practitioners across the perinatal process. Respectful maternal care promotes a sensitive and supportive care environment to ensure that women feel safe and respected during childbirth, with a focus on preventing disrespectful and abusive behavior inflicted by health practitioners and related staff [43]. In their qualitative study, Muhayimana et al. (2025) emphasized that RMC increased mothers'birth satisfaction and that the positive attitudes of health professionals and effective communication during birth were perceived very positively by women [44].

A study by Patel et al. (2024) reported that age (especially younger age) was the most important determinant of the mistreatment of women in childbirth [45]. Similarly, Yismaw et al. (2022) reported that women aged 15–19 were 75% less likely to receive RMC than participants aged 20 years [46]. Yadav et al. (2022) reported that women aged ≥19 years had a better perception regarding RMC [47]. Consistent with the previous studies, the perception of respectful care decreased with decreased age in the present study. This could suggest that older women report better respectful maternal care associated with their maturity and higher awareness about respectful maternal care. Contrary to the research finding, Kaur et al. (2025) found in their study in India that age was not an effective factor in receiving respectful maternal care [48]. As a result of the present study, women with lower socioeconomic status (indicated by low education level, employment status, social security status, and lower income perception level) had significantly lower perceptions of RMC than other groups. Present studies suggested that healthcare professionals were consistently biased against women with lower socioeconomic backgrounds [43, 49–51]. Contrary to the research finding, Mahuyimana et al. (2024) revealed that working in a job that generates income does not affect the perception of respectful maternal care. This different finding may be because respectful maternal care is affected by many factors such as culture, environment and the measurement tool used for evaluation [52]. There was a significant relationship between the number of births, number of children, prenatal care status, and receiving RMC in the participant mothers [53]. Siraj et al. (2019) reported that the number of births was significantly correlated with the perception of disrespectful care and abuse at birth. In a different study, Fares et al. (2023) suggested that mothers'satisfaction with childbirth was influenced by parity, a result consistent with the perception of respectful care [54]. In the same study, primiparous mothers had lower levels of satisfaction. In the present study, primiparous mothers had a lower perception of RMC. These results may suggest that multiparous women could better adapt to the challenges of childbirth due to more experience, which might have increased the satisfaction rate. On the other hand, primiparous mothers'lower perceptions of respectful care may be attributed to the fact that they had a longer labor period and experienced a complex and more stressful birth. Unlike the above result, Yadav et al. (2022) did not report a significant relationship between the number of children and prenatal care and RMC [47]. The results, which are consistent with and contradictory to the results of the present study, may be due to the use of different questionnaires and scales in the collection of study data and the individual and cultural traits of women.

In the study, there was a high level of negative correlation between the perception of RMC and the perception of trauma in childbirth. This result indicates that as women receive respectful and supportive care during childbirth, their perception of birth trauma significantly decreases. It is thought that RMC has a preventive or mitigating effect on birth trauma. The impact of respectful maternity care in preventing birth trauma can be explained through several key mechanisms. Firstly, informing women about the childbirth process and actively involving them in decision-making can enhance their sense of control, thereby reducing their perception of trauma. Additionally, the physical and emotional support provided in midwifery care can help women feel less alone, positively influencing their birth experience. Furthermore, it is believed that women who do not experience verbal, physical, or psychological violence during childbirth perceive it as a more positive experience. Previous studies suggested that disrespectful and abusive care was associated with postpartum trauma symptoms [55–59]. The results reported by previous studies are consistent with that of the present study. Women's intimacy with healthcare professionals during childbirth can empower and comfort them, or otherwise, when they are treated with disrespect, undesired encounters with

healthcare providers during childbirth can leave long-lasting damage and induce emotional trauma. RMC care is considered an important component of safe motherhood; further, it is a critical and explicit welfare and human rights issue, which includes respect for maternal independence, self-esteem, emotional state, and preferences [60].

In addition to the strengths of this study, there are also some limitations. The study was conducted only in a state hospital in southern Turkey, which may limit the generalizability of the findings to other geographical regions or private healthcare institutions. Turkey is a country with significant cultural diversity, and different cultural contexts and healthcare systems may affect the applicability of these findings. The cross-sectional design may be insufficient to examine the long-term effects of respectful maternity care and the variable impacts on birth trauma. Therefore, future studies should encompass different regions of Turkey, include long-term follow-up studies, and consider various sociodemographic variables. Another limitation of the study is that the effect of episiotomy, which is almost routinely applied in the hospital where the study was conducted, especially in women who are giving birth for the first time, was not examined. It is recommended that more comprehensive studies be conducted in future studies that evaluate the effect of interventions during birth.

This study aimed to examine the impact of respectful RMC on the perception of traumatic birth among Turkish mothers. The findings suggest a significant relationship between sociodemographic and obstetric variables and both the perception of traumatic birth and RMC. Specifically, there was a high negative correlation between RMC and the perception of birth trauma, supporting the idea that respectful care can mitigate feelings of trauma during childbirth.

The multiplicity of analyses and the diverse range of variables examined highlight the complexity of trauma perception. The mixed findings from previous research regarding the impact of age, education, and employment on birth trauma align with the multifactorial nature of trauma, as evidenced by the results of this study. Similar studies have reported varying outcomes, such as the effects of maternal age and parity on trauma perception, which suggests that additional factors, such as cultural context and individual personality traits, may play a role.

Furthermore, while this study found that RMC significantly reduces birth trauma perception, similar studies have indicated that lack of respectful care and experiences of mistreatment during childbirth are linked to postpartum trauma and stress disorders [55–62]. The present findings are consistent with this body of evidence, underscoring the importance of RMC in improving maternal psychological outcomes and preventing birth-related trauma.

In conclusion, despite promising results, they should be interpreted cautiously due to the study's limitations. Further research is needed across different regions and with long-term follow-up to better understand the enduring effects of RMC on birth trauma. Nonetheless, these findings emphasize the importance of promoting respectful care during childbirth as a critical factor in improving maternal health outcomes and reducing traumatic birth experiences.

## Conclusion

The study found that women had a high level of psychological trauma perception and a moderate level of respectful maternal care perception. The findings suggest that various socio-demographic and obstetric factors influence women's experiences of respectful care and birth trauma. More importantly, a strong negative correlation was found between RMC and perception of birth trauma. The adverse effect of disrespect and abuse during childbirth is a significant barrier to increasing the use of skilled care and improving maternal health outcomes, as identified in Millennium Development Goal 5 [4]. Based on these results:

- Healthcare professionals should be trained in respectful maternity care and trauma-informed care practices.
- Women's individual needs, preferences, and rights should be considered during childbirth, and they should be actively involved in decision-making processes.
- Policies and protocols that promote respectful care practices should be developed in hospitals, and childbirth environments should be made more women-friendly.
- Secure feedback systems should be established to allow women to evaluate their birth experiences and express their concerns.
- Women should be provided with comprehensive information about the birth process during pregnancy, along with psychological support services.
- Women should be allowed to have a companion of their choice during childbirth to provide emotional support.
- Regulations should be implemented to prevent verbal, physical, or psychological violence during childbirth, and respect for women's privacy in birth settings should be ensured.
- Public awareness should be raised through media and social media to promote respectful maternity care and inform women about their birth rights.

- Psychological support and counseling services should be offered to women who experience traumatic birth.
- The birth process should be allowed to progress as naturally as possible, and unnecessary medical interventions should be avoided.

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**Authors' contributions**
Özlem KOÇ contributed to the concept, design, data collection, and drafting of the manuscript. Both Özlem KOÇ and Süleyman Cemil OĞLAK were involved in the literature review, data analysis, and final revision of the manuscript. All authors read the final version of the manuscript and do not have any conflict of interest.

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**Data availability**
The data that support the findings of this study are available from the corresponding author upon reasonable request.

## Declarations

**Ethics approval and consent to participate**
All participants signed informed written consent before being enrolled in the study. The study was reviewed and approved by the Tarsus University Ethics Committee (Decision no: 2024/36–04/22/2024). The study was conducted in accordance with the principles of the Declaration of Helsinki.

**Consent for publication**
Not applicable.

**Competing interests**
The authors declare no competing interests.

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## Publisher's Note