Women’s experiences of emotionally and psychologically traumatic birth; hegemony and authoritarianism in Victorian public maternity settings

A Thesis submitted in fulfilment of the requirements for the degree of Masters of Science - Nursing

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Arimaya Yates
8 October 2016
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Abstract

Background: Contemporary birthing practises in Australia pose a medicalised technological environment whereby women’s needs are often secondary to the hospital-medical environment. As a result of the increased removal of human connection and touch, there have been reports of increased desensitisation, even disembodiment of midwives and obstetricians from the labouring woman, and an associated increase in birth trauma experiences in maternity care settings. Despite current studies of women’s trauma when involved in a caesarean section, instrumental delivery or other emergency scenario, however little research has been done into women’s lived experiences of psychological and emotional trauma related to vaginal births. Contemporary birthing practices inside Victorian metropolitan public maternity hospitals within Australia pose significant risk of psychological and emotional trauma to mothers experiencing vaginal births.

Method: This study employed a qualitative exploratory descriptive approach. Selection criteria included: First time mothers who gave birth within the last year in a maternity hospital in Australia, had a vaginal birth with no instruments, experienced some perceived form of self-reported birth trauma, live in the northern corridor of Melbourne, a permanent resident of Australia, able to converse in fluently in English, over 20 years of age. Exclusion criteria: obstetric co-morbidity (for example. Pre-eclampsia, gestational diabetes), recent immigrant to Australia - less than five years, psychiatric co-morbidity, complex birth event, caesarean and twins. Women were recruited who birthed within a Melbourne metropolitan public maternity hospital. This was a convenience sample of women who had a traumatic birthing experience. Data were collected using an in-depth semi structured interview and data saturation was achieved after seven interviews.

Results: The data analysis revealed nine themes, I was determined to birth naturally; Not telling me what they were doing; I just had to force her to be born; I felt traumatised; it was really horrific; I know that is just what the system is like… they’re hospital midwives… they’re medical; I didn’t feel connected to them; She stood up for me/ I felt powerful; After
the birth, just horrible/ Your stuck with the consequences; I deserve a better birth. These themes each identified areas of deep distress for the women leading to perceived traumas exacerbated by midwifery and obstetrical procedures and attitudes. Women experienced varying degrees of trauma, ranging from wishing they would die to feeling as though they were violently assaulted. One of the most commonly reported experiences for women in the study was that they felt powerless, out of control, ignored and abandoned by the midwives and obstetricians. The actions or inactions of midwives and obstetricians had a direct involvement to how women perceived their trauma. A series of recommendations for better midwifery practice were made including introducing a maternity care model based on caseload midwifery practices, improved antenatal education and continued postnatal support through debriefing of a woman’s birth event.

**Conclusion:** Key findings included the new discovery that birth trauma perceptions are not exclusive to actual obstetrical acts during labour and birth. Rather that a vaginal birth can hold equally as much of a traumatic impact than, for example, a caesarean or emergency forceps birth. The results highlighted the depth of trauma for women experiencing vaginal births within metropolitan Melbourne public maternity hospitals. These findings emphasise the need for changes to hospital processes including antenatal education, midwifery and obstetrician education, staff attitudes and women’s capacity to act assertively during labour.
Chapter 1. Introduction

This thesis reports on research that explored experiences of psychologically and emotionally traumatic birth for women who had a vaginal birth within Victorian metropolitan public maternity hospitals in Australia. This chapter presents the background and justification of the research, the aim and objectives of the research, a brief introduction of the research design and an overview of each chapter of the thesis.

Background

Before the beginning of the medicalisation of birth in Australia, which occurred during the 1950s, childbirth was the sole domain of women (Fahy, 2008; Kitzinger, 1997). Women birthed in their own homes, attended to by women skilled as lay midwives educated under apprenticeships by women who had previous experience (Kitzinger, 1997). Culturally and socially men were strictly forbidden to enter the birthing room and women were provided care from either semiskilled local women, their friends and at times a community based midwife (Kitzinger, 1997; Wagner, 1994). Women began to birth in hospital around the 19th century during a period in time where birthing in hospitals become a legitimate social event along with the beginning of prenatal care (Wagner, 1994). The obstetric profession thus began its course of medical control over childbearing women (Wagner, 1994). Before the complete medicalisation of birth in the early 1950s, birthing rooms were largely absent of medical equipment with equality in relationships between the labouring woman and her midwife, hence the distribution of power was egalitarian with particular attention on the labouring woman (Kitzinger, 2005).

Contemporary birthing practices, however, pose a much more medicalised technological environment whereby women’s needs are often secondary to the medical environment and staff (Davis-Floyd & Sargent, 1997). Commonly women lie supine, alone with unfamiliar people in an unfamiliar environment (cold, sterile, bright) (Lawrence, Lewis, Hofmeyr, & Styles. 2013) In addition, the prior skills of the birth attendants have been replaced by technological equipment for example, use of hand held pinnards replaced by large mechanical fetal monitoring equipment or cardiotocographs (Davis-Floyd & Sargent, 1997).
It has been argued that such invasive approaches such as probes, sensors and intravenous cannulas indicate ill health of the labouring woman and her unborn baby (D’Oliveira, Diniz, Schreiber et al. 2002). This poses a threat to women’s wellbeing, especially psychological (D’Oliveira, et al. 2002; Midgley, 2006; Thomson & Downe. 2008). As a result of the increased removal of human connection and touch, there have been reports of increased desensitisation, even disembodiment of midwives and obstetricians from the labouring woman, and an associated increase in birth trauma experiences in maternity care settings (Fahy, 2008; Filc. 2006; Goer. 2010; Thomson & Downe. 2008).

During the 1970s women entered the domain of anthropology and began to uncover some of the hidden meanings behind birth and birthing practices (Davis-Floyd & Sargent, 1997). Throughout cultures and history women’s experiences of childbirth mark a significant rite of passage, marked by a series of ritualistic events and social signifiers. Women were supported during labour in a woman centred, communal style of birthing that, when compared to the more contemporary medicalised practices of today’s birthing environment, showed a significant benefit for the mother and her community (Jordan & Davis-Floyd 1993).

These contemporary medicalised practices involve further institutional elements preventing midwives from acting in a woman centred manner (Fahy, 2008). Elements such as hegemony, authoritarianism, Australian public policy that favours economic benefit to the medical professionals (usually obstetricians) and hospital culture (Fahy, 2008). Flint (1995, cited in Fahy, 2009, p. 153) describes the Australian medical culture as a system “borrowed from the army and adapted for nursing”. Fahy (1995) goes on to describe this system as “a culture of medical dominance, horizontal violence, and oppressive power imbalances that stifle woman-centered care”. With this current institutional climate midwives are ultimately placed in a position of subordination (Fahy, 2008).

Even so, woman centred care and collaborative relationships between midwives and obstetricians are now a central component of policy driven care for Australian birthing institutions (Page & McCandish, 2006). Woman centred care involves placing the woman as the focus of a midwife’s work, supporting a woman physically, emotionally and practically during pregnancy, birth and the postnatal period. The role of the midwife becomes that of
building relationship with a woman within this working partnership, from which a foundation of trust, rapport and care is bonded (Page & McCandish, 2006). The most accessible avenue for midwives to work this way is through current Australian practices that include midwifery models of care such as caseload midwifery whereby a woman would meet with the same midwife throughout her entire pregnancy, birth and postnatal period. Victoria has only a few of these caseload models available and most commonly, women only assessed as low risk can access this service while the majority of women are limited to accessing standardised midwifery care (Tracy, Hartz, Tracy, Allen, Forti, Hall & Kildea. (2013). This standardised care involves a fragmented system offering women a different midwife and/or obstetrician at each visit during her pregnancy with no known care giver present during her birth (Tracy, et al... (2013). Further to these difficulties, although obstetricians have been mostly applauding the concept of midwifery autonomy they have for the most part been unwilling to work in collaboration with midwives (Fahy, 2008).

**Defining the phenomena**

For the purpose of this study it is important to define certain terms when defining women’s traumatic experiences of birth. Given that relatively new terms such as ‘obstetric violence’ and, with gender based violence generally belong in the arena of intimate partner violence, it was deemed that specific terminology be used to describe these experiences of birth by Victorian women.

**Birth trauma**

Birth trauma has been defined by Simkin (2015) as “when the individual mother, father, or other witness believes the mother’s or her baby’s life was in danger, or that a serious threat to the mother’s or her baby’s physical or emotional integrity existed” (Simkin, 2015, p 1). However, the definition of traumatic birth and birth trauma are interchangeable and inconsistent (Elmir, Schmeid, Wilkes & Jackson, 2010). Other definitions used also describe birth trauma as "actual or threatened injury or death to the mother or her baby” (Beck & Watson. 2008. p 229). Other concepts such as ’helplessness’, ’horror’, ’terror’, ’fear’, ’barbaric’, ’intrusive’, ’horrific’ and ’threat’ commonly appears in sociological medical literature describing women’s emotional responses to birth trauma (Elmir, et al., 2010; Goer,
Specific childbirth experiences, and factors in the development of birth trauma include:

- Forceps birth, caesareans for uncomplicated vaginal births (Alcorn, O’Donovan., Patrick, Creedy, & Devilly, 2010; Thomson & Downe, 2010).
- Episiotomy, vaginal tear, vacuum birth, general anaesthetic, emergency caesarean, baby being placed in intensive care unit, medical complications for mother or infant, injuries to either mother or infant, premature birth, or baby being born with a medical illness or disability (Alcorn, et al. 2010).
- Fear for self and baby, perceptions of control, personality and prior vulnerability factors (such as history of sexual assault) and birth experience factors (Bailham & Joseph, 2003).

Currently one of the most commonly found causes referenced in psychology literature associated with post-traumatic stress disorder (PTSD) are mothers experiencing birth trauma. A recent meta-ethnographic review by Harris and Ayers (2012), revealed four main categories of emotion women experience associated with birth trauma. These include: (1) Feeling invisible or out of control; (2) Feeling trapped; (3) Being treated inhumanely; and, (4) Reporting a rollercoaster of emotions (Harris & Ayers, 2012, p 1170). These emotional categories lead the critical mind into the arena of human rights and, the questioning of when and how does obstetric intervention become abusive or violent.

**Overview of the study setting**

Victoria has 27.7 percent of Australia’s population and is the second fastest growing population state next to NSW (Department of Immigration and Citizenship, 2012). Melbourne is also the second most favourable city for new immigrant’s destinations promoting a high level of cultural and linguistic diversity (Department of Immigration and Citizenship, 2012). With Melbourne being one of the top two cities for population growth, it follows therefore, that there is exponential obstetric health services demand.
Health demographic background/ Obstetric Indicators

Melbourne public maternity care settings include a range of maternity care options including private obstetric care, shared care between midwives and a woman’s local GP, caseload midwifery or group midwifery practise where a woman is cared for by a midwife from a small team attached to a hospital, obstetric led care for high risk women, and family birth centre (“Pregnancy Care and Birthing Options”, 2015,) In Victoria, 69.8 percent of women birth in public hospital settings (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2011). Victoria has an average of 73,969 women birthing annually in major maternity settings (Australian Bureau of Statistics. 2013). Of these women nearly 20 percent experience postnatal depression (PND) (Peri-natal depression 2010). It is unclear how many of these cases of PND are caused by post-traumatic stress associated with birth trauma. With such high rates of PND requiring treatment and only 23 beds in public mother baby units’ state wide (Victoria’s mental health services 2012), (six at Monash Clayton, six at the Austin Heidelberg and eight in Werribee Mercy), there is a serious threat to Melbourne women’s mental health with such minimal available in-hospital treatment. Furthermore, with a high rate of birth trauma and complex post traumatic stress disorder (CPTSD) (most commonly caused by caesarean and instrumental delivery trauma) (Boorman, Devilly, Gamble, Creedy, Fenwick. 2014; Alcorn, et al. 2010; Fernandez, 2013; Elmir, et al. 2010), it is important Victoria commits to quality maternity care in Melbourne and to have an empirical review into potential resultant birth trauma within the Australian context.

Gap in Literature

The current data on birth traumas, and associated emotional responses have been reviewed with both causative psychological, physiological and emotional consequences. The majority of these studies were predominantly quantitative and following caesarean section or instrumental births. There is minimal evidence on women’s qualitative experiences of perceived birth trauma for vaginal births in an Australian context. There are also minimal studies on how health service provision may either enable or inhibit women’s experiences of perceived trauma. Also lacking in the literature review was an examination of Australian women’s capacity to express agency in labour and birth.
Significance of the study

As outlined above, birth trauma is currently experienced by approximately half of all birthing women in Victoria (Alcorn et al. 2010; Boorman et al. 2014). Birth trauma has been associated with negative experiences for women and this holds potentially long-term negative consequences for the new mother, her baby and family. The consequences of this trauma in turn impacts on the woman’s community through loss of income, participation, fragmented relationships and withdrawal from community participation (Boorman, et al. 2014; D’Oliveira, 2002; Fernandez, 2013; Kitzinger, 2012; Midgley, 2006). Also reported has been an increase demand on the economic and health workforces as birth traumatised women tend to increase their use of medical services (Alcorn, et al. 2010). Birth trauma and obstetric violence is now highlighted in the professional medical and allied health literature as an offence to human rights (D’Oliveira, 2002; Hodges, 2009).

Research aim

This qualitative phenomenology study aimed to uncover social phenomena and behaviours between women their carers, and the birthing institution. In addition, how women’s experiences of vaginal birth can lead to emotional and psychological trauma, and how women’s experiences of this type of perceived trauma can be improved. Benefits to exploring perceptions of birth, women’s trauma related experience, are improved maternal and neonatal outcomes. Further outcomes could be personalised protocols for midwives and obstetricians underpinned by competency-based standards of practice in order to improve care provision.

The aim of this study was to discover women’s experiences of, and uncover the social phenomena of, psychologically and emotionally traumatic birth inside Victorian metropolitan public maternity hospitals in Victoria. From this then the study explored the experiences of women who had a vaginal birth and the link to perceived traumas, and how women’s experiences can be improved. Findings will be used to inform hospital and maternal health care policy and service birth protocols. Outcomes include potentially improved birth outcomes as well as improved relationships between women and their care providers, for a larger population of Victorian women. The diminished experiences of birth trauma will
lessen the burden on the health care system. Finally, findings will help inform psychosocial curriculum content for the education of nursing, midwifery and medical students as well as associated post graduate education of these health professionals.

Research objectives

The objectives of this study were to explore within the context of Victorian maternity settings, women’s meaning of and nature of a perceived trauma, explore women’s beliefs surrounding a perceived birth trauma event, explore women’s capacity to express agency during childbirth, explore women’s perceptions of health care barriers and health enablers to her birthing process, and to form recommendations for minimising the risk of birth trauma through women centred birth protocols in maternity suites.

Research questions

- What is the nature of a perceived trauma experienced during birth for women?
- What is the meaning of birth trauma for women?
- How are these experiences seen to impact on maternal wellbeing?
- In what ways may agency be employed as a buffer to protect from birth trauma?
- In what ways does a woman’s maternity provider facilitate or protect her from experiences of birth trauma or not?
- What kind of support might women receive from their maternity provider to prevent or to manage birth trauma?

Research design

In order to explore women’s experiences of psychologically and emotionally traumatic birth, a qualitative approach using descriptive phenomenology was employed (Van Manen, 2014). Qualitative research aims to explore and understand the meaning individuals or groups assign as a social or human problem (Creswell, 2013). Using a qualitative method is useful when little is known about a topic of phenomenon (Holloway & Todras, 2010). Women were recruited using convenience sampling. Recruitment consisted of seven women all who had birthed in a Victorian public maternity hospital within the past five years and self-identified as having experienced psychological or emotional birth trauma.
Chapters

This thesis has been divided into seven chapters. Chapter 1 introduces the research topic by providing a brief overview of the study, including the rationale and brief description of the study setting. The chapter also includes an overview of the research design used to undertake the study. Finally, an overview of the thesis is provided. Chapter 2 includes the literature review and literature background for this study. Definitions of birth trauma are discussed including women’s experiences of birth trauma through caesarean section and instrumental birth, power asymmetries and social structures inside birthing institutions. Further discussion includes influences of power asymmetries and hierarchies on women’s experiences and the impact this has on midwives’ capacity to care for women. Women’s experiences and perceptions of birth trauma is also discussed along with attitudes and perceptions of midwives and obstetricians. Chapter 3 is a detailed outline of the methodology used for this study. The rationale for qualitative research is discussed along with the definition of phenomenology and its use for this study. Chapter 4 discusses the method used for this study. Sampling and participants’ recruitment, ethical considerations, and details of the processes involved in the method of this study will also be discussed in this chapter. Chapter 5 includes discussion of the data analysis and results. After a brief introduction to the demographics of the women included in the study, this chapter goes in depth into each of the nine themes found from the data. Chapter 6 discusses each of the emergent themes in detail, relating them back to the literature and touches on possible recommendations for these. Chapter 7 discusses the recommendations from the findings, explains limitations, suggests future research and provides a final conclusion for the study.

Summary

This chapter contains an introduction to this study including a brief background and definition of birth trauma, the overview of the study setting and health demographics. The gap in literature was discussed along with the significance for the study. The research aim, objectives, questions and design had been outlined and finally a brief description of each of the chapters included in this study.
Chapter 2 Literature

Introduction

This integrated literature review examines the nature of birth trauma in maternity care settings. The review discusses the following emerging themes from the literature: women’s perceptions of birth trauma, power asymmetries between women and their doctors and midwives, and women’s capacity to express agency in the birthing suite. The majority of literature was derived from high to medium resource countries to enable relevance for local Melbourne maternity settings. This literature review begins with a description of the search strategy used, followed by defining the key words, the reviewed literature and lastly the gaps in the literature.

Search Strategy

The aim of the literature review was to retrieve and critically review literature on birth trauma in Victorian maternity settings, using health sciences, social sciences and midwifery databases. This included PubMed, Informit, ProQuest and Google scholar over a 10-year period from 1995 to 2015. Keywords searched included: Birth trauma, women’s perceptions and trauma, obstetric violence, post-traumatic stress and birth, trauma and birth, violence and obstetrics, women’s perceptions of birth trauma, power asymmetry, postnatal trauma, birth and trauma. Excluded articles were those written in languages other than English.

Vaginal birth

For the purpose of this study the term ‘normal birth’ has been used to describe a birth where no instruments have been used to help birth the baby and no special medical interventions needed or measures taken during the first and second stages of labour (Henderson & Macdonald, 2004).

Birth trauma

A traumatic event involves a person’s subjective perception of that event described as:

Where the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat of physical
integrity of self or others and where the same person experienced an intense emotional response of fear, horror or helplessness (Soet, Brack, & Dilorio, 2003, p 36).

One of the issues with birth trauma is the difficulty defining it. For instance, a meta ethnographic review of women’s reported perceptions and experiences of birth trauma by Elmir, et al. (2010) found that “there is no consistent definition of birth trauma” (p 2143), describing the use of the terms ‘birth trauma’ and ‘traumatic birth’ as intertwined.

Birth trauma has been defined by Simkin (2015) as “when the individual mother, father, or other witness believes the mother’s or her baby’s life was in danger, or that a serious threat to the mother’s or her baby’s physical or emotional integrity existed” (Simkin, 2015, p 1). Other definitions describe birth trauma as ‘actual or threatened injury or death to the mother or her baby’ (Beck & Watson, 2008: p 229). ‘Helplessness’, ‘horror’, ‘terror’, ‘fear’, ‘barbaric’, ‘intrusive’, ‘horrific’ and ‘threat’, commonly appear in sociological medical literature describing women’s emotional responses to birth trauma (Elmir, et al, 2010; Fernandez, 2013; Goer, 2010; Hodges, 2009). All definitions suggest negative long term outcomes for mother and baby, with an emphasis placed on perceptions of the mother (Elmir, et al. 2010).

There are a number of specific childbirth experiences, and factors that have been identified to contributing in the development of birth trauma. These include:

- Forceps birth, caesareans, and uncomplicated vaginal births (Alcorn, et al. 2010; Thomson & Downe, 2010).
- Episiotomy, vaginal tear, vacuum birth, general anaesthetic, emergency caesarean, baby being placed in intensive care unit, medical complications for mother or infant, injuries to either mother or infant, premature birth, or baby being born with a medical illness or disability (Alcorn, et al. 2010).
- Fear for self and baby, perceptions of control, personality and prior vulnerability factors (such as history of sexual assault) and birth experience factors (Bailham & Joseph, 2003).
Of interest to this study are the heightened vulnerability levels of lower socio economic women and their interactions and experiences during birth (Ayers, 2004).

In Australia a prospective longitudinal study reported in several medical journals that up to 45.5 percent of women per year experience childbirth as traumatic (Alcorn, et al. 2010: Boorman, et al. 2014). In addition to this, studies in Australia and the United Kingdom show that between one to six percent, or 1:3 of all birthing women will experience complex posttraumatic stress syndrome as a direct result of their birthing experiences (Elmir et al. 2010; Fernandez, 2013; Thomson & Downe, 2008). Of central importance is why Australian women are having increasingly negative obstetric experiences associated with birth trauma and PTSD (Boorman, et al. 2014). Another question is, why do women in a modernised industrialised and developed country experience such trauma around a life event that should be considered a physiological, social and normalised rite of passage (Kitzinger, 1997) It is further contended that necessary attention needs to be directed towards how obstetricians and midwives, can work together with women in the birthing process.

Most commonly found in references in the psychology literature is that PTSD is associated with, and a direct result of a birth trauma. An existing meta-ethnographic review revealed four main categories of emotion women experience associated with birth trauma. These include: (1) Feeling invisible or out of control; (2) Feeling trapped; (3) Being treated inhumanely; and, (4) Reporting of a rollercoaster of emotions (Harris & Ayers. 2012). These emotional categories lead the critical mind into the arena of human rights and, the questioning of when and how does obstetric intervention become abusive or violent?

The literature has further reported the widespread effect of birth trauma. Further impacts of birth trauma were testified to be on their communities through loss of income, participation, fragmented relationships and withdrawal from community participation (D'Oliveira. 2002; Fernandez. 2013; Kitzinger. 2012; Boorman. et al. 2014; Midgley. 2006).

Consequences of birth trauma include the interruption of mother infant bonding by adversely affecting women’s perception of their infants (Davies, 2008), poor breastfeeding rates and other feeding difficulties (Bailham & Joseph, 2003). Further to this, the relationship
difficulties women face not only include that of the mother-infant dyad, but also that of a woman’s relationship to her partner, extended family and social networks (Bailham & Joseph, 2003). Birth trauma often leads to delayed sexual intercourse and sexual avoidance post birth (Bailham & Joseph, 2003) and further relationship interruptions between a woman and her partner, including communication difficulties, coping within the relationship difficulties, and negative emotions within the relationship (Nicholls & Ayers, 2007). A fear of future childbirth becomes a continued threat for women impeding their family planning (Bailham & Joseph, 2003; Harris & Ayers, 2012). Overall, birth trauma consequences are broad, diverse and long term for many women.

**Contributing factors to birth trauma**

Systematic review evidence suggests perceptions of birth trauma are most clearly influenced by interpersonal difficulties between women and their birth service provider, with the most frequent subcategory being that of ‘being ignored’ (Harris & Ayers, 2012: Thomson & Downe, 2008). These interpersonal difficulties have been shown to be over four times more likely than neonatal complications to predict experiences of posttraumatic stress syndrome (PTSD) as a result of perceived birth trauma (Harris & Ayers, 2012).

Similarly, a cross sectional internet survey of 699 women who had experienced difficult birth or “birth trauma” found that a key concern was the “fractured relationships” that existed between women and their midwives and obstetricians (Harris & Ayers, 2012). The associated significant subscales being: communication breakdown between midwives and obstetricians and women, differences of opinion, misuse of power in hierarchical approaches of midwives and obstetricians, lack of information given to women during labour, and hostile and uncaring treatment by midwives and obstetricians (Harris & Ayers, 2012). Further to this, studies have found that midwives and obstetricians often feel entitled to perform obstetric intervention on labouring women with the generalised attitude of ‘we know best’, this is then coupled with a fetocentric model of health, dismissing women’s basic human rights to autonomy over her body, women become voiceless and ashamed for feeling anything but elated after the birth of her baby (Hodges, 2009; Fernandez, 2013). Consequently, women’s experiences are inevitably nullified (Swahnberg, Thapar-Bjorkert & Bertero, 2007).
Also documented in the literature is that birthing women are feeling ‘let down’ by their caregivers during labour (Harris & Ayers, 2012). In addition, women felt invisible, and were treated inhumanely by midwives and obstetricians (Elmir, et al. 2010). Furthermore, women experienced non empathic attitudes, behaviours and carelessness by midwives and obstetricians during childbirth (Swahnberg, et al. 2007).

Other environmental factors with documented links to women’s perceptions of birth trauma include a past history of sexual trauma, obstetric complications, unrealistic expectation of labour pain, and emergency caesareans (Boorman, et al. 2014). There were also identified factors of the levels of social support and women’s expressions of agency (Soet, et al. 2003). Limitations in the afore stated studies were possible recall inaccuracy due to length of time between being interviewed and re-telling their birth stories and predominantly white European middle class participants, meaning results cannot be generalised.

Further well documented, is that women felt that obstetricians and midwives failed to consider them as individuals with the capacity to make informed decisions (Kitzinger. 2006), and provide informed consent (D’Oliveira, et al. 2002; Swahnberg, et al. 2006). Other researchers have taken a human rights approach finding that women have had their opinions ignored and are subjected to authoritarian decision-making (Bergstrom, Roberts, Skillman & Seidel. 1992; Davis-Floyd & Sargent, 1997; D’Oliveira, et al. 2002; File, 2006; Harris & Ayers, 2012; Thomson & Downe, 2008). Suggested in this summary is that instead of birth being an empowering experience, for some women, it is traumatic, carrying life long consequences.

Evidence contends that women, who are unsupported by birth partners, are more prone to birth trauma and commonly face difficulty bonding to their infants (Soet, et al. 2003). A traumatic birth event has been found to extend to problems with bonding with both a birthing woman’s partner and her child (Boorman, et al. 2014; Nicholls & Ayers, 2007). Commonly reported in qualitative research literature on birth trauma following caesarean section, is that inadequate maternal care, such as midwives and obstetricians ignoring or not recognising signs of psychological or emotional trauma (Fernandez, 2013) results in traumatic birth
events. Similarly, findings from a meta-ethnographic analysis of women’s experiences of birth trauma, indicated that women’s experiences of birth trauma were “a direct result of the actions or inactions of nurses, midwives and doctors attending to the needs of labouring women” (Fernandez, 2010. p 48).

Sociologically women, in particular those from low socio economic backgrounds, as well as non-partnered, experience power asymmetry and a fetocentric model of care when pregnant (Fernandez, 2013; Kitzinger, 2006; Parry, 2006). In contrast evidence suggests women who are well supported, cared for and have a familiar person in the birthing room not only have improved outcomes at birth and more positive perceptions, but so to does that of her newborn child (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson & O’Brien, 2013). However, change to clinical birthing practise has proven to be slow to integrate into a more supportive women centred policy, leaving un-partnered lower socio economic women most commonly birthing with obstetricians and midwives, that are unfamiliar to her or her prenatal history.

Common to the literature reviewed to date of traumatic birth events are feelings of a lack of control, powerlessness, and cognitive avoidance of connecting with obstetricians and midwives, (Harris, & Ayers, 2012), panic, anxiety, grief, anger and tearfulness (Fenech & Thomson. 2014), feeling disconnected, helpless and isolated (Thomson & Downe. 2008), and the generalised feeling of being ignored (Swahnberg, et al. 2007).

**Power and control - Hegemony**

Subjective experience of trauma can be formed by pre-existing themes and thoughts about oneself, the world and others (Brewin, Dalgleish & Joseph, 1996). Trauma symptoms becoming enhanced if there is a lack of postnatal debriefing or support for women who have experienced birth trauma (Iles & Pote, 2014). Also of influence in perceptions of birth trauma are women’s own antenatal anxieties, attitudes, beliefs and expectations both negative and positive, of labour and birth (Iles & Pote, 2014).

Power and subordination commonly occur between a women and their health care provider (Filc. 2006). This occurs when a woman becomes de- personalised to being a body in need of assistance upon entry to the healthcare institution. Social hegemony becomes apparent and
the handing over of power and authority of women to obstetricians and midwives become socially acceptable and expected behaviours (Soet, et al. 2003). Conceptualised and perceived notions of the physiology of labour and birth have become a medical model of health (Parry, 2006), thus needing medical involvement of those who are perceived as the authorities, that is midwives and obstetricians (Filc, 2006). Hegemony can be argued to be reproduced in the birth room through this over medicalisation of the normal physiology of a woman’s body during labour. A single model of each phase of labour is a common approach during labour, dictating hospital policy and protocol (Filc, 2006). This model is fitting only for systems that can ‘cure’ or ‘control’ under a bureaucratic agency (Filc, 2006) rather than accommodating individual women’s bodies and processes. This commonly used model therefore reinforces authority and power in the hands of the midwives and obstetricians not the women. Furthermore, midwifery skills in supporting women through the pain of labour or complications of labour, become solutions focused on pharmacology and intervention (Filc, 2006), removing agency of women. Perceptions of women being defiant if they refuse treatment or ask questions about their progress and care are formed and a sense of resistance becomes evident in the birthing suite (Hodges, 2009). Women become under surveillance for further obedience or defiance, with manipulation and coercion techniques used by midwives and obstetricians. For example, offering women pain relieving drugs under threats of removed choices later in labour (such as an unavailable anaesthetist, no access to water for pain relief, staff going home for the night therefore unavailable to support women, etc.) and so forth (Filc, 2006; Hodges, 2009). By excluding women’s social etiologic, women are integrated into societies hegemonic institutional structures and autonomy, agency and women’s power are minimised or dismissed.

Women are often under control of doctors who assume authority in the birthing room (Parry, 2006), these doctors conceptualise birth as a time of danger and risk, requiring intervention, monitoring and control (Kitzinger, 2012; Parry, 2006). This gives rise to the power structures between women and healthcare providers. Authoritarian power; the expected and given power to medical figures of authority over a labouring woman, as well as control, can equate to trauma in women during labour (Wijma, Thapar-Bjorkert, Hammarstrom & Swahnberg, 2007). If the same behaviours were witnessed outside of the birthing suite, they would easily be perceived as serious offences of violence (Hodges, 2009). Women are expected to comply
with authoritarian hospital culture and are socialised to expect trustworthy and professional behaviour from health care providers while deferring to authority (Hodges, 2009). This leaves complex social psychology in the birthing suite that women are required to negotiate. During a time when women are most vulnerable and in a state of physiological response, birth for women becomes a political environment in which they have to either respond with ‘fight or flight’ or ‘tend and befriend’ (Hodges, 2009). This results in a woman responding based on fear rather than allowing her body to run its physiological course (Hodges, 2009).

Most midwives and obstetricians understand the fight or flight response, as a result of the sympathetic nervous system. The fight or flight response is a process that occurs unconsciously by the body during times of emotional or physical stress, it’s a survival strategy aimed at decreasing body functions that better serve to store energy (e.g. digestion) while activating bodily responses that are simulating and used for survival (Tortora & Derickson, 2006). Effects such as pupil dilation, blood pressure and heart rate increase, dilated airways allowing for faster inhalation and exhalation, greater blood flow to skeletal muscles, cardiac muscles, liver and adipose occur allowing for faster and stronger movements aimed at surviving an imminent threat (Tortora & Derickson, 2006). This is especially in the context of birth as it can be a commonly experienced response to pain in labour (Gottesman, 2016). However, there is another response, the para-sympathetic nervous system, that is commonly experienced amongst women and titled ‘tend and befriend’ (Goer, 2010). This response is primarily governed by the hormone oxytocin, or better known as the ‘love’ hormone. Produced in copious amounts during a physiological labour, during bonding of mother and infant, and while breastfeeding, this response to ‘tend and befriend’ is a loving, gentle and somewhat altered state of mind women possess. This response to ‘tend and befriend’ while a wonderfully appropriate response in feeding and bonding with baby, disables women from perceiving birth trauma as trauma, and might explain why some women submit to authoritarian healthcare providers during labour to invasive procedures that may turn into trauma (Goer, 2010). However, should women find ways to express agency and self-determination during labour and birth when their voices are often left unheard and silenced (Bergstrom, et al. 2002; Davis-Floyd & Sargent, 1997; D’Oliveira, et al. 2002; File, 2006; Harris & Ayers, 2012; Thomson & Downe, 2008).
The silence of abuse

The silencing of abuse in maternity wards is common, along with the dismissal and justification of abuse (Hodges, 2009). Studies have found, that midwives and obstetricians often feel entitled to perform abuse on labouring women with the generalised attitude of ‘we know best’, coupled with a fetocentric model of health, dismissing women’s basic human rights to autonomy over her body (Swahnberg et al., 2007). Therefore, women become voiceless and ashamed for feeling anything but elated after the birth of her baby (Hodges, 2009; Fernandez, 2013) and their experiences are inevitably nullified (Swahnberg, et al. 2007).

Addressing the systemic silencing of abuse by hierarchical social constructs in healthcare institutions requires a dramatic change, not only across institutions, but also within gender specific societal expectations and responses. Existing literature suggests the general social structure of hospitals in Australia is one of authoritarianism, a hierarchy of dominance and submissiveness (File, 2006; Goer, 2010; Hodges, 2009; Thomson & Downe 2008). In addition, there is a culture of impunity, whereby the obstetricians at the top of the hierarchy are the least to notice the trauma and last to report it (Goer, 2010). Furthermore, there is solid hierarchal systems in place preventing agency of women and nurses/ midwives to report (File, 2006; Goer, 2010). So, how do women express their autonomy and agency?

Gender roles in society have been well defined throughout history, generally placing men in more powerful positions with more control (Diekman, Goodfriend & Goodwin, 2004). However, reviews of gender and power have shown that the stability in social positioning between the sexes is unstable, allowing room for challenge and change (Diekman, et al. 2004). The dynamic stereotyping of women in today’s society means women have made significant change to societies expectations. Evidence shows that women have substantially increased their self-power and along with it, their ability to make choices for one’s own life (Diekman, et al. 2004). However, although women’s gender roles have shifted and women have become over time, more empowered, in the context of pregnancy and birth, agency for women in labour is limited and sporadic (Campo, 2010). Depending upon their relationships with care providers and the presence or absence of trust (Campo, 2010), women have
opportunities to express agency; however, there are a myriad of complexities involved in this expression. Given the domination and control of childbirth by obstetricians (Murphy-Lawless. 1998; Nall, J., 2012) and hierarchical approaches of power (Harris & Ayers. 2012), women’s expression of agency is complex and embedded in the western socialisation of the medicalisation of birth with dependency upon midwives and obstetricians in labour (Davis-Floyd. 1992).

While history shows that women birthed unassisted, or with only the support of other women (Kitzinger, 2006), women often opt for an over medicalised form of birth (Soliday & Mammenga, 2015). Nonetheless, some women inside this hegemonic model of birth are able to express agency through having access to wider ranges of knowledge and can negotiate, contest and resist medical control (Davis-Floyd, 1992; Lorentzen, 2008). Evidence shows depending on socio-economic status, a woman either increases or decreases in her ability to express agency, access knowledge and make choices around her healthcare (Lorentzen, 2008). One successful coping strategy that enhances women’s feelings of control and positivity is when a woman focuses on the wellbeing of her baby (Iles & Pote, 2014).

Factors that contribute to a positive birth experience

During pregnancy and birth, evidence suggests women who are well supported, cared for and have a familiar person in the birthing room have improved outcomes at birth and more positive perceptions. So too, does her newborn child (Kozhimannil, et al, 2013). However, despite this empirical evidence to date, changes to childbirth practice has proven to be slow to integrate this evidence into policy and health service birth, leaving women commonly birthing with unfamiliar health professionals - obstetricians and midwives, and a lack of continuity of carer.

The significance of this support is evidence in a study undertaken by Thomson and Downe (2010). This was an interpretive phenomenological study of 14 women in the United Kingdom on women’s experiences of a positive birth after a birth trauma, which revealed four key themes. These were: resolving the past and preparing for the unknown, being connected, being redeemed and being transformed (Thomson & Downe, 2010). Of the 14
women interviewed 12 went on to experience redeeming and transformative, positive birthing experiences which altered their perceptions of their previous birth traumas. While two were so severely affected by their birth trauma they were unable to consider another pregnancy and were contemplating sterilisation (Thomson & Downe, 2010). One of the key findings, crucial for women to experience a positive birth after birth trauma (Thomson & Downe, 2010. p 106) was the level of connectedness women felt with their care providers. All 12 women were partnered with a caseload midwife, where continuity of carer was provided, enabling women to build relationships based on trust, mutuality and respect (Thomson & Downe, 2010). These connections with their midwives have been described as more of a professional friendship in which the women were able to express their previous trauma to an empathic person who validated and understood them. The significance for women sharing their birth trauma story with an empathic ear has been raised in the work of Gamble and Creedy (2004), who describe this practise as being emotionally supportive.

Care plans and birth plans have been shown to enable women to feel in control of their experiences regardless of outcome (Kuo, Lin, Hsu, Yang, Chan., Tsao, & Lin, 2010). For example, those who still experienced intervention can feel more in control and that they had made decisions regarding intervention during labour (Kuo, et al. 2010). A randomised controlled trial of 296 pregnant women described women being asked permission by obstetricians and midwives, for any intervention and were offered choice. Women were also well informed during pregnancy enabling women to feel they could challenge medical authority if needed during labour. Overall this study’s findings show that continuity of carer and friendship based professional relationships between women and caregivers, mutual respect and giving women information and choices, empower women to experience positive birth (Kuo, et al. 2010). This was so joyful they were able to transform and redeem any negative feelings or perceptions from their previous birth traumas. Similarly, considerable amount of literature shows the direct link of well supported women during labour and birth, well informed and feeling in control of her decision making, perceive birth to be a non traumatic even in the face of what others may perceive as a traumatic event (Cleveland, 2009; Davis-Floyd & Sargent, 1997; Harris & Ayers, 2012; Kitzinger, 2012).
Following this theme of well supported women, there is a plethora of evidence supporting the importance of this support, improved perceptions for women, and the marked differences between women’s and infant’s health post birth between supported and unsupported women (Kitzinger, 2005, p 156; Wagner, 1994, p 116-117; Mottl-Santiago, Walker, Ewan, Vragovic & Winder, 2008; Green & Hotelling, 2007; Kozhimannil, Attanasio, Hardeman & O’Brien, 2013; Hans, Thullen, Henson, Lee & Edwards, 2013). Important to note is that while support sourced from family, friends and community is important, studies have found the most important form of support for women to reduce birth trauma, is that of the midwife and obstetricians caring for her (Iles & Pote, 2014).

Well supported women have a sense of control and power in their choices during childbirth, they birth faster and birth outcomes for infants are better, breastfeeding rates are higher and women’s overall perceptions of birth is more positive (Green & Hotelling, 2007; Kitzinger, 2005: Mottle-Santiago et al, 2008). Women also experience power, control and agency in the planning of their childbirth. By discussing their birth plans and writing up their desires and boundaries in a formal agreement with midwives and obstetricians, women gain a sense of control over their choices during birth (Cook, 2010).

Women face an enormous amount of politics and influences during labour and birth that potentially dis-empower them during a time of great vulnerability (Wagner, 1994). Further to this, a feminist standpoint theory inquiry into women’s challenges of pregnancy in a medicalised and fetocentric context have shown that although the system is inherently designed for patriarchal power, women often find their expressions of agency and resistance in episodic moments of self-expression, self-protection and in their decision making (Parry, 2006).

The support of midwives is crucial in women’s overall perceptions of birth and experiences of birth trauma. A well supported and cared for woman in labour has the potential to perceive a traumatic experience as empowering; depending upon the level of communication and support she receives from midwives and obstetricians (Thomson & Downe, 2008). Faced with such a complex matrix of influences over women in labour, women still manage to find ways of expressing their agency and power. Women’s voices being heard depend upon caring.
and emotionally available midwives and obstetricians placing women at the forefront of the experience not treating them as simply a vessel in a fetocentric model of health care. In order for women to experience more empowerment and less trauma in birth, midwives and obstetricians need to build strong working relationships with women based on trust, openness, communication and listening skills. Education of midwives and obstetricians needs to be directed at communication skills and a woman centred model of care that perceives birth as a normal, physiological experience.

Of note is that in contemporary birth suites within westernised health care systems, women are able to express agency through having access to wider ranges of knowledge and can negotiate, contest and resist medical control (Davis-Floyd, 1992; Lorentzen, 2008). However, evidence shows that a woman’s socio-economic status, impacts on her ability to express this agency, as well as her access to knowledge to make choices around her healthcare (Lorentzen, 2008).

**Gap in Literature**

Considerable data on birth traumas, emotional responses to, and related PTSD and PND exists with both causative and emotional response themes being identified (Bergstrom, et al. 1992; Boorman, et al. 2014; D’Oliveira, et al. 2002; Fernandez, 2013; Goer, 2010; Harris & Ayers, 2012; Soet, et al. 2003; Thomson & Downe, 2008). Causative factors for women’s birth trauma and related PTSD include, but are not limited to:

- The actions or inactions of midwifery staff or obstetricians leading to the inadequate quality of care (Fernandez, 2013);
- Interpersonal difficulties such as, women’s feelings of powerlessness and feeling ‘invisible’ (Harris & Ayers, 2012; Soet, et al. 2003);
- Increasing medical intervention such as using drugs to induce labour, use of forceps and vacuum extractions, use of drugs when not necessary and caesarean section (D’Oliveira, et al 2002; Hodges, 2009; Soet, et al. 2003);
- Neglect, such as women being left alone in labour rooms, abandonment not listened to, inadequate information given, and lack of compassion (D’Oliveira, et al 2002; Harris & Ayers, 2012; Hodges, 2013; Soet, et al. 2003);
• Physical trauma such as unnecessary medical intervention, forced interventions such as caesareans (Boorman, et al. 2014) refusal of pain relieving medications or coercion into use of these medications (D’Oliveira, et al. 2002; Hodges, 2009) and unnecessary vaginal examinations and episiotomies (Bergstrom, et al. 1992; Hodges, 2009).

Caution must be made when reading current findings as most current data has been collected from well-educated (Bachelor degree), middle class, Caucasian primigravidas. With a substantial length of time (over 5 years) between women giving birth and being interviewed for studies meaning there may be recall distortion. Data needs to be found in women who have recently given birth (within the past five years), so recall has more accuracy potential.

While there are studies reporting birth trauma, and women’s emotional responses and experiences, these predominantly focus on quantitative data. There are no current qualitative studies on women’s experiences of birth trauma. Gaps in literature exist in an Australian context on in depth rich description of experience of birth trauma, and how current health service provision enable or inhibit women’s childbirth experiences. Also lacking in the literature review was an examination of Australian women’s capacity to express agency in labour and birth.

**Summary**

This chapter discussed the search strategy used in this study along with the definitions and discussion of what birth trauma is. The effects on women were discussed while further developing the discussion on the contributing factors to birth trauma and power and control inside Victorian maternity settings. The chapter went on to explore the silencing of abuse and how women are able to express autonomy and agency inside this hegemonic birthing system. Contributing factors to women perceiving a positive birthing experience were also discussed followed by a final explanation of the gap in literature used as a basis for this study.
Chapter 3 Methodology

Introduction

This chapter explains the research methodology used to explore women’s experiences of birth trauma. The methodology used was qualitative exploratory descriptive design. This chapter discusses the differences between qualitative and quantitative methodologies with a description of the methodology and how it was used in this study.

Research aim

This qualitative explorative descriptive study aimed to uncover social phenomena and behaviours between women their carers, and the birthing institution. In addition, how women’s experiences of vaginal birth can lead to emotional and psychological trauma, and how women’s experiences of this type of perceived trauma can be improved. Benefits to exploring perceptions of birth, women’s trauma related experience, are improved maternal and neonatal outcomes.

The aim of this study was to discover women’s experiences of, and uncover the social phenomena of, psychologically and emotionally traumatic birth inside Victorian metropolitan public maternity hospitals in Victoria. From this then the study explored the experiences of women who had a vaginal birth and the link to perceived traumas, and how women’s experiences can be improved. Findings will be used to inform hospital and maternal health care policy and service birth protocols. Outcomes include potentially improved birth outcomes as well as improved relationships between women and their care providers, for a larger population of Victorian women. The diminished experiences of birth trauma will lessen the burden on the health care system. Finally, findings will help inform psychosocial curriculum content for the education of nursing, midwifery and medical students as well as associated post graduate education of these health professionals.
Research objectives

The objective of this study were to explore within the context of Victorian maternity settings, women’s meaning of and nature of a perceived trauma, explore women’s beliefs surrounding a perceived birth trauma event, explore women’s capacity to express agency during childbirth, explore women’s perceptions of health care barriers and health enablers to her birthing process, and to form recommendations for minimising the risk of birth trauma through women centred birth protocols in maternity suites.

Quantitative and Qualitative research

To simplify the differences between the two methodologies basically, quantitative employs measurement, qualitative does not; rather qualitative research engages theory of meaningful lived experiences (Bryman, 2016). Quantitative research emphasises the quantification in the collection and analysis of data and views social reality as an external objective reality, and entails a deductive approach to the relationship between theory and research (Bryman, 2016). Quantitative research tends to be associated with a realist ideology, pertaining numbers from knowledge of the world as it is known to exist, things can be measured and have numerical values and statistics, and can produce facts about the world and behaviours (Jupp, 2006). With quantitative research, information is collected and turned into quantifiable data (Bryman, 2016).

There are four main preoccupations of quantitative research these are: measurement, causality which describes why things are the way they are, generalisation which aims to generalise the findings to beyond the sample group used in a study, and, replication a deductive process to remove any biases or lack of objectivity (Bryman, 2016). A great strength of quantitative research is the fact it allows obtained data to be subject to stringent analysis processes which remove any question of doubt (Jupp, 2006).

On the other hand, qualitative research aims to study people in their natural environments focusing on the meanings of people’s attachments to their social settings. “Qualitative research investigates aspects of social life which are not amenable to quantitative measurement” (Jupp, 2006: p 348).
Qualitative research emphasises words rather than quantification, viewing social reality as a constantly shifting emerging property of an individual’s creation, this utilises an inductive approach to the relationship between theory and research and places emphasis on the generation of theories (Bryman, 2016). Qualitative research focuses on the meaningful experiences of daily life, with commonalities across the qualitative methodologies involving focusing on problems of daily life or phenomena that occur in natural settings, and the study of the intricacies and complexities of these phenomena (Leedy & Ormond, 2005). Furthermore, qualitative researchers are aware of the multifaceted aspects of a subject or study, they consider the various individual’s perspectives and experiences as each being valid within its own right and attempt to interpret these experiences and perspectives, creating an objective theory that brings about an understanding to a group of these individual’s experiences (Bryman, 2016). Thus, finding a commonality of these shared meaningful experiences. By doing this, qualitative research brings an understanding and relevance to the nature of the lived experiences (Leedy & Ormond, 2005).

Typically, qualitative research aims to explore purpose of one or more of: interpretation, description, verification and evaluation (Leedy & Ormond, 2005). Interpretation allows a researcher to explore the problems within a phenomenon, gain new insights into this phenomenon and develop theoretical perspectives (Leedy & Ormond, 2005). Description can reveal the nature of the social worlds being examined and, can allow a researcher to describe or emphasise the importance of the contextual understanding of the phenomena (Bryman, 2016). Verification allows the researcher to test their theories or evaluations of the studied phenomena and, evaluation offers the researcher an opportunity to assess the effectiveness of their suggested recommendations from their study. For example, new polices, protocols or other innovations (Leedy & Ormond, 2005).

A key difference between quantitative and qualitative research is, the use of qualitative methodology focusing on the meaningful lived experiences of the subject matter, whereas quantitative research focuses on the analyses of natural sciences (Bryman, 2016). Qualitative methodology allows a richer, deeper insight into lived experiences and the importance of understanding these social behaviours for future developments and improvements for areas
being studied. Often qualitative research is used in the areas of social sciences, nursing, psychology, anthropology, sociology, history, as well as education, medicine, and political science (Leedy & Ormond, 2005). Qualitative research offers a unique approach to understanding lived experiences relevant to these social sciences that quantitative research cannot and allows a researcher to see through the participant’s eyes (Bryman, 2016). Using qualitative research to examine women’s experiences of birth trauma and the actions of agency and hegemony in the birth suite was deemed as the most appropriate form of research given the identified gap in current available literature.

**Five qualitative approaches**

Creswell (2013) outlines five qualitative approaches to inquiry. These include qualitative exploratory descriptive, phenomenological, grounded theory, ethnographic, and, case study research. All approaches share commonalities in the general processes of research including, finding a research problem, development of questions, collection of data, data analysis and finally writing of a research report. Each approach, however, has a unique theory that shapes the overall design, collection and analysis of the chosen project and is best suited to a particular type of inquiry (Creswell, 2013). For example, narrative research focuses on exploring the life of an individual; phenomenology focuses on understanding the essence of an individuals’ experiences; grounded theory focuses on developing a theory grounded in data from the field; ethnography focuses on describing and interpreting a culture sharing group; and, case studies focus on developing an in-depth description and analysis of a case or multiple cases (Creswell, 2013). For the purpose of this study qualitative exploratory descriptive has been chosen as the best design suited for the study exploring and describing women’s experiences of emotionally and psychologically traumatic birth.

**Qualitative exploratory descriptive: Definition and background**

Denzin and Lincoln (2005) describe qualitative research as ‘a well-positioned activity that locates the observer in the world’ and that ‘qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of meanings people bring to them’.
Qualitative research focuses on the meaning of lived experiences, striving for understanding. The researcher assumes that the participants are already knowledgeable in their experiences, what’s going on for them, how life is like in the chosen setting (Patton, 1985). Qualitative research aims to uncover the hidden meanings and understand deeply the participant’s experiences and their own meanings within (Patton, 1985). Qualitative researchers are invested in how people interpret their own world, how they develop meaning for themselves (Van Manen, 1979). The job of the researcher therefore is to understand and communicate these meanings and interpretations of the participants to the wider audience.

The aim of exploratory research is to formulate problems, clarify concepts, working with participants already knowledgeable about a topic, the research seeking to understand new concepts inside a topic. As Jupp (2006) describes “Exploratory qualitative descriptive research is primarily concerned with discovery and the new development of theory” (p 4).

Selection of Method

The researcher in this study felt a deep sense of concern for women’s rights and a perception of a violation of those rights that led to the chosen topic. While looking at this topic the researcher reflects on themes such as ‘what constitutes the nature of this lived experience’ (Creswell, 2014). While maintaining a strong connection to the chosen topic of enquiry and themes, the researcher writes a description of the interpretation of the shared lived experience of the studies participants (Creswell, 2014).

Qualitative research allows for a rich descriptive or interpretive, approach to viewing the world, viewing things in their natural settings, while attempting to make sense of, or interpret, phenomena in terms of the values and meanings that people bring to them (Denzin and Lincoln 2003).

Qualitative exploratory descriptive is best suited for a study designed to understand a group of individuals shared experiences, with the view of developing polices and protocol or practices, which can be implemented into everyday life of this study’s focus. For the purpose of this study, qualitative exploratory descriptive has been chosen as an approach to best uncover and interpret women’s shared lived experiences of emotional and psychological
trauma in Victorian maternity settings, with a view of developing protocols and policies to prevent this type of birth trauma in the future.

In this study the topic of interest has been identified as women’s lived experiences of emotionally and psychologically traumatic birth and the meaning of these traumatic experiences. While looking at this topic the researcher reflects on themes such as ‘what constitutes the nature of this lived experience’ (Creswell, 2014). While maintaining a strong connection to the chosen topic of enquiry and themes, the researcher writes a description of the interpretation of the shared lived experience of the studies participants (Creswell, 2014). Using a qualitative exploratory descriptive approach this study aimed to uncover the meaning and causes of birth trauma. Qualitative exploratory descriptive methodology allows the researcher to find commonality within women’s experiences and develop themes that explain and understand this important topic.

Polkinghorne (1989) recommends qualitative studies include the use of multiple interviews with participants of in depth nature. As aligned with qualitative exploratory descriptive, in depth interviews were used for data collection in this study, recording audio communications during the interview process. The researcher created and used a semi structured interview guide with broad open-ended questions, allowing for women to articulate their experiences without prompt.

**Evaluation of qualitative exploratory descriptive research**

Data analysis involves building on data collected during in depth interviews, creating themes and sub themes (Creswell, 2013). This is done by highlighting significant statements or shared mentioned experiences and quotes which exemplify the meaning of women’s lived experiences. From these significant statements and quotes, clusters of meaning are drawn from the data and developed into themes. These statements and themes are then created into textural description whilst simultaneously the researcher notes and records any personal reflections and statements and includes these in the role of the researcher for rigour and clarification of interpretation (Creswell, 2013). From these descriptions and themes the researcher writes an “essential invariant structure” (Creswell, 2013, p 62). This is a
descriptive piece of writing that describes the essence of women’s lived experiences of psychologically and emotionally traumatic birth, a section of the thesis that will leave the reader with a better understanding of women’s lived experience of this kind of trauma and how it might feel for them. Given the nature of the study being of such personal and individual nature, phenomenology best suits as a structure to capture the hidden meaning behind emotionally and psychologically traumatic birth.

**Summary**

This chapter discussed the differences between quantitative and qualitative research methodologies, highlighting why qualitative was best used for this study. Five approaches to qualitative methodology were explored along with a detailed description of qualitative exploratory descriptive definition and background. The chapter went on to discuss qualitative research procedures with a final explanation of evaluation techniques.
Chapter 4. Method

Introduction

This chapter will discuss the methods used for this study. An overall view of the research setting, recruitment method and interview guide will be explained. How content validity and rigour were met will also be explained.

Participants

Research setting

All of the seven women who participated in this study birthed in Victorian metropolitan public maternity hospitals. Each mother had midwifery based care but also had the presence of an obstetrician during the final moments of birth. Melbourne is also the second most favourable city for new immigrant’s destinations promoting a high level of cultural and linguistic diversity (Department of Immigration and Citizenship, 2012). With Melbourne being one of the top two cities for population growth, it follows therefore, that there is exponential childbirth health services demand.

Inclusion criteria:

These section criteria were chosen to eliminate any potential adversity that may affect women’s perception of traumatic birth. The following selection criteria enabled the researcher to focus on vaginal births with mothers who had good birth recall.

Women were eligible to participate if they were:

- First time mothers who gave birth within the last five years in a maternity hospital in Australia;
- Had a vaginal birth with no instruments;
- Had experienced some perceived form of self-reported birth trauma;
- A permanent resident of Australia;
- Able to converse in fluently in English; Birthed within a Melbourne metropolitan public maternity hospital
- Over 20 years of age.
Exclusion criteria:

This exclusion criterion allowed the researcher to focus on vaginal births and not include any adverse events that would significantly impact on a woman’s perception of trauma, and included:

- Obstetric co-morbidity (for example. Pre-eclampsia, gestational diabetes);
- Recent immigrant to Australia, less than 5 years;
- Co psychiatric morbidity;
- Complex birth event such as caesarean, twins.

Table 4.1 provides the demographic details of the seven women who were interviewed for this study.

<table>
<thead>
<tr>
<th>Demographic information</th>
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<tr>
<td><strong>Bianca</strong> is a 30 to 34-year-old mother of a 21-month old child, married, and from a household combined income of $75,000 p/a. Bianca identifies as Australian nationality. Bianca had a vaginal birth with a midwife and her general practitioner (GP) obstetrician. She had no known complications in pregnancy or labour. Bianca did a lot of antenatal reading independently.</td>
</tr>
<tr>
<td><strong>Sophie</strong> is a 25 to 29-year-old mother of a one-year-old child, married and from a household income of $75,000 p/a. Sophie had a vaginal birth with a midwife and obstetrician. Sophie went into labour spontaneously at 35 weeks.</td>
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<tr>
<td><strong>Charlotte</strong> is a 30 to 34-year-old mother of a two-year-old child, married and of Australian descent. Charlotte is from the $75,000 income bracket and had a vaginal birth with a midwife and an obstetrical team and paediatrician. Charlotte and her baby had no complications during pregnancy.</td>
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Sonia is a 30 to 35-year-old mother of two-year-old child, married and identifies as Australian. Sonia had a vaginal birth with a midwife and her GP Obstetrician. She had no known medical complications during pregnancy or labour and is from a household income of around $75,000 p/a. Sonia attending hospital run antenatal classes and had read a lot of independently written birth preparation material. This was her first birth, followed by a subsequent birth of her second child.

Alex is a 25 to 29-year-old mother of an eight-month old child, married and of New Zealander identity, she had a vaginal birth with manual rotation of baby by an obstetrician with midwives present. Complications for Alex included an ‘incompetent cervix’, irritable uterus, posterior presentation, and a history of endometriosis. Alex is from the $57,000 to $67,000 income bracket. Alex did not attend any antenatal classes due to the hospital loosing her referral.

Mary is a mother of 35+ years of age, married. She identifies as English/British nationality. Mary had a vaginal birth with a midwife, had no complications during pregnancy or birth and is from the $57,000 to $67,000 household income bracket p/a. She has had a second child born at home with a private midwife.

Hilda is a mother of 25 to 29 years of age, married, identifies as Australian and is from a household income bracket of $24,000 to $34,000. This was Hilda’s second birth a VBAC, Hilda had a midwife and obstetrician present for her birth with no known complications during pregnancy or labour. Hilda did not attend any antenatal classes. she did a lot of prenatal reading and research, joined various prenatal mothers’ groups and VBAC support groups.

Table 4.1 Demographics of women interviewed
Sampling and participants

Given the nature of the topic, and many women not identifying with birth trauma, convenience sampling was employed to enable easier access to these women (Jupp, 2006). Participants were selected according to the criteria established from a convenience sample of first time mothers who had experienced a perceived trauma following a vaginal birth. Seven women were interviewed over a six-week period between 14 August 2015 to 25 September 2015 (Glaser & Strauss, 1967).

Procedure

The study was based in the northern growth corridor of Melbourne. This area has one of the lowest deciles of socio-economic disadvantage in Melbourne (Hulse, Pawson, Reynolds & Herath, 2014). The average household income for these areas is between $420 and $480 per week (Victorian Environment Assessment Council, 2009: Australian Bureau of Statistics: Household Income and Income Distribution, 2011-2012). Maternal and Child Health centres in the municipalities of Darebin, Moreland and Whittlesea, along the northern corridor of Melbourne were therefore, used for recruitment. These lower socio-economic municipalities were used given women from areas of socio-economic disadvantage have heightened vulnerability and potentially less capacity to express agency (Lorentzen, 2008).

Recruitment

- Recruitment to the study was solicited through posters and flyers distributed in all Maternal and Child Health Centres in the above municipalities. A total of 48 clinics were contacted to advertise the study (18 in Darebin, 15 in Moreland and 15 in Whittlesea) (Appendix A);
- Permission to distribute flyers and posters was sought from The Department of Education and Education as they oversee the maternal child health (MCH) services in Victoria;
- Once permission was received, the researcher contacted the Maternal and Child Health Coordinator from each municipality to arrange local permission and a suitable time to distribute flyers and posters.
The researcher then posted an advertisement/flyer on participating in the study, the aim of the study and the nature of participation. Anyone interested in participating was therefore able to contact the researcher from one of the advertised contact numbers, email or online contact pages. Due to the lack of recruitment through this process, a Facebook page designed for the sole purpose of recruiting women for the study was created and promoted throughout relevant Facebook groups and pages of potential interest of the study. Once willing participants contacted the researcher, participants were given an information package which included a plain language statement with a cover letter introducing the study in more detail, ethics and privacy information and consent forms. The researcher also identified whether the participants met the inclusion and exclusion criteria prior to sending out the information package. A time and place to conduct the interviews were arranged by mutual agreement to be either in the women’s home or closest Maternal Child Health clinic.

**Ethical considerations**

Ethics approval notices were obtained from RMIT University Human Research Ethics Committee and the Department of Education and Education (see Appendix F & G). Date of final approval 14 August 2106, approval number 19428.

Once participants contacted the researcher, detailed information on the study in the form of informed plain language consent was given to potential participants outlining the overview of the study, purpose of the study, use of results from the study and privacy and confidentiality. Participants were then informed that participation was voluntary and they could withdraw their participation at any time. Further, participants were informed that their information was de-identified when reported in the study, and their identity was kept confidential at all times. After reading the Plain Language Statement, women were given a consent form to sign prior to commencing the interviews (see Appendix D). Participants were also given contact details of locally available support services on completion of their interview. All completed surveys, documented interviews, recordings and any data from the interviews has been stored in a secure locked cabinet with no unauthorised access, with only the researcher and supervisor having access.
Pilot

The pilot study was undertaken involving two informants who meet the selection criteria independent from and prior to the conduct of the main study. A pilot study is commonly used in research to prove feasibility and test for any ambiguity and the timing of the interview allowing the researcher an opportunity to refine interview questions prior to the main study. (Van Teijlingen. 2002). The aim of the pilot study is to determine any error, ambiguity, limitations of the interview questions, also to help the researcher to prepare for any unexpected outcomes from feelings arising in participants as a direct result of the topic of the interview (Van Teijlingen. 2002).

The pilot data allows the researcher to refine interview questions, implement any changes necessary, such as wording and terminology used, themes or topic, unexpected reactions to questions by participants and review the timing. The pilot interview for this study allowed for changes to be made to the interview questions in the semi structured interview guide. Questions were adapted accordingly.

Materials

Women were recruited using two methods, the first which returned zero recruitment was through advertisement of recruitment flyers placed in maternal and child health nursing centres in three municipalities of Melbourne: Darebin, Whittlesea and Moreland. This was a timely and involved process that returned no participants. As a secondary approach after ethical amendment approval, was use of a social media page, created solely for the purpose of advertisement of the study and recruitment of participants. This was overwhelmingly successful and returned a group of seven (7) women who met inclusion criteria and a further six (6) who did not meet inclusion criteria. The latter group of mothers who did not meet inclusion criteria were due to complicated births, higher socio economic status and length of duration between birth and interest in the study. The social media page was promoted on various mother’s forums and groups of interest. Since the completion of these interviews a further nine women have approached the researcher wishing to be included, representing further community interest and need for future studies in the field.
Half (4) of the women recruited for this study were from low socio economic backgrounds, all birthed within Victorian public maternity wards and self-identified as having experienced a psychologically or emotionally traumatic birth. All participants mentioned throughout the study met inclusion criteria.

In depth retrospective interviews was used in this research to explore women’s experiences of birth trauma in public Victorian maternity settings. Open-ended questions used for this interview guide were derived from the critical review of the literature provided above (see Appendix B). The interview guide was semi-structured enabling concurrent analysis throughout capturing new agreed themes as they emerged (Guest, MacQueen & Namey. 2012). Women also completed a short list of demographic questions which included their age range, the age of their babies, partnership status, ethnicity, support person in labour, type of birth, midwives and obstetricians present at their birth, any known medical complications during pregnancy or labour/ birth, and finally, and each woman’s average annual household income.

**Data collection**

The qualitative data was collected through in depth semi structure interviews conducted with women who had perceived trauma following a vaginal birth. Interviews were recorded once consent had been obtained, with two audio devices to ensure data was accuracy collected, one being a recording app on a phone, the other being a hand held recording device. The interviews lasted between 50 and 120 minutes. Questions were asked in a story telling fashion in order to encourage interviewees to provide detailed information. Probing was then used to gather more details or seek clarification. This was done through the semi structured interview guide and flexibility of changing questions accordingly to women’s input. Interviews were conducted either in the woman’s home or via skype at a time that was convenient for them. The researcher ensured the environment was quiet, private and supportive for women to share their stories. Each woman commented at the end of the interview that it was a healing process for them and they appreciated and enjoyed the opportunity to share it.
Data analysis

Audio data was translated verbatim into a written format for coding, identifying and describing the ideas both explicit and implicit within the data (Guest et al., 2012). The analysis then involved double checking the recordings in order to check the match to written format. Meanings were coded thematically from the actual data, which are then analysed, often changing as they build on ideas throughout the study as more data unravels in the course of analysis (Sandelowski, 2000).

Once codes were developed the data was read and re-read to confirm and create themes (Strauss, 1987). Relying on researchers’ interpretation of data themes, the coded themes were read and re-read by both the student researcher and supervisors. The researcher used thematic analysis techniques to ensure a cascade effect of thematic coding of data, identifying and describing the ideas both explicit and implicit within the data (Guest, et al. 2012). Meanings were coded thematically from the actual data, which were then analysed (Fetterman. 1989; Sandelowski. 2002). The analysis consisted of identifying sub themes and clustering these into main themes (Guest, et al. 2012). Once codes had been developed the data was read and re-read to confirm and create themes (Strauss, 1987). Relying on researcher’s interpretation of data themes, the coded themes were read and re-read by both the student researcher and supervisors.

Content validity

Content validity was achieved by asking one hospital midwife and one maternal and child health nurse to rank independently the interview guide. The aim was to ensure that this in depth interview guidelines measure what the researcher intended it to. There are general aspects used to determine validity of content of a qualitative semi structured interview guide:

1. Asking select professional staff as experts if the in depth interview guidelines, measures what the researcher intended it to;
2. Validity of explanation. Asking experts in the field outside of the main study if the potential explanations derived from the semi structured interview guide could be appropriate for the specific content of the study (Jupp. 2006).
3. A senior supervisor to cross check content validity was also review this work.

**Saturation**

Saturation is reached when the researcher collects data which is no longer repeated and no new data is obtained through continued sampling (Morse & Maddox, 2014). Saturation for this study was reached after seven interviews when no new themes emerged and current themes were repeated without any new sampling (Glaser & Strauss, 1967).

**Rigour**

Rigour has been described as the demonstration of competence and integrity within a study (Aroni., Goeman, Stewart, Sawyer, Abramson, & Thein, 1999).

Rigour was achieved in this research through a number of aspects, including:

- Audio recordings provide credibility in accuracy of data;
- A process review panel (supervisory team) worked together for coding of sub themes;
- Trustworthiness was demonstrated by methodology, interview questions, and aim of the study being checked by supervisors and one midwife and one maternal and child health nurse to ensure the accuracy of chosen methodology to data collection and appropriateness of study design (Jirojwong, Johnson, & Welch. 2011).

Simultaneous collection and analysis of data shape each other to develop not only frequency but also meaning to the research findings. The student researcher did not use observational data collection during interviews due to women most commonly wishing to be interviewed via skype. The student researcher did however use audio recordings and written notes to ensure all aspects of the interview were covered, making thematic coding richer and more accurate.

Transcriptions of audio recordings were done by the student researcher as well as a professional transcription service. This was done due to funding limitations with the student researcher needing to take over the remaining un-transcribed audio tapes. Data was then read and re-read along with supervisors. Transcribed data was member checked where feasible.
with the study participants to gain feedback on accuracy of recordings. Thematic coding was read and re-read by student researcher and supervisors to reach agreement and where disagreement discussion was held after the initial collection of data.

**Summary**

This chapter discussed the method of research used for this study. The research setting was described, sampling and participants, the inclusion and exclusion criteria of participants and ethical considerations. The method of recruitment was explored along with a description of the interview guide and processes used. Content validity was explained and a description for the pilot study used was also shared. Details of how data was collected were discussed and data analysis explained with a further description of how saturation was reached for this study and how rigour was met. Finally, a brief description of how rigour was used for this study.
Chapter 5. Results

Introduction

The purpose of this chapter is to present the findings from the in depth interviews conducted with the seven study participants exploring their experiences and perception of birth trauma. In depth interviews were either conducted in the mother’s home or through skype where the mother was unavailable locally. The initial pilot study was collapsed into the main study. Convenience sampling of mothers was used in recruitment. Recruitment consisted of seven women all of whom had birthed in a Victorian public maternity hospital in the within the past five years and self-identified as having experienced psychological or emotional birth trauma. The findings from the interviews were presented using quotations where appropriate, with main themes grouping together experiences and sub themes taken form direct quotes received during the interviews. Table 5.1 outlines the main themes and subsequent sub themes followed by detailed discussion of each.

Participants

While all women experienced a vaginal birth, the women who participated in this study did have obstetricians present in the birthing room during the moments of birth. This placed a medicalised model of care on the women’s labours, more so than a typical vaginal birth, simply due to the presence of one or more obstetrician in the birthing room. Obstetricians generally are trained to have a medicalised pathological approach to birth where as most midwives are trained to have a normal physiological approach.

Table 5.1 List of themes

It can be seen from the analysis of the data that many of the women interviewed reported shared perceived traumatising experiences and consequences of those experiences. Reaching saturation after seven interviews was achieved because most women experienced similar situations and had similar perceptions about their trauma. Every mother when asked in the demographics pre interview questionnaire ’would you birth at the same hospital again? Why/
why not?’ answered ‘no’ with different elaborations. Participants highlighted the themes throughout their interviews emerging as concurrent analysis and reframing of the interview guide took place throughout the interview process based on the semi structured interview guide design.

<table>
<thead>
<tr>
<th>Themes</th>
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<tr>
<td>1. <em>I was determined to birth naturally</em></td>
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<td>2. <em>Not telling me what they were doing</em></td>
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<tr>
<td>3. <em>I just had to force the baby to be born</em></td>
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<tr>
<td>4. <em>I felt traumatised, it was really horrific</em></td>
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<tr>
<td>5. <em>I know that is just what the system is like... they're hospital midwives...they're medical</em></td>
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<tr>
<td>6. <em>I didn't feel connected to them</em></td>
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<tr>
<td>7. <em>She stood up for me/ I felt powerful</em></td>
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<tr>
<td>8. <em>After the birth, just horrible/ You’re stuck with the consequences</em></td>
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<tr>
<td>9. <em>I deserve a better birth</em></td>
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</table>
Thematic analysis

The following section discusses the themes interpreted from the data. Quotes from the interviews and focus groups are used to demonstrate the findings of the study.

**Theme 1. *I was determined to birth naturally***

All of the women who participated in the study aimed to have an intervention free normal natural/ vaginal birth. For the purpose of this study the definition of ‘vaginal birth’ includes an instrument free vaginal birth without the use of any painkillers or manual removal of the baby. Most women attended hospital run childbirth preparation classes or independently run childbirth preparation classes. For some women however, for one reason or another, they did not make it to these classes. For example, one mother’s referral was lost in the system:

*They lost my referral for the hospital at five weeks pregnant… so by the time I was 20 weeks pregnant their classes were booked out from 16 weeks so we missed out* - Alex

Most of the women undertook independent pre reading to prepare themselves for the birth as well as attending the childbirth preparation classes. For the women in the study they felt a vaginal birth was an ideal outcome that they did as much preparation for as possible, on other words;

*I wanted it to be as natural as possible – Mary*

The women however, were realistic about the fact that things may not always go as planned and felt prepared for any unexpected events that may impact on their experiences of a vaginal birth. The following quote demonstrates how the majority of the women who participated in the study truly desired to have as complication free birth as they could:

*I had really wanted to go for as intervention free birth as possible - Sophie*

The desire to birth naturally among the women ranged from feeling it was an ideal outcome to feeling it was such a strong desire it impacted on their experiences when things became...
complicated or needed medical intervention. For instance, Charlotte expressed how her desire for a natural birth was more of a determination; her will was stronger than simply a desire. Charlotte felt she would do everything in her capacity to have the birth she wanted:

\[ I \text{ was very determined to have a natural birth, to not use any pain relief. to have a natural vaginal birth – Charlotte } \]

In order to make this determination transparent to the staff that would be caring for them in hospital, women wrote them up in:

\[ ... \text{ a birth plan, I’d said what I wanted to happen - Mary} \]

A birth plan is a written document outlining a woman’s choices and preferences for her labour and birth, the use of drugs, interventions and anything else the mother feels is important for her birthing experience (Pairman, 2006). Some women used this birth plan to make specific requests about what they wanted. For instance, it was not uncommon for women to say that they did not want an epidural or an episiotomy. Other women used the birth plan to say what they did want. For example:

\[ I \text{ wanted a water birth, I wanted it to be as natural as possible – Mary} \]

As a result of gaining knowledge from attending the childbirth preparation classes and/or reading, the women commented that they felt prepared for their labour and birth. They felt informed about what to expect and therefore:

\[ ... \text{ wasn’t feeling stressed about birth – Sophie} \]

Despite (or maybe as a consequence) this preparation, women felt that they could not adapt accordingly to the changing situation and felt unprepared to make choices in the event of an adverse outcome during labour. For instance, in Bianca’s experience she felt her strong desire for a natural birth impacted negatively on her capacity to change dynamically to her situation.
I went in there with a really kind of single mindedness of what I wanted to do and I wasn’t going to let any, you know, male dominated patriarchal system force me into all that stuff. it was almost to my own detriment I guess, that I definitely stuck to my guns for a long time... when they gave me the epidural I cried because I felt like it was being taken away, that I didn’t have any choices anymore. I was crying because things weren’t going the way I had hoped they would. – Bianca

Theme 2. Not telling me what they were doing

This theme explores how women perceived critical information as being withheld from them that could have dramatically impacted how their birthing process went. All of the women expressed during their interviews that midwives and obstetricians did not inform them or ask consent for a range of various procedures. Women felt as though their choices were denied and taken away, best described as:

They were taking control of me and my body without my permission - Hilda

This resulted in women not understanding what was happening to them based on a lack of information they received:

I just hadn’t had the knowledge, no one said this is why this is happening - Mary

Albeit the plethora of both hospital-distributed and independent readings the women researched during pregnancy, they each felt uninformed and completely unaware of what was happening to them, let alone any choices they had in processes or their care. This resulted in women feeling:

I was so confused about the suggestions they were making - Charlotte

Each woman wished to have respectful communication between themselves and midwives and obstetricians but felt they were not listened to and their questions were left unanswered:
I felt like I wasn’t really informed enough on what I was agreeing to, I felt generally like I was uninformed. Not because I didn’t ask questions but because they chose what they wanted to tell me… I felt like it wasn’t ok for me to ask questions – Charlotte

In regard to informed consent women responded almost unanimously that they did not feel informed about procedures, risks, or options, nor asked their consent for certain procedures to be done. Some women also experienced these procedures or interventions being done to them without anyone telling them what was happening before hand:

*The midwife or doctor didn’t explain procedures or ask for consent... that didn’t happen - Charlotte*

*They just walked in and said “we’re checking your dilation” and just went for it... it would have been nice to have been warmed up to that one, didn’t realize it was so painful... They weren’t explained they were just done - Sophie*

A shared feeling among the women of having midwives and obstetricians act in an authoritarian manner toward them was also found:

*They were just doing whatever they thought they needed to do next... there was no notification for me or anything – Hilda*

*They (midwives and obstetricians) weren’t that keen to give me a lot of information. The doctor was very, because I said that’s what’s best, you know. I was asking a lot of questions and it didn’t (sic) – it felt like to me she didn’t really like that, that I was asking questions. I felt like it wasn’t ok to ask questions – Charlotte*

This authoritarianism was further developed into fear, anxiety and panic for some of the women which lead into further feelings of trauma and violation:
So I was really flat, my legs were up and I was really far back so I couldn’t see what they were doing and I was thinking ‘what the hell are they doing?’ I was so scared, I think I was frozen... I couldn’t communicate with anyone and no one was communicating with me... it was really horrible - Alex

Women also felt midwives and obstetricians knew information but kept it from them, withholding important physiological information regarding their babies and their bodies, that had they known, could have changed the course of their birthing experiences and prevented a traumatic birth:

She didn’t explain any procedures... it added a whole other level of anger to my experience because she did know that information and she had the knowledge and chose to keep it to herself, which is kind of dismissive... I felt it would have made such a difference to my care if I’d have known... without the knowledge I can’t make informed decisions... there was none of that – Mary

No one had mentioned that he (baby) was posterior. When I got my notes it said that, on her (midwife) initial consultation straightaway she said “baby posterior”, she’d circled baby posterior, but she hadn’t told me that - Alex

The degree of not knowing impacted all women in the study. All of the women felt moments of being controlled by midwives and obstetricians during which the authoritarian attitude and practices of staff left women feeling completely unknown as to what procedures were being done and how their bodies or their babies were coping with the labour:

I just kept thinking what the hell are they doing? I had no idea, and then I kept thinking, they’ll explain any minute now, they’ll explain what’s going on, and um, I’m still waiting for that explanation – Alex

Another aspect of misinformation was the fact that the women felt they had no understanding or knowledge of hospital policies and procedures. Feelings of loss of control were amplified
by not knowing these policies and protocols, reinforcing the fetocentric model of care and power asymmetry in the birthing suite.

*I had no idea of the hospital policy around the amount of hours you’re allowed (once induced) – Charlotte*

Part of a midwife’s role is to enquire to what a woman wants, how she is feeling and progressing and to create a dialogue that involves the mother, placing her at the center of care. Women felt staff did not make any of these enquiries before making their own decisions about what procedures, positions or steps to take next in the labour and birth:

*She was instead of sort of being with me and saying ‘come on you can do it’, or breathing or different positions, or just showing a bit of empathy or something, she was just on the phone trying to call the doctor the whole time! – Sonia*

The experience of betrayal for women on being ill informed, uninformed or having information given that was misleading, left women distrusting midwives, obstetricians and medical institutions. Each woman felt, had this communication breakdown been improved and included an information exchange between the woman and her midwife, their experiences and perceptions of trauma could have been lessened.

**Theme 3. I just had to force the baby to be born**

Each of the women felt pressured to have their babies quickly. This was either for the purpose of the midwives and obstetricians where women felt the staff were rushed, or for their own desire to have the experience over as quickly as possible in order to end the trauma.

*I just had to like force her to be born as soon as possible to make them all stop – Hilda*

Women felt staff were rushing, pressured and unavailable to support them. This placed counter pressure on women to feel they needed to birth quickly and were unable to proceed
naturally with their labours. This was defying the natural processes of labour and birth, forcing women to feel out of control and they could not push their bodies beyond their physical limitations:

> My impression of her [the midwife] was she was extremely rushed, trying to get somewhere... I thought she must have been ready to go home, we just felt she was in a big hurry – Alex

Further to this sense of urgency to birth women perceived a fetocentric model of care, whereby each woman felt she was less important or unimportant to midwives and obstetricians in comparison to her baby:

> I felt like Poppy was important and I was just a piece of meat, they were going to get the baby out one way or the other - Alex

Women felt their voices were unheard and were simply a vessel for which to get the baby out of:

> So it wasn’t really about me anymore - Bianca

As this was each woman’s first birth, they trusted the midwives’ expertise. However, women commonly reported feeling the midwives were misdirecting their instructions during labour, asking women to push when they were not feeling an urge to, or encouraging them to push too early.

> I just think she [the midwife] got me to do it (push) too early - Sonia

This resulted in women feeling disconnected to and distrustful of their midwives and obstetricians, confused and distrustful of their own bodies capacity to birth naturally, resulting in complications and exhaustion of the mother.

> I thought, ok well she’s saying it (to push) that must be the right thing to do, it wasn’t! Her instructions for me to push I think were wrong, when there was no reason - Sonia
Along with this misdirected pushing and sense of urgency women also felt they were coerced and pressured into procedures or drugs.

*The midwife came in and she was like – they kept offering me drugs every five minutes*  
– Sophie

The use of fear to persuade women to consent to procedures was also found throughout the interviews, whereby women experienced midwives and obstetricians using authoritarian language and attitudes that places women as victims, coercing them into consenting to interventions based on the premise of the ill safety of their unborn child:

*So she (doctor) threw me the – you know you’re going to put your baby at risk card, so we agreed to an induction* – Charlotte

This form of perceived coercion also left women feeling they had to deny their own instincts therefore their choices. Women felt forced to ‘obey’ midwives and obstetricians:

*It was really hard because my body was screaming that it was wrong but they kept telling me it was the only way to go and I had to do it for my baby and I know, they knew it was hard… you know, it was for the best interests of my child, and I was trying to suppress my own feeling about, this is just so wrong* - Sophie

Overall, the women’s experiences of feeling rushed, pressured and forced to give birth, led them to feeling they were incredibly unsupported and pressured to ‘perform’ instead of ‘birth’ their babies, therefore women further lost trust in midwives, doctors and the medical system. Feeling that this ‘system’ worked against them rather than for them:

*I was let down by the medical system* - Sonia

**Theme 4. I felt… traumatised, it was really horrific**

This section explores how women felt deeply traumatised by their birthing experiences. Women experienced feelings of shock and trauma during labour. These feelings sent women into survival strategies such as disembodiment or disassociation. On reflection and the
retelling of their birth stories, women often became distressed in sharing this information with the researcher.

Women experienced varying degrees of trauma, their perceptions and recall of their birthing experiences ranged from wishing they would die to feeling as though they were violently assaulted. Each woman expressed a disturbing degree of trauma and violence during labour, and each woman perceived this trauma to be partially due to the emotional abandonment of the midwives and obstetricians present at their labours.

Women felt strong sensations of anger during labour directed toward midwives and obstetricians:

\[ I \text{ feel angry and that the labour was badly managed – Sonia } \]
\[ I \text{ feel angry, like they should have known better – Sonia } \]

Terror, fear, and feeling tortured were also commonly heard terms throughout the interviews. With women feeling they were nullified as people and so heavily traumatized they were completely lost of all sense of humanness:

\[ I \text{ felt like I was butchered... tortured for a fair amount of it – Alex } \]

For some women they were in such shock, they let go completely of their birth plans and ideas. The trauma pushed them past their limitations:

\[ \text{By the end of it I didn’t really care about the baby. I was like whatever just grab a leg and rip it out, don’t care.... I was so traumatised I just didn’t really care – Bianca} \]

Questioning the birthing environment also became a prevalent consideration for women on reflection of their births. The women felt that the hospital was not the ideal environment or it housed unfriendly and unsupportive staff. For many of the women they felt home would have been a safer more preferential option. The trauma of the birthing environment and midwives and obstetricians impacted women greatly:
I do wish I had stayed home. there was no way for me to know how the staff were gonna be when I got in there - Hilda

Some of the women felt the birthing environment promoted an uneasy feeling, a feeling of unsafety and disturbance. When expressed they felt so strongly that:

The hospital was just the most horrible environment to be in. I wouldn’t wish it on my worst enemy – Sophie

The importance of the birthing environment also impacted women’s physiological processes for a safe place to birth. Darkness, privacy, some disorder in the room, size of the room all affect the production of hormones needed for uterine contractions (Fahy, 2008; Odent, 2002). Women commonly reported feeling the birth suite impacted them negatively:

Until we got inside I was still feeling I’ve got this under control... as soon as they got me on the bed and pulled up all the monitoring equipment I knew that was it. - Hilda

The negative effects of the hospital birthing environment were further impacted by the fractured relationships between midwives and obstetricians and women. In an ideal relationship between midwife and mother, a midwife would support a woman to feel more empowered and confident in her birthing capacity. However, for most of the women interviewed they reported feeling their sense of self and trust in their body’s capacity to give birth, was damaged by these poor midwife/ mother relationships, leading to heightened feelings of fear and distrust during the birthing process.

I stopped believing in myself and I think that... I started to become really scared because I thought if I can’t trust my body on this how can I trust my body to do anything – Sophie

Women also experienced feeling uninvolved in the decision making over her body and birth:
She didn’t explain any procedures... it added a whole other level of anger to my experience because she did know that information and she had the knowledge and chose to keep it to herself, which is kind of dismissive... I felt it would have made such a difference to my care if id had known... without the knowledge I can’t make informed decisions... there was none of that - Mary

Further to the perceived lack of support from midwives, women also experienced moments of abandonment and aloneness. Lack of rapport and connection to midwives and obstetricians enabled these feelings and women experienced directly the impact of not having staff present in the room for her:

I felt totally abandoned, I felt that... the requests that I had made were either ignored or dismissed, so I just, I felt I was just completely left to my own devices” Mary

I was pretty much ignored. Kept telling them I was in labor and they were like ‘oh no sweetie that’s just pre-labour, you’ve got no idea – Sophie

Some of the women interviewed felt they were verbally and physically assaulted by midwives and obstetricians during labour. This resulted in women feeling unsafe and afraid. Verbal abuse or language used by midwives and obstetricians also contributed to these feelings along with actual physical pushing or pulling of a woman’s body, her partner or her baby:

I got attacked in there (NICU) at three o’clock in the morning by midwives while I was coming to breastfeed – Sophie

Women throughout the interviews expressed a shared feeling of being meaningless and that their bodies were treated with very little respect. The degree of torment and trauma varied, however most women had an experience of feeling they were treated in a manner that was unexpected and abusive:
I was screaming like I was being murdered and I didn’t feel like anyone was aware of what was happening to me and I like started to black out every now and then, no one was communicating with me, I felt like I was abandoned, no one was caring for me... I felt like I was butchered... tortured for a fair amount of it – Alex

I felt out of control and stuff, like a lot of people do. I really felt like I was getting run over by a truck. You know how you see that in the movies. So incredibly painful and really basically like sitting there being, having petrol poured on you and getting set on fire and running around screaming and everyone’s just standing there and there’s nothing they can do – Bianca

Further to this, women felt objectified to a birthing machine, removing them from feeling an active participant, to feeling an object with no sense of importance for their own wellbeing or life:

_I was an inconvenience, because I was not progressing_ - Alex

For a few of the women they each reached a point where death was a preference over enduring any more of the trauma of birth. The women felt so completely out of control and in terror, pain and horror, women either believed death was imminent or they wished it upon themselves with conviction that it would be a better experience than to continue birthing. It can be seen from these statements the degree of fear and helplessness these women experienced:

_I got the point where I thought ‘if I die now that’s good_ – Mary

_I was just trying to like not pass out and die basically_ – Bianca

_I remember a really young anesthetist standing over my head, because I was saying to him, ‘I can’t feel my body, I’m dying, I’m going to die’ and I was giving him this message to give to my baby and he was... he was saying, you know you’re not going to die, just close your eyes and rest. You know that was really distressing, I remember_
being terrified and you know really feeling as though I was not going to survive – Charlotte

These traumas were not only momentary, women expressed long term impacts both physically and emotionally and described the extent and seriousness to which the trauma is experienced and felt by women:

I felt abandoned and traumatised... it was horrific. It was the absolute worst, the singular worst experience of my life. Ill carry that forever, even though I’ve dealt with it, that will always be his birth...I’ve always explained it like as I felt like I’d been gang raped, I felt like a truck had been driven through my vagina... no one cared – Mary

Women felt they were so depleted of power and control or energy that they were agreeing to procedures they ideally did not want:

At that point I was so exhausted. Like, I just didn’t have anything left in me. I just wanted it to be over with, so I agreed – Sonia

I was in, you know, no position at that time to – you know I just said I don’t care – Charlotte

The effects of traumatic childbirth were not only exclusively felt by the woman giving birth. This extended to the woman’s entire family and support team/ network, who were also affected by the impact of birth and any associated trauma. Partners, birth support people and even staff were reported as showing signs of trauma throughout the interviews.

Women interviewed explained to the researcher that they felt their entire birth team were also traumatised:
Everybody in the room was traumatised, my support people were pretty traumatised too - Bianca

Women expressed how when their families were also traumatised it rendered them incapable of supporting them, therefore furthering their feelings of abandonment:

he (husband) was freaking out and so like, my mother went, apparently she went and had a big cry in the waiting room – Bianca

They didn’t know how to support me. So basically they just sat there and went Arrgghh – Alex

The long term effects of birth trauma also heavily impacted women’s families:

it had such a huge impact on me, (and then extend, you know), through to, through to my family, to my son, and it, all of it was so easily remedied – Mary

everybody was like so stressed out and all freaking out and stuff, because it was really quite hard for everybody there – Alex

Theme 5 I know that is just what the system is like... they're hospital midwives…they're medical

In an ideal relationship between women and midwives, midwives are seen as supportive and caring partners in the birthing process (Page & McCandish, 2006). Birthing partners know this woman and her family, and have an innate understanding of how this woman wants to birth and what her strengths and weaknesses are. However, in the commonly accessed public birthing services in Victoria, women are often confronted with an unknown midwife in the middle of labour, a stranger to her and her family. It is purely luck if they have a connection
or rapport, with the attitudes of the midwife impacting greatly upon the woman and how she will go on to labour and birth her baby.

Throughout the interviews women expressed how the midwives they were working with were not only unknown to them but radically different to how they had perceived midwives to be. Women felt midwives were more attuned to following protocol and policy rather than working with them in a partnership that these midwives were also lacking in midwifery skills, confidence and authority inside the hospital. This left women disheartened and somewhat complacent about their treatment inside the hospital by midwives:

*I know that is just what the system is like... they’re hospital midwives... they’re medical, they don’t make the decisions themselves they just look to the Dr.* - Sonia

Women also felt often let down and unsupported by midwives, not listened to, dismissed and ignored. Demonstrated as:

*I said to her “I’m going to need pain relief, this is more than I can cope with already” and she was just very dismissive... she was just doing her paperwork* – Mary

*I was asking for help and my body just took over, I couldn’t control me screaming or not screaming it wasn’t a choice. I had a midwife come in and tell me basically I was wasting energy which is completely incorrect... that’s not the support you need in that moment* – Alex

*Not being listened to made me feel very much that they didn’t care so much about me as getting this over and done with... I actually ended up screaming at one of the nurses (midwives)... screaming at her to back off and she had to like look around the room at everyone else... then after getting a few nods from them backed off, so yeah, even she wouldn’t listen to me* - Hilda

Trusting midwives to tell women the truth and keeping women informed was an area women felt let down in. Regardless of the scenario, universally throughout the study women felt that
Midwives did not take them seriously and often acted in a manner that dismissed a woman’s ‘knowing’ of where she was at in her labour and what she needed. One woman experienced this directly in the manner of being denied she was even in labour at all and was having panadeine forte™ offered as pain relief for this incorrect assessment:

Absolutely not, this is not labour” and I took the panadeine forte... and about 10 minutes later I was in the bathroom like I wanted to shit out a watermelon... I was already nine centimeters dilated - Sophie

Women experienced midwives to be verbally abusive, coercive and controlling, destroying any faith the women had in their midwives:

They yelled at me for refusing to take sleeping pills... they were quite aggressive about it... I got really worried about what it was going to be like for the rest of my birth... She actually yelled at me, grabbed my baby and said ‘how can you be torturing this baby in the freezing cold like this, you know. You young mothers, you have no idea what your doing – Sophie

I went from I’ve got this handled to your all making me do what you want and not letting me comfortable or anything...I felt like she was the one in authority, it certainly didn’t feel like she was trying to partnership with me to have my baby. It felt like she was telling me what to do, but even literally just pushing me around – Hilda

Midwives should be educated in normal physiological birth, trusting in women’s capacity to birth and managing a labour for a normal healthy mother and baby (Page & McCandish, 2006). Using movement, positions and non-pharmaceutical pain relief options were common expectations women had that their midwives would be experts in. Women also expected that their midwives would keep them informed of what was happening during labour with their progress and the health of their babies. This expectation was often unmet, creating distrust and feelings of betrayal for women toward their midwives:
Nobody was kind of saying you know we’re kind of looking at it from a physiological kind of way, let’s try and do some massage or what about we do this... all of that would have been helpful. Either the midwife didn’t know or didn’t say, she didn’t seem to have any of the skills to support a natural birth – Bianca

Some of the women perceived a power hierarchy between midwives and obstetricians, feeling the midwives were not capable of supporting them or advocating for them. This ultimately led to a huge fracture in the relationship between women and their midwives and a sense of power asymmetry that confronted their ideas about hospital intentions and how capable they were in supporting this mother:

* I felt as though they (midwives) had to stand back when the obstetricians entered the room... it felt like they couldn’t say anything... I didn’t always trust them, that they would stand up for me... or stand up for what they felt was right or what they felt that I thought was right to the doctors... – Charlotte

For many of the women they were left with long-term ramifications from certain procedures or interventions that were used or performed during labour. Women also perceived that staff were treating them in manner that was meaningless to the staff, whereby staff would perform certain interventions that may lead to long term trauma for the women but were meaningless to the midwife:

* It’s all fine for them, they just give you and episiotomy, get the baby out, stitch you up and go home – Sonia

The impact this medicalised model of midwifery had on women often left them feeling deeply betrayed with changed perceptions of hospital midwives that meant each woman would not birth at the same hospital again. Midwives, for these women, went from being perceived as a supportive birth partner to someone to fear, loath, resent and distrust:

* Yeah she was the worst I hated her... I hated the midwives, I think it really poisoned me against midwives – Sophie
I can honestly say after the birth I hated her (midwife). I absolutely hated her, I wished terrible things upon her. I raged internally about what an awful human being she was. I was just shocked that somebody who could be in such a caring profession could be so at odds with that in her, her manner - Alex

Women felt staff let them down in their duty of care for the mother. That midwives and obstetricians were not reliable and safe but rather completely unavailable for them resulting in feeling that midwives and obstetricians were not there or present for the woman but rather simply doing their day to day job with no emotional investment in the laboring woman or her baby:

It felt to me that the midwife thought, well the babies coming anyway, I don’t really have to do anything - Alex

I didn’t need some crazy, expensive piece of metal medical equipment that wasn’t available. I didn’t need some magic thing that’s really hard. All I needed was really, compassion and to be cared for and for somebody to show me empathy and love and you know, be present for me and care for me, and give me the support when I needed it. That was all. And that would have made my whole experience different – Mary

Many of the women interviewed felt certain procedures done by obstetricians were overtly painful and unnecessarily invasive. These procedures had been previously done by midwives with no pain, however women identified when done by obstetricians there was often a sense of urgency and lack of compassion that meant these procedures were often more painful:

This man that I’d never laid eyes on before is elbow deep and I’m like ‘holy rap balls, oh okay, yeah, wow – Sophie

So in walks Doctor Spikey fingers (we named him) – Charlotte
Women developed a loss of trust in midwives and obstetricians, based on the communication or lack of, actions and choices made by midwives and obstetricians that did not align with women’s wishes or values. Women felt staff did not have their best interests in heart, rather following daily working practices that may not apply to them:

As soon as we got inside they laid me down on a bed on my back, would not let me move, had a midwife holding each leg up in the air and had several other midwives checking on mine and my babies’ vitals... including one who was pressing the little disc thing they use to get the babies heartbeat right into me and actually stopping me from moving - Hilda

Women felt through the lack of relationship with midwives and observation of power asymmetries between midwives and obstetricians that their midwives would not protect them during adversity during labor. They wished for their midwives to be a ‘voice’ for them and advocate for them if needed but often felt they would not trust their midwives to protect them during any adverse events:

I knew the hospital midwives would make things worse – Sonia

Women also feared midwives would make things more difficult for them both during labour and postnatally:

I thought, if they (midwives) thought I had postnatal depression they’d just make my life hard. Like they might put me on a care plan or blah, blah, or get more involved. I didn’t want them to put me on a list of like risk mothers or something – Bianca

Some women experienced midwives and obstetricians speaking negatively toward them or using language that disempowered women leaving them feeling vulnerable and powerless. Some women experienced midwives and obstetricians raising their voices and yelling at them if they did not passively agree to their requests:
I was told that I needed to be quiet by a senior midwife, she just kinda bowled in pushed my partner out of the way and got in my face, just turned down the gas, took it off me and said ‘this is too high’ and told me I was wasting my energy, I did not feel safe at all – Alex

Women also found midwives often made poor suggestion of positions to use in labour if they made any at all. Women reported midwives not offering position changes that would create optimal birthing space for the position of their babies, and on reflection of their births and reading their birthing notes, realised that midwives and obstetricians did not support them in this physiological element of birth:

Why didn’t somebody say well, look, obviously you need to lie on, like do the side lying release? That was obviously what needed to happen. But then there was nobody there to support me to do that. Nobody, the midwife either didn’t know or didn’t say. She didn’t seem to have any of the skills that support a natural birth – Bianca

This developed into feeling controlled by the midwives poorly timed or misdirected suggestions:

It (changing positions) was really ridiculous. I was like, I can’t believe your making me do this – Bianca

Women also knew inherently the type of support they did need from midwives but each felt they did not receive it:

I felt like if id had more actual support, not just somebody standing on the other side of the bed yelling out something to me, but somebody actually coming in and being part of it and working that through with me, that would have been really, really helpful - Bianca

The presence of unknown people in the birthing room was also common among the women. With teams of midwives and obstetricians both not known and not introduced to the mother
making their presence from time to time during the labour. With these unknown midwives and obstetrician visits, came feelings of authority and insult to women as the staff continued to talk about the mother as if she was not in the room with them:

_The team came in and had a conversation standing around my bed, and I remember this really vividly because it was - yeah, it just seemed ridiculous to me and then the chief obstetrician said 'your just not pushing hard enough – Charlotte_

Further to these teams of midwives and obstetricians entering the room unannounced, there was a tendency for them to act in an authoritarian manner that dismissed and denied women’s choices and preferences for procedures:

_I would rather have an episiotomy than a tear, and they said “we don’t do episiotomies” and that was it, the obviously didn’t read that or listen to that - Alex_

_She (doctor) had a look at my perineum and said she thought an episiotomy would be a good idea. I’d said in my birth plan I didn’t want an episiotomy - Sonia_

Some of the participants felt their opinions or views were not only dismissed but they were also disrespected by midwives and obstetricians. These staff were not enquiring about the women’s views or wishes and were completely dismissive of birth plans. The mothers’ verbal statements during labour resulting in women’s feelings of disrespect:

_I was being advised on what to do by people who didn’t really have similar views on these things to me. Like, you know, they follow their policies and that was it – Sophie_

The experiences each woman had of midwives during their traumatic births left them deeply tainted toward any other hospital employed midwife in the future. This level of betrayal was heightened by the feeling that the midwives and obstetricians cared more about their job security than the woman or her baby. Each woman expressed differences in their perceptions of hospital practicing and private practicing midwives, with a post birth perception that they
would not be safe in the hands of any midwives or obstetricians who practice within hospital institutions.

**Theme 6. I didn't feel connected to them**

A woman needs to feel whoever is present in the birthing room is not ‘observing’ her or acting in manner that places them in control if she is to birth easily without interference of her natural processes. Following on from the changed perceptions of midwives’ women had during their interviews, women also emphasised how their midwife was unknown to them until they met during labour. For a number of reasons including not knowing the individual midwife, most women felt disconnected to their midwives:

*I never really made a connection with the new midwife... I didn't really see her... all I could do was hear her voice. She never kind of came into my sphere of what was happening, she was always outside – Bianca*

*I didn't feel connected to them. I didn't feel like they knew me or understood me - Charlotte*

*Straight away there was no rapport, there was no connection... there was no trust... I guess because I’d never met her before and she just wasn’t particularly my sort of person...it wasn’t even a professional relationship. There was no courtesy or respect - Mary*

Midwives each have a different idea of how to best support a woman, and each woman has a different need for how they want to be cared for during labour. Often this cannot be known until labour is commencing. However, within this model of care provided throughout public maternity hospitals in Victoria, midwives are required to work with women to support them in feeling empowered and capable. Women most commonly did not feel any support and referenced feeling isolated, alone and unsupported:

*At no point had she been in any way reassuring, she basically left me to my own devices, and I was becoming increasingly panic stricken – Mary*
So I felt like I was abandoned... just abandoned me when I was really asking for help – Alex

I felt very alone. With all the people in the room it didn’t feel like they were helping me at all, and I didn’t expect them to be able to take it away or to help me but it felt like if they weren’t there it wouldn’t have made a difference – Bianca

Power dynamics and distorted asymmetries were evident throughout the interviews with women expressing how they felt their midwives were in control of the women’s experiences and their bodies. Women felt the birth was often more about the midwife in control than the woman herself:

She held all the power and I was in such, you know at my most vulnerable... I had been totally open, totally laid bare and laid raw, and she hadn’t done anything to help me – Mary

While women had initially expected to feel safe with their midwives, most women expected to feel disconnected to obstetricians:

I had in my mind a wariness of Doctors. I wasn’t really interested in anything she had to say... the Dr. she was the evil one who’s going to try to have interventions that were going to spiral out of control, it was like a giant medical conspiracy - Bianca

Further to this pre conceived expectation of disconnection with women’s doctors, most of the women reported the doctors did actually enable negative feelings for women:

The Doctor made me feel anxious, uptight, and like I couldn’t you know, like I wasn’t good enough, like I wasn’t doing enough, and yeah, unsupported and like bossed around and told what to do – Charlotte
Theme 7. She stood up for me/ I felt powerful

In contrast, two women reported feeling connected to, and supported by their midwives. This enabled these two women to feel safe, supported, and trusting in the options their midwives were advising them of:

*The midwives generally made me feel supported and calm and confident in my abilities... I had 4 different changes of midwives... but they were all lovely and really supportive She stood up for me*” - Charlotte

The importance of human touch, connection and empathy shown by staff in the birthing suite had a powerful and positive effect on these two women:

*I’ll always remember she stroked my arm and that was the first time anyone had shown me any comfort. And I remember, and she said “You’re okay”, and I remember thinking why are you the first person to have done this? It’s nearly over and you’re the first person to have shown any compassion* – Mary

Simple acts of physicality, movement and gentle reassuring techniques left a positive imprint on the relationship between these mothers and their midwives:

*The midwife was really good. She didn’t necessarily do much, but she would come and squat down to my level next to me. So she was right down on the same level and she wasn’t kind of like a voice coming from outside, she’d almost come into my zone and then touch base with me so I could be aware she was there. I really appreciated that* – Bianca

The importance of these women’s experiences show how midwives can work with women. Amidst the trauma, these women still remember having positive connections to and working relationships with midwives, describing how a positive midwife-mother partnership can be.
In contrast to the women experiencing trauma, each woman felt a moment of self-determination, a moment of power in which they felt they could state what they wanted and create clear boundaries between themselves and the midwives and obstetricians. This moment gave each woman a sense of purpose and importance and showed the absolute resilience of women and their capacity to be strong during extreme adversities and fear:

I yelled at them basically and said “you know, how hard would you push while you had 10 people staring, standing around staring at your vagina!” - Charlotte

Either you discharge me now or I’m taking this baby home! – Sophie

Theme 8. After the birth, just horrible/ Your stuck with the consequences

The expectation that birth trauma includes only birth itself has been misleading. From these interviews women reported post birth to also be a time of torment and trauma. The implications of trauma varied between women but commonly included the results of continuing intervention and physical limitations due to these:

That first night I couldn’t get up because of my legs being still numb and I had a catheter in... it felt like for the first 12 hours I had to keep asking the staff to pass me my baby... I felt quite disconnected... I didn’t change her first nappy, I didn’t put her first clothes on... and the midwife who was working that night didn’t offer. I could have done those things... it wasn’t until some time after that I realized id missed out on those really big first type things - Charlotte

Many of the women interviewed felt they missed out on time to bond with their babies post birth. This was either due to trauma, hospital policy that removed partners or overwhelming feelings of shock post birth. Some women took a long time to bond with their babies in the postnatal period as a result of the trauma while others made up for their lost bonding time by creating a safe place at home with their families:
I wanted to have bonding time after the birth, but yeah, that didn’t really happen, I didn’t feel like I had enough time to sort of bond as a new family, it was maybe 5 or 10 minutes of quiet time and then my husband had to leave, hospital policy – Sophie

That was the worst part for me, because of everything that went on, when my baby was born, I didn’t get the oxytocin rush. It ruined everything. Because then I didn’t bond with my baby. That (bonding) was one of things I was looking for the most. For that moment. So when I didn’t get it it was like, yeah, I’m stuck with it (baby) – Bianca

The experience of being in a hospital left a negative impact on women that on reflection on their birth stories, the women in this study felt was a large contributing factor to their trauma:

The hospital was just the most horrible environment to be in. I wouldn’t wish it on my worst enemy. I was actually starting to feel my milk supply dwindle because I was in this horrible stressful environment... I just needed to be at home with stability – Sophie

The impact of the hospital left women feeling scared to return and distrustful of any postnatal services the hospital provided:

I was terrified to go back to hospital, so had to lie to midwives so we didn’t go back to the hospital – Alex

Women were left feeling traumatised and shocked post birth. Their birth not only did not go as planned it left them feeling deeply traumatised and impacted in their daily lives. Many of the women recall not remembering their babies during this time, how they functioned daily or how they felt about their births:

I was so bewildered by what had happened, I was very confused... the first two months I don’t remember a lot of it – Alex
The degree of trauma women experienced also had significant impact not only on the women but also their families. Relationships between mother and child, mother and partner and surrounding family were all affected by the woman’s traumatic birth:

*I think I spent probably the first two weeks just feeling as though id survived some sort of battle... I think shell shocked, I honestly felt shell shocked...It has a hugely negative impact on me, and then extend through to my family, to my son, and all of it was so easily remedied - Mary*

The longer term impacts of this kind of traumatic birth are evident throughout the interviews. It can be clearly seen the devastating effects on women postnatally and how these experiences also affected their children and partners. Women were left with memories that meant birth equated to deep trauma, fear, pain and suffering:

*It (birth) was horrific. It was the absolute worst, the singular, like worst, experience of my life. And ill carry that forever, even though I’ve dealt with it, that will always be his birth – Mary*

Women’s mental states were affected not only immediately post-partum while in hospital, but also once they went home and had the difficult task of integrating back into daily life. The internal questioning along with the women’s expectations that these feelings were normal, often left these women feeling even more under resourced in their capacities in managing day to day life, understanding their births and bonding with the new babies.

**Theme 9. I deserve a better birth**

This section looks at women’s future plans or ideologies for any planned pregnancies and births. Each woman said they would under no circumstances attend the same hospital they had given birth in. Women’s future plans varied. One mother’s future plans included wanting a private obstetrician to enable the woman to feel completely in control of her birth with a
planned caesarean. Another mother feeling she was so traumatised and let down by the medical system she will never have another child. The devastating impact of trauma could be easily seen in each woman’s response to their future family plans.

Four of the women stated they would go on to have a homebirth with a private practicing midwife with whom they could build a relationship with based on respect, communication and care, a trusting professional relationship where their midwife would become part of her family for the course of her pregnancy, birth and postnatal period. The emphasis for this choice was placed on the type of relationship they wanted with their midwives in the future, a caring and supportive team for her to give birth in an environment where the women felt safe, that is at home. Each woman felt the cost was irrelevant in the purpose of creating safety and trust with their midwives or doula’s. Although none felt they could afford it financially, they all stated it was not optional to go through the public system in the future and would do whatever it took to pay for a private midwife or doula, and have the birth they want:

*I would definitely be saving up for a doula and if it was low risk birth again I would probably stay at home* – Hilda

*My plan is to get into the home thing here so I can get a midwife to come out* – Bianca

*A midwife that cared for me throughout my pregnancy and birth and postnatally as well* – Charlotte

*Homebirth, I deserve a better birth* – Mary

*Continuity of care... my doctor right through the pregnancy* - Sophie

*I would like to have a homebirth with my private midwife* - Sonia

Birth trauma affected women differently; however, each woman felt a deep impact that affected her bond with her baby, her relationship with her partner and most importantly her sense of self. The experience of the trauma affected women daily in many ways, strong
feelings of anger, regret, confusion and devastation were predominant for the women in this study:

Afterwards my husband was freaking out... my mother went and had a bit cry in the waiting room... she was so upset... for both of them to sit there and watch me go through all that... they didn’t know what to do - Bianca

I was having flashbacks I was constantly reliving the birth... I just couldn’t let it all go... I wasn’t sleeping. I was angry 80% of the time - Mary

I would never ever do that again, I wouldn’t wish it upon my worst enemy – Bianca

I was so devastated how I let that happen to myself, I should have said no, I do blame myself – Alex

For some of the women, when reflecting on the birth in the postnatal period, even though they had felt disempowered during labour and unable to make choices, they blamed themselves for the adverse outcomes of birth. Women felt they were responsible for any events and this spiraled into regret and anger:

Angry, disappointed, let down, frustrated with myself that I didn’t prepare better, doing more research, yeah but mostly I know that I was let down by a medical system and that’s not my fault – Sonia

I had an afternoon when I just broke down into tears and I said to (partner), I consented for them to cut me and I don’t know how I managed to say yes to that, I don’t remember, because in my birth plan I would clearly, clearly say no, like utterly clearly refuse to. I was so devastated how I managed to, like, how I let that happen to myself, I should have said no, I do blame myself because I’ve had a horrendous recovery – Alex
Women identified during the interview that they had participated in various healing modalities to help come to terms with their birthing experiences. This included various types of counselling, psychology and other healing modalities to come to terms with their birthing experiences. One woman was so severely traumatised she will not have any more children, she felt she simply could not survive another experience like her traumatic birth. Some of the women went on to develop complex post-traumatic stress disorder requiring long term systemic support while others went on to feel they had emotionally healed from this experience but would forever remember it as a life changing trauma.

Summary

This chapter presents the findings of the analysis, by the researcher and supervisors. It is clear from the interviews and analysis of data that women felt deeply distraught, traumatised and experienced what they felt was irreparable damage based on the interactions between themselves and their midwives and obstetricians during labour and birth. The key finding being communication breakdown or fractured relationships between midwives and obstetricians and pregnant mothers, and midwives not being midwives. There was a great deal of testimonies to suffering in birthing experiences with some of the women feeling they “may die during the birthing process”. Words such as “butchered” “tortured” “raped” and “complete loss of self-identity” emerged as descriptions of women’s birthing experiences, while, most interestingly, in contrast, every woman interviewed at some stage displayed a strong sense of self-determination and courage to continue through the trauma and fight for their self-preservation.
Chapter 6 Discussion

Introduction

This chapter provides an overview of the key findings from the data. These findings were explored in terms of the literature in order to gain new insights into this area. The insights are categorised into those that confirm existing knowledge, those that build on existing knowledge and also where this reveals new knowledge in this area. The fundamental aim of this study was to uncover social phenomena and behaviours between women, their midwives and obstetricians, and how women’s experiences of birth can be improved.

Research objectives

The objective of this study was to explore within the context of Victorian maternity settings, women’s meaning of and nature of a perceived trauma, explore women’s beliefs surrounding a perceived birth trauma event, explore women’s capacity to express agency during childbirth, explore women’s perceptions of health care barriers and health enablers to her birthing process, and to form recommendations for minimising the risk of birth trauma through women centred birth protocols in maternity suites.

Summary of findings

From the analysis of the data from the seven participants the following themes were revealed. The main points are summarised.

I was determined to give birth (Theme 1), found that women want positive natural birthing experiences and do prepare themselves very well with readings, research and attending antenatal classes.

Not telling me what they are doing (Theme 2), found failure to ask consent, enquire upon women’s wishes or birth plans, provide adequate information and that women felt they were uniformed and underprepared for their birthing experiences.

I just had to force the baby to be born (Theme 3), found women felt pressured to birth quickly, perceived a fetocentric model of care, and that coercion and manipulation were frequently used tactics by midwives and obstetricians.

I felt traumatised it was really horrific (Theme 4), describes how women felt staff were disinterested in the mother therefore enabling feelings of distrust and unsafety,
there was significant evidence supporting the reasons for the fractured relationship between women and their midwives and obstetricians. *I know that is the just what the system is like... they’re hospital midwives... they’re medical* (Theme 5), found power asymmetries, authoritarian approaches by midwives and obstetricians, over medicalisation of birth, a fetocentric social hegemony and that midwives were not acting as midwives. *I didn’t feel connected to them* (Theme 6), found the main cause of the perception of birth as traumatic is the fractured relationships between midwives, obstetricians and the mothers. That this perception is in fact a direct result of the actions or inactions of midwives and obstetricians. *She stood up for me/ I felt powerful* (Theme 7), found how well supported women have a significantly reduced perception of birth as traumatic regardless of the actual birthing event or outcome. *After the birth just horrible* (Theme 8), found that perceptions of trauma for women were not only formed during labour but also in the immediate post-partum period. That elements such as environment, staff attitudes and communication toward women all impacted negatively upon women. That a lack of postnatal support deepened feelings of trauma and the extent of the trauma was experienced directly in immediate family members as well as the mother. *I deserve a better birth* (Theme 9), found that women were so severely traumatised by birth that some women will not have another child.

The following part of this chapter will go on to discuss these themes with current literature.

**Theme 1. I was determined to birth naturally, but…**

This theme describes women’s desire to birth naturally, without intervention or use of drugs during labour. Women expressed the importance of initially wishing for a natural labour. Most of the women had done a lot of pre labour reading and preparation on how to best support themselves for a natural birth. In addition, each woman had written a birth plan outlining their preferences to support their wishes. The interesting point in this theme was the intensity of the desire to achieve a natural birth. Such was the intensity to birth naturally, that for some women, this actually impeded on their ability to adapt to changes as they were occurring. In other words, women were so fixed on the idea of a natural birth that they could not adapt progressively with the unexpected changes that occurred during childbirth. Women
reported feeling that this fixed idea of a natural birth had the potential for impacting their perception of trauma.

So while all of the women had these ideals about how they wanted their births to be, they were also realistic that things might not go to plan. The women felt at the time that they were prepared for that. However, on reflection women reported feeling very underprepared for any adversity during labour. The women found their prenatal classes and readings just did not cover enough to prepare them for any complex events or how to manage these experiences.

Since the early 1960s in Australia and UK, consumer organisations, women’s groups and health professionals were concerned that maternity services neglected important emotional and social aspects of childbirth (Brodie, 2002; Jones, 2005; Lane, 2002). Women wanted change, women wanted more personalised care from their midwives, they wanted to experience birth as naturally as possible and they wanted hospitals to support them to do this. There was a call from childbirth advocacy groups for the acknowledgement of the childbearing experience as a normal event (Battersby & Thomson, 1997). This resulted in a number of maternity services inquiries at both jurisdiction (Lumley, 1990; Michael, 1990; Shearman, 1989) and national levels in Australia (Robinson, 1996) and more recently (Bryant, 2009). These inquiries provided an opportunity to evaluate existing services and make recommendations for improvement in the areas of women centred care and physiological childbirth (Jones, 2005).

However, the findings from this study indicated that once again, these changes have not been fully implemented into clinical practice. Women included in this study commonly reported how they felt let down by the maternity services system to have a natural birth and be supported once any slight variation interfered with a normal physiological labour. In addition, the midwives were not supporting women to work with their bodies for optimal fetal positioning (Sutton & Scott, 1996) or offered non-pharmaceutical pain relieving options (Marshall & Raynor, 2014). Women felt midwives were not skilled in supporting women to have a natural vaginal birth and were more interested in ensuring they practiced under the authority of obstetricians and hospital policy. This is supported in the literature that identifies that some midwives prefer a traditional mentality and shielded themselves behind
obstetricians (Jones, 2005). This choice often resulted from a lack of confidence that occurred in midwives as a consequence of former professional conflicts with obstetricians (Cochrane, 1995). A further issue identified by Waldenstrom (1996) is that midwives are too dependent on obstetricians for managing childbirth care, even when the process was normal. Midwives’ perception of childbirth could be distorted when faced with obstetric catastrophe (Fenwick, 1995). The midwife then seeks consolation in the hospital safety net and her role as an obstetric handmaiden (Jones, 2005). It would appear from the results from this study, that this is unfortunately still the case.

Women prepared themselves for their desired natural birth by doing a lot of pre reading and attending hospital run and independently run childbirth preparation classes. Past research and knowledge indicates that women who have access to wider ranges of knowledge can negotiate, contest and resist medical control reducing the likelihood of trauma perceptions (Lorentzen, 2008; Davis-Floyd, 1992). However, this study’s findings show that the access to knowledge did not support women in negotiating, contesting or resisting medical control. These findings contest the knowledge by showing that women were still rendered voiceless and felt massively unprepared for the adversities that arose during their labours regardless of the large amount of prenatal readings and education they had received and sought out.

This theme also explored how reading materials and antenatal classes provided to women during pregnancy did not prepare them for the type of birth experiences they had. Women included in this study felt their hospital run childbirth preparations classes did not adequately prepare them for birth or how to cope with changes to their birthing plans. Women reported feeling overwhelmed and lost, unprepared and under resourced for anything outside of ‘normal’ ‘natural’ childbirth. There has been a number of studies that have identified that antenatal classes do not adequately prepare women for childbirth, including effect on pain relief or childbirth outcomes (Lumley & Brown, 1993; Svensson, Barclay & Cooke, 2009; McCourt, 2006; Murphy Tighe, 2010). This finding of public hospital antenatal preparation classes underpreparing women for vaginal birth with unexpected changes without providing them with the flexibility to adapt is a new finding/ contribution the midwifery literature.
The key aspect of this study’s findings is that women are not feeling that they were prepared to go with the changes that occurred during labour. In other words, that antenatal education did not adequately prepare them for the diversity and resilience needed during anything outside of ‘normal’ during labour and birth. These findings lead to the recommendation that the content in childbirth education classes be reviewed to include more on diversity in labour and birth and resilience techniques such as mindfulness techniques, which involve the use of breath and mindful meditation practices. These mindfulness practices have been found to improve women’s feelings of empowerment and sense of control during childbirth (Byrne, Hauck, Fisher, Bayes, & Schutze. 2014).

Theme 2. Not telling me what they were doing

This theme explores women’s experiences of having their requests for information denied or dismissed, given misleading information or being ignored. Women reported feeling decisions about their bodies and their babies were being made without their consent or even given information about what was being done to them. Furthermore, women reported midwives and obstetricians commonly did not request permission from mothers to perform medical interventions such as episiotomy’s, intravenous cannulation, vaginal examinations and emergency procedures. Women also reported feeling these procedures were not explained to them, nor were they given options for alternatives to these procedures. In addition, the women felt that the midwives and obstetricians acted in an authoritarian manner and would use certain language to support this.

There already exists a plethora of evidence that shows how midwives and obstetricians do not seek out informed consent for procedures during labour while ignoring women’s opinions or requests and subjecting women to authoritarian decision making about her body or baby (Swahnberg, et al. 2006; Thomson & Downe, 2008; Filc, 2006; Bergstrom, et al. 1992; D’Oliveira, et al. 2002; Harris & Ayers, 2012; Davis-Floyd & Sargent, 1997). This theme is explored in D’Oliveira et al. (2002) literature review with reports of “Violence against health care users can occur when medical or nursing authority is threatened, or perceived as being threatened. As Harris and Ayers (2012) pointed out in their cross-sectional internet survey of 699 women, “interpersonal difficulties were the strongest predictor of PTSD, with over four times increased risk, interpersonal events were mostly concerned with lack of support (e.g.
being ignored, feeling unsupported or abandoned). In this situation, violence is used in an attempt to restore hierarchy and ensure obedience” and “documented frequent and repeated disrespect and abuse of women by health-service staff” (D’Oliveira et al. 2002, p 359). Thomson and Downe (2008) go on to describe in their study “the findings revealed that women felt violated and powerless. Participants considered that they were dominated by health care professionals and that their own knowledge and expectations were dismissed and minimised” (Thomson & Downe, 2008, p 108). The findings from this study regarding midwives and obstetricians not seeking informed consent and women experiencing this authoritarian decision making over them, therefore, contributes to already existing knowledge in this field.

Current knowledge indicates that women are generally not well-informed by midwives and obstetricians during labour (Harris & Ayers, 2012). The women in this study reported feeling important information about their bodies, their babies, the progress of their labour and what was happening to them, was withheld from them intentionally by the midwives and obstetricians. The women felt had they known that information things would have been dramatically different for them. This was because they could have worked with their bodies in a different way that might have meant it helped with the childbirth process. Furthermore, women felt by this not sharing of information, women’s choices were therefore denied and that their autonomy was taken away leaving them feeling powerless. Some women actively sought out information during their labours only to feel their requests were denied, or they were given misleading information that was not an accurate or true representative of what was happening to themselves and their babies. The women could sense the information given to them by midwives and obstetricians during these requests was inaccurate or misleading with a perceived purpose of ‘calming’ the women during moments of distress. This type of manipulation meant women felt distrustful toward midwives and obstetricians thus deepening their feelings of risk of harm and trauma.

Knowledge shows how women who experience caesareans and other emergencies in labour are often not treated as individuals, are ignored and subject to authoritarian decision making in the birth suite, subject to manipulation and coercion by midwives and obstetricians (Swahnberg, et al. 2006; D’Oliveira, et al. 2002). This knowledge also shows how women are
denied information, ignored and dismissed, and how these elements of treatment by midwives and obstetricians contribute significantly to perceptions of birth trauma and resultant PTSD (Harris & Ayers, 2012; Thomson & Downe, 2008; Swahnberg, et al. 2007; Goer, 2010; Boorman, et al. 2014; Fernandez, 2013; Hodges, 2009). Therefore, the findings from this study add to existing knowledge of how women not knowing information impacts negatively on their perceptions of birth trauma and resultant feelings and PTSD.

However, the findings from this study also highlight new knowledge in that these experiences for women of being ignored and having information withheld from them, is not as a direct result of an emergency occurring during labour. It is expected that during an emergency midwives and obstetricians may need to focus on the tasks at-hand more than communication with the expectant mother (Marshall & Raynor, 2014). These findings indicate that in fact women who are having vaginal births are still having information withheld from them that impact on their perceptions of birth as negative and traumatic. These findings show how midwives and obstetricians perceive birth in an authoritarian manner that places women as disempowered and their voices unheard. This is a significant new finding to the contributing knowledge of birth trauma and highlights the need for midwives and obstetricians to develop better communication skills with women during any labour.

These findings lead to the recommendation of midwives and obstetricians receiving education emphasising the importance of informing women on what is happening during labour and birth and what informed consent is. This could be achieved through in-services, education modules, clinical checklists for ensuring information is given, conference presentations of this study’s findings, published journal articles and input into midwifery and obstetrician curriculum that emphasises the importance of keeping women informed during labour.

**Theme 3. I just had to force the baby to be born**

This theme explores where the women perceived a sense of urgency to birth their babies, regardless of what was happening. Despite the fact that things were progressing normally, the women felt the staff still came in with a sense of urgency and emergency. Women felt this pressure as a direct result of staff attitudes and mannerisms in the birthing room. This
consequently put pressure on women to birth their babies very quickly. Some of the women felt this pressure because they just wanted the experience to be over; the trauma of what they were experiencing was so severe. This sense of pressure and force furthered the women’s distrust of the midwives and obstetricians who were present.

Women went into hospital with a perception that staff would treat them with care and sensitivity that their wishes would be respected and they would work together as a team to birth their babies. What women found instead was a hospital policy and protocol driven hierarchy that left women at the bottom of the ladder of importance. In support of the literature women perceived a power asymmetry and hierarchy that left women expected to comply with authoritarian hospital culture and trusting of midwives and obstetricians regardless of their behaviour toward them during labour (Bryant, 2009; Hodges, 2009). This power asymmetry resulted in coercion and manipulation of women during labour to use certain medications for pain relief, or interventions. This then influenced women’s decision making by using fear for their own safety or that of her baby. Women felt these elements of coercion and manipulation by midwives and obstetricians added to the intensity of pressure to birth their babies quickly. Existing knowledge shows midwives and obstetricians use coercion and manipulation to render women submissive to the hospitals policy driven needs rather than a woman centred approach (Filc, 2006; Hodges, 2009).

Further to this, current knowledge shows how midwives and especially obstetricians commonly perceive birth as a time of danger and risk that requires intervention, medical control and monitoring giving rise to power structures that further disempower women in their birthing experiences (Kitzinger, 2012; Parry, 2006). Women in this study reported repeatedly how they felt coerced, manipulated and threatened into procedures and interventions. Women also reported commonly having procedures ‘done’ to them and not knowing what was happening until after the procedure had been performed. One mother included describing how she was so lost and confused while procedures were being done to her that she felt like a ‘piece of meat’ and wished for death to be the resolve to this sense of complete powerlessness and ‘torture’. This mother went on to further describe how she was asking many questions about what was happening to her to only find she felt lies were being used to calm her down. Even on recall of her birth two years on, this woman had not found
any true answers of what had happened to her. This mother's story is only one of the many included in this study that highlights this deep sense of pressure and urgency to birth quickly as a direct result of midwives and obstetrician’s coercion and manipulation tactics as also seen in current knowledge. Therefore, these new findings contribute to current knowledge of midwives and obstetricians using coercion and manipulation to control women’s birthing experiences.

Women in this study reported staff seeming disinterested and rushed, that there was a sense of urgency for women to birth quickly and staff were not present nor connected to them. These findings support exiting current literature that shows staff can be disinterested in women during labour, treat women inhumanely (Iles & Pote, 2014) and that staff are non-empathic and careless (Swahnberg, et al., 2007).

Past research shows that midwives are encouraged to move away from the clock, to be more present with women and less focused on timing of a woman’s progress (Page & McCandlish, 2006). However, what this study found is that this moving away from the clock is still yet to be implemented into clinical practice. That midwives are in fact still operating focused on policy and protocol, timing of women’s physiological responses to labour and increasing women’s perceptions of trauma by adding to this pressure and sense of urgency and emergency in the room. The contributing factor is this, however, would have been the fact that many of the women had an obstetrician involved in their care. There is anecdotal evidence that suggests that midwives try and protect women from the obstetricians by being gate keepers (Jones, 2005). In relation to current literature, this is a new finding and shows that the research supporting midwives moving away from the clock and timing a woman’s progress is yet to be implemented into clinical practice.

Women under this theme also described perceiving a fetocentric model of care where the baby was placed as far more important than the mother, women felt they were just a vessel to get the baby out. Furthermore, women reported feeling their babies were the priority that meant women’s voices were not heard, or even dismissed and ignored. Women felt they had no power over what was happening to their bodies or control over their birthing experiences. Instead, a fetocentric model of care made the women felt objectified and nullified.
Current research shows the contributing evidence of a hierarchical and fetocentric model of care in Australian hospitals contributes to perceptions of birth trauma and related PTSD (Harris & Ayers 2012). With authoritarian decision making by midwives and obstetricians causing women to perceive birth as traumatic, deepening the fetocentric model of care that places women as powerless in the hospital hierarchy (Bergstrom, et al. 2002; Davis-Floyd & Sargent, 1997; D’Oliveira, et al. 2002; File, 2006; Harris & Ayers, 2012; Thomson & Downe, 2008). The findings from this study of women observing this fetocentric model of care, contributes to current knowledge.

These findings lead to a recommendation that midwives and obstetricians should receive education on women’s perception of birth trauma. In addition, there needs be an examination of the structural influences on a policy level. Midwives and obstetricians need to receive education around authoritarianism and power roles inside hospitals between woman and caregivers. This is also a need for professional debriefing for staff with a focus on institutional influences placing pressure on them and their capacity to work ‘with women’. This could be achieved again through in-services, conference papers, published journal articles of this study and input into midwifery and obstetrician educational curriculum.

**Theme 4. I felt… traumatised, it was really horrific**

This theme explored the intensity of the trauma, what it meant for the the women in terms of their sense of self and describing how terrifying the trauma was. Such was the intensity of the trauma that a few women felt death would be a better option than continuing with the traumatic event they were enduring. The theme also describes the related events and things staff did or did not do, that resulted in a negative emotional response in the women.

There is a large volume of existing knowledge on the emotional responses women have during a complex or emergency related traumatic birth (D’Oliveira, et al. 2002; Giliane & Thomson. 2014; Harris & Ayers, 2012; Soet, et al. 2003). This existing research demonstrates women’s feelings of powerlessness, lack of agency and feeling nullified by midwives and obstetricians (Harris & Ayers, 2012; Soet, et al... 2003). One of the most commonly reported experiences for women in the study was that they felt powerless, out of control, being ignored and abandoned by their midwives and obstetricians. These feelings of
intense emotion coupled with feeling that midwives and obstetricians were not there to support women through these experiences meant women’s perceptions of the birth as traumatic were heightened and harder to come to terms with in the postnatal period. Women in the study often reported not understanding why staff acted this way toward them and were so disconnected to them and what they needed. These findings are supported by current literature highlighting that women feel abandoned by midwives and obstetricians, also how feelings of out of control and powerlessness leads to perceptions of birth trauma and difficult recoveries (Fenech & Thomson. 2014; Harris, & Ayers. 2012; Swahnberg et al. 2007; Thomson & Downe. 2008).

In support of this current exiting knowledge, women who participated in this study experienced feelings of shock and trauma during labour. These feelings sent women into survival strategies such as disembodiment or disassociation. Women experienced varying degrees of trauma, their perceptions and recall of their birthing experiences ranged from wishing they would die to feeling as though they were violently assaulted. Each woman expressed perceiving a disturbing degree of trauma and violence during labour, and each woman experienced this trauma to be partially due to the emotional abandonment of the midwives and obstetricians present at their labours. Women described some of these experiences as:

*I’ve always explained it like as I felt like I’d been gang raped, I felt like a truck had been driven through my vagina... no one cared – Mary*

*I felt like I was butchered... tortured for a fair amount of it – Alex*

*I was saying to him I can’t feel my body, I’m dying... I remember being terrified and you know really feeling as though I was not going to survive – Charlotte*

*I was just trying to like not pass out and die basically...I felt very alone. With all the people in the room it didn’t feel like they were helping me at all, and I didn’t expect them to be able to take it away or to help me but it felt like if they weren’t there it wouldn’t have made a difference - Bianca*
I didn’t feel like anyone was aware of what was happening to me and I like started to black out every now and then… so I felt like I was abandoned… just abandoned me when I was really asking for help… I didn’t feel cared for by anyone – Alex

There was really no support – Hilda

This finding highlights how a woman’s perception of trauma is not directly related to any particular event so much as it is related to her relationship, or lack of support with, or by, midwives and obstetricians. Another element found in the findings is that women commonly felt powerless, disabled and unheard. Even post birth when women sought out debriefing with the medical institution and staff they birthed with, women felt they were ignored and dismissed. This dismissal and ignoring of women has been supported in the literature showing that women commonly have to negotiate their own needs rendering themselves voiceless due to the medical hierarchy and submission of women’s needs (Parry, 2006).

Some of the emotions women expressed experiencing included: anger, shock, horror and terror. These emotions led women to lose trust in midwives and obstetricians and fractured the relationships between women and midwives and doctors. One of this study’s key findings was the communication breakdown between women and midwives and obstetricians, the lack of information sharing and the power asymmetries present in the birthing room. This is an unsurprising finding given current literature shows women who had experienced a difficult birth or birth traumas also experienced relationship breakdown with their midwives and obstetricians. This was due to communication breakdown, differences of opinion, misuse of power in hierarchical approaches of midwives and obstetricians, lack of information given to women during labour, and hostile and uncaring treatment by midwives and obstetricians (Harris & Ayers 2012; Soet et al. 2003; Thomson & Downe, 2008).

It is not at all surprising that women experienced very strong emotional response to these fractured relationships and experiences of birth trauma. With supporting literature showing how women commonly feel let down by the medical system and abused by their care givers (Harris & Ayers, 2012), In further support of these studies findings of women’s negative
perceptions of caregivers during labour, evidence supports that women commonly feel treated inhumanely by staff (Elmir, et al... 2010),

Literature also has shown how unnecessary medical interventions such as episiotomies or use of instruments during birth are key triggers for perceiving birth as traumatic (Bergstrom, et al... 1992; Boorman, et al... 2014; D’Oliveira, et al... 2002; Hodges, 2009; Hodges, 2009). In alignment with these findings this study found that for some of the women unnecessary medical intervention involved the use of an intravenous cannula or unnecessary vaginal examinations, and having these interventions made the women feel objectified, as well as intrusive and obstructive for the women.

The findings of this study not only showed women’s personal traumatic experiences but also that of their partners and families who were present during the birth. This impact of the birth trauma was perceived by a woman’s entire support team and each member of her team was left with negative perceptions and traumatic feelings. This is unsurprising given the literature shows that it is not uncommon that a member of the support team can also experience birth trauma related PTSD symptoms after an instrumental birth or caesarean (Nicholls & Ayers, 2007). This same study also supports how women’s families and partners reported the trauma affected not only the mother but those being witness to the event (Nicholls & Ayers, 2007).

In contrast to the existing literature, women in this study found a strong association between the birthing environment and their feelings of unease. Women reported feeling unsafe, that the hospital was a disruption to birth and that the staff within it were unfriendly and uncaring. On reflection of their births, women stated they wished they had stayed home as this would have been a safer place for them to birth in. The importance of the birthing setting including lighting, mood, staff and presence of medical equipment impacted women’s perceptions and slowed their labours down. This reinforces the work undertaken by Foureur (2008) which demonstrates how important the birthing environment is in producing oxytocin, the essential hormone in birthing babies while minimising stress hormones. Foureur discusses the importance of midwives and obstetricians speaking with gentle, calm and respectful voices, darkened rooms, guaranteed privacy for women and creating spaces that promote a woman’s feelings of safety, security, control, and un-inhibition (Foureur, 2008).
Research demonstrates the impact of birth trauma for women who have had a caesarean or instrumental delivery but does not include women who have had a vaginal birth with no instruments (Gamble & Creedy, 2005). The findings from this study show the impact of birth trauma as being irrelevant to the type of birth a woman had. All of the women who participated in the study had vaginal births. The perception that birth trauma is only linked to obstetric interventions or complications is therefore disproved. This is an important finding as the common perception among midwives and obstetricians is that women must have had a complicated birth to experience birth trauma (Beck, 2004). Midwives and doctors therefore need to be educated that vaginal births do lead to birth trauma and related PTSD for women.

What is most noteworthy from the findings from this study is that women who have a vaginal birth are as equally inclined to experience birth as traumatic as someone who has had an instrumental delivery or caesarean section. That emotional and psychological birth trauma perceptions are not indicative of a physically traumatic birth but rather it can occur to any woman under any level of stress and that the instrumental delivery or cesarean section is not the key indicator for these perceptions.

These findings lead to the recommendation that through in-services, journal publications, conference presentations and midwifery and obstetrician education curriculum, midwives and obstetricians be educated about potential emotional and psychological birth trauma. In addition to how important it is that all women regardless of her birthing experiences be treated with the care needed to prevent this type of birth trauma.

**Theme 5. I know that is just what the system is like... they're hospital midwives…they're medical**

This theme explores where women’s feelings of connection to their midwives was non-existent. Women felt instead that the midwives were working more in a position of power rather than in partnership with the women. Therefore, further deepening the feeling that midwives are acting not as midwives. Even with all the information and education about how midwives need to be in partnership with women, the women felt the midwives were more interested in writing their notes and ticking their boxes. This resulted in women feeling very
disconnected, afraid and unsupported. The general social structure of Australian hospitals has been found in research to be that of authoritarianism, a hierarchy of dominance and submissiveness (Filc 2006; Goer, 2010; Hodges, 2009; Thomson & Downe 2008). In addition, a hierarchal system in place is preventing agency of women and midwives and putting the obstetricians as the ultimate authority (Goer, 2010; File, 2006).

Women reported staff working in an authoritarian manner ‘over’ women instead of in partnership with them. Midwives acted as an authority over women that rendered women voiceless, powerless and nullified. These findings are supported by the current research that shows midwives and obstetricians often feel entitled to perform in this manner with a ‘we know what’s best’ attitude. This attitude furthers the distrust and can lead to heightened feelings of trauma due to the lack of rapport and support the women have with midwives and obstetricians (Fernandez, 2013; Hodges, 2009; Swahnberg et al. 2007). Further to this, data has documented the “frequent and repeated disrespect and abuse of maternity clients by health service staff” (D'Oliveira, et al. 2002: p 1681) with considerable witnessing of such abuse (Hodges, 2009). Women reported throughout this study varying degrees of abuse by midwives and obstetricians. These findings also support existing knowledge of midwives and obstetricians acting in an abusive manner toward women leading to fractured relationships (Thomson & Downe, 2008; File, 2006; Bergstrom, et al. 2002; D'Oliveira, et al. 2002; Harris & Ayers, 2012; Davis-Floyd & Sargent, 1997). Broken relationships between women and midwives and obstetricians encompass a lack of trust as a result of the abuse of staff and power roles over women (D'Oliveira et al. 2002; Fenech & Thomson. 2014; Harris & Ayres. 2011; Thomson & Downe. 2008).

Further to this, research has found that midwives and obstetricians have over medicalised birth with an overtly medical model of care in partnership with a conceptualised version of the physiology of labour and birth that requires intervention, medicalization, instrumental support and medical involvement (File, 2006). Thus, creating a hegemonic authoritarian attitude in the birth suite by staff that has a tendency to be managed by midwifery and obstetric skills that involve pharmacological pain relief and medical management (File, 2006). This is instead of the traditional midwifery skills of working with a woman’s body and the position of her baby for optimal birthing capacities. This again, reinforces the idea that
authority lies in the hands of the midwives and obstetricians and not the mother. The findings from this study confirm this current knowledge with the majority of women reporting a perceived hegemonic authoritarian attitude in the birthing room that was overtly medicalised to the point women spoke of midwives not having any traditional midwifery skills, nor working with a woman and her body to create a better birthing position. For example, one mother found in her notes post birth that her baby was positioned posterior, however her midwife neither told the mother at any point during labour that her baby was in this position, nor did she offer any non-medicalised remedies for optimal positioning or pain relief. For example, lower back massage, hot packs and maternal positioning to support the baby to rotate. These findings also support the previous literature which shows how contemporary birthing practices are more medicalised and fetocentric (D’Oliveira et al... 2002). Furthermore, that this more medicalised environment and clinical practices do in fact increase a woman’s risk of birth trauma perceptions and related post-traumatic stress (D’Oliveira. et al... 2002; Midgley. 2006; Thomson & Downe. 2008).

This study’s findings also support the existing knowledge of women having their opinions ignored, requests for information mislead, and women being subjection to authoritarian decision making (Bergstrom, et al... 2002; Davis-Floyd & Sargent, 1997; D’Oliveira, et al... 2002; File, 2006; Harris & Ayers, 2012; Thomson & Downe, 2008). In addition, these experiences are the leading cause of perceived birth trauma (Harris & Ayers. 2012: Thomson & Downe. 2008). Women throughout this study expressed their shared experiences of being nullified, ignored, mislead and powerless in a perceived hierarchy inside the birthing room. Further to this, existing knowledge also has found the social expectations of women to submit to authoritarian attitudes by obstetricians and midwives inside a fetocentric model of care create power roles leaving women at the lowest list of importance (Fernandez, 2013; Kitzinger, 2006; Parry, 2006) The findings from this study therefore, support this existing knowledge. Social hegemony has been reported in existing studies as being a social norm, that women are expected to hand over their power and autonomy to obstetricians and midwives upon entry to the hospital institution (Soet, et al. 2003). This study’s findings support this knowledge. The majority of the women who participated in this study found at some point during their labours that they had no power, control or autonomy and that they had no choice other than to ‘trust’ the staff making the decisions for them.
In relation to the obstetricians present for this study’s participants births, all of the women reported the doctors entering the birth suite with an authoritarian attitude over the midwives that left women feeling distrustful and unsafe in the care of these specialists. This was possibly a key trigger in women’s perceptions of their birth as traumatic. These findings support current knowledge of obstetricians acting with authority over mothers and midwives, conceptualising birth as a risky event requiring intervention, control and medical management rather than a normal physiological event (Kitzinger 2012; Parry, 2006). This therefore is extending to the increased risk of perceptions of birth as traumatic based on this authoritarian attitude by obstetricians (Wijma. et al. 2007).

Women felt midwives also lacked in midwifery skills and did not facilitate any maternal positioning to assist in her birthing processes. These findings of midwives not acting as midwives and working against women rather than with them, is new to this field of knowledge. This is a surprising finding, given Australia’s popular Bachelor of Midwifery students being educated under a more feminist ‘with woman’ approach to midwifery care (Page & McCandlish, 2006). Instead, to find that hospitals are still practicing under an outdated authoritarian fetocentric model. The fact that some hospitals had not yet integrated this new wave of midwifery philosophy raises questions regarding the institutional hegemony within the public maternity system. Further to these findings, this study has also found women perceived a power asymmetry and hierarchy between midwives and obstetricians. Placing obstetricians at the top of the hierarchy and in ultimate control of a laboring woman’s body, followed by the midwives, the baby and finally the mother at the very bottom of the hierarchy and authority inside the birth suite. The advent of midwifery models of care, including caseload, is slowly being introduced into Victorian maternity hospitals, however, progress is slow.

To date there is no current research on midwives not practicing with traditional midwifery skills of optimal positioning or non-pharmaceutical pain relieving options. Midwives acting outside of midwifery philosophy within the context of public maternity wards is also an unexplored topic. This is especially surprising given current midwifery education in Australia under the Bachelor of Midwifery programs deliver a strong feminist, woman centered
approach to educating midwives to work in partnership with mothers. These midwifery philosophy approaches are still not filtering through to clinical practice inside Victorian public maternity hospitals. This is a new key finding from this study that shows midwives are not acting under midwifery philosophy, unless they are employed under a continuity of care model.

These findings lead to the recommendation that midwifery and obstetrician education curriculum include content on emotional and psychological birth trauma. In addition, hospitals employ a specialist to run an in-service education program for midwives and obstetricians to understand and prevent this type of trauma. Introduction of midwifery care models, including caseload, would also assist.

**Theme 6. I didn't feel connected to them**

This theme explores women’s feelings of disconnection with midwives and obstetricians. The theme explores the gap in partnership between women and their midwives, where relationship did not exist between women and their midwives, how this impacted women’s experiences of birth and heightened women’s perceptions of trauma. The main cause of birth trauma found in current knowledge is the fractured relationships between women and midwives and obstetricians (Harris & Ayers, 2012; Thomson & Downe, 2008). These interpersonal difficulties have been shown to be the leading cause also of PTSD as a result of perceived birth trauma (Harris & Ayers, 2012). Also contributing to knowledge is the findings from an ethnographic study that showed women’s experiences of birth trauma were as a direct result of the inactions or actions of the midwives and obstetricians attending a woman’s birth (Fernandez. in; Elmir, et al. 2010: p 48).

In support of this existing knowledge, this study found that women’s leading cause of perceived traumas was the lack of connection or relationship that women had with midwives and obstetricians and the lack of support midwives and obstetricians provided to women. There is however a key difference in the findings between existing knowledge and new findings from this study. That is, this study shows that the traumatic perceptions are irrelevant to the actual birth events and more as a direct result of these poor and disconnected relationships with women’s midwives and obstetricians. Therefore, women who have had a
vaginal birth are equally as likely to experience birth trauma based on these fractured unsupportive relationships with midwives and obstetricians rather than the birth trauma being dependant on actual traumatic events during labour and birth. This is a new key finding in knowledge.

Possibly one of the most significant findings for women included in the study was their feelings of disconnection to midwives and obstetricians present, the fractured relationships having a major impact on how women perceive their experiences and cope with difficulties during labour or not. Women’s feeling of disconnection to caregivers is supported in phenomenological studies in existing literature that shows how the impact of disconnected midwife/ obstetrician and mother interactions are crucial in the later developing perspectives of birth as traumatic (Thomson & Downe, 2008).

Existing evidence based midwifery practice supports how to connect with women and develop meaningful working partnerships (Page & McCandish. 2006: Thomson & Downe, 2010). However, the hospital culture in some instances appears to have not adapted to this research. With women reporting they felt midwives did not act under midwifery philosophy or working with women in partnership. Instead, women’s perceptions of midwives were that they were more interested in following policy and protocol and acting as an authority over the mother.

Women in the study did not know their midwives before labour and there was no bridging between that gap to create a connection between women and their midwives. The women also felt the midwives were lacking in midwifery skills, so they felt that midwives did not know how to support them to have a normal physiological labour, or how to work with their bodies and the position of their babies to optimise natural birth without medical intervention. The women also perceived a power asymmetry in the room between midwives and obstetricians whereby the obstetricians were the ultimate authority. Women and midwives therefore became voiceless meaning that the women became further nullified. Currently, inside most Victorian public maternity hospitals, there is little structure to bridge the relationship gap between women and their midwives, except where midwifery models of care exist. Women reported midwives were not offering words of support and encouragement, rather, they were
busy writing notes and leaving the room, deepening the disconnection between women and midwives and obstetricians resulting in further distrust.

Again, the recommendation for this theme include hospital in-services, education in midwifery and obstetrician curriculum, conference presentation and journal publications on emotional and psychological birth trauma, hospital institutional power asymmetries and authoritarianism and how midwives can prevent this influence of their autonomy in their clinical practice. It is important to educate midwives on the importance on relationship building with women, on communication strategies and hospitals developing continuity of care midwifery models.

**Theme 7. She stood up for me/ I felt powerful**

This theme describes the fact that some of the women did feel connected and supported by their midwives. This theme also explores the elements and acts of midwives that made women feel connected and that lessened their experience of trauma because they felt that connection and support. It is important to include this theme because it highlights that it is not every midwife that is promoting perceptions of trauma and disconnection. Some midwives are working within the midwifery philosophy of partnership with the women and showing empathy and support for women in labour. Not every midwife is under-performing, there are skills that midwives have that can bridge that connection. Two of the seven women who participated in this study expressed a connection to their midwives that was positive in nature and supported these women to birth their babies and feel cared for during traumatic events. These two women spoke of how simple gestures such as touch, or reassuring words, timing of physical contact between mother and midwife, the midwife physically getting down onto the same level as the mother, and staying present with her rather than leaving the room, all meant these mothers felt connected with and supported by their midwives.

The *I felt powerful* part of this theme is where woman during their labour, stood up for themselves, and had a moment of self-determination where they voiced what they wanted or what they did not want. Each woman no matter how intense the trauma, had that moment of empowerment where she could express ‘No’ or ‘this is what I want/ what I don’t want’.
Existing knowledge supports the importance of quality midwifery support for women, support that aligns with midwifery principles of ‘being with woman’ and working in partnership with her rather than in an authoritarian manner. In addition, the positive effects this kind of support has on women’s decreased perceptions of trauma has been well documented along with the enhanced relationships women have with their babies, and marked differences in maternal and infant health post-birth (Green & Hotelling, 2007; Hans, et al. 2013; Mottl-Santiago, et al. 2008; Kitzinger, 2005; Kozhimannil, et al. 2013; Wagner, 1994: p 116-117). There exists a plethora of research on midwifery qualities that engage women and enable feelings of partnerships and connection (Davis-Floyd, 1997; Harris & Ayers, 2012; Kitzinger, 2006; Thomson & Downe, 2010). Considerable literature also shows the direct link of well supported women during labour and birth, who is well informed and feeling in control of her decision making, and they perceive birth to be a non-traumatic even in the face of what others may perceive as a traumatic event (Cleveland, 2009; Davis-Floyd & Sargent, 1997; Harris & Ayers, 2012; Kitzinger, 2012).

Women’s expressions of agency and feeling powerful inside the current hegemonic fetocentric birthing environment in Australia was found throughout this study. In support of these findings, current research shows that although the current birthing system is inherently designed for patriarchal power, women do often find their expressions of agency and resistance in episodic moments (Parry, 2006). Some woman in this study did find a moment of power, a moment of self-determination where albeit the trauma and fear she was feeling, she managed to defend herself and her choices by speaking up and defining what she wanted or did not want. This goes against the literature that shows women are left submissive entirely due to societal pressure on them to not challenge authority (Goer. 2010; Soet. Et al... 2003). Women did make formal complaints and did follow up on the ramifications for staff who behaved in a perceived violent manner. This is again a surprising finding going against literature that states women withhold reporting any dissatisfaction of their birthing experiences due to societal pressures and medical hierarchy (Goer. 2010; Soet. Et al... 2003). However, even for the women who did choose to follow up on their negative experiences of birth, research shows their voices are commonly left unheard, with patriarchal hegemonic systems inside hospitals that are inherently flawed for creating change or repercussions when obstetricians or midwives perform in an inhumane or abusive manner toward women.
(Bergstrom, et al... 2002; Davis-Floyd & Sargent, 1997; D’Oliveira, et al... 2002; Filc, 2006; Harris & Ayers, 2012; Thomson & Downe, 2008). The findings of this study support current literature of how a well-supported woman during labour has a decreased risk of birth trauma perceptions. This is contributing to current knowledge in this arena. During pregnancy and birth, evidence suggests women who are well supported, cared for and have a familiar person in the birthing room not only have improved outcomes at birth and more positive perceptions, but so too, does that of her newborn child (Kozhimannil, et al. 2013).

Previous research found that in the context of pregnancy and birth, agency for women in labour is limited and sporadic (Campo, 2010). Often depending upon their relationships with care providers and the presence or absence of trust (Campo, 2010), women have opportunities to express agency. However, there are a myriad of complexities involved in this expression. This study found that regardless of the complexities that enabled or disabled feelings of powerlessness, women had a moment of empowerment and self-determination where they spoke up and demanded what they wanted or did not want. This argues against previous research (Davis-Floyd, 1992) that shows women’s momentary expressions of agency were dependant on the support of the midwives and obstetricians present at her birth. That while the support or lack of support from midwives and obstetricians certainly impacts on a woman’s perceptions of trauma, they are not the only factor that contributed to women’s capacity to express agency in labour. This is a key new contribution to the literature that shows how women can and do express their agency and self-determination amidst severe trauma and fear.

These findings lead to the recommendation that midwives and obstetricians be educated in emotional and psychological birth trauma and the positive impact of treating all women equally and respectfully. This education will be done through in-services, journal publications, conference presentations, midwifery and obstetrician education curriculum, and updated hospital policy and protocol. Implementation of midwifery models of care would also assist.
Theme 8. *After the birth, just horrible*

This theme explored the ongoing traumatic experience for women postnatally. Exploring how it is not only the birth itself but how women were treated in the immediate postnatal period up until the first 6 weeks by midwives, lactation consultants and maternal child health nurses, that left women feeling traumatised. This theme also describes how the impact of the trauma had affected women’s relationships with their children, partners and their extended families. That is, looking at the long terms effects of the trauma on the family.

Several studies have documented women’s shared birth trauma stories (Bergstrom, et al., 1992; Boorman, et al... 2014; Goer, 2010; Harris & Ayers, 2012; Hodges. 2009; Kitzinger, 2005, 2006, 2012; Soet, et al., 2003; Thomson & Downe, 2008). Most of these stories contain negative experiences associated with perceptions of birth trauma and the interruption with mother infant bonding and relationship difficulties women face post birth trauma (Bailham & Joseph, 2003; Nicholls & Ayers, 2007). Further case evidence supports this link between birth trauma and poor mother infant bonding, as well as poor breastfeeding rates and other feeding difficulties, sexual avoidance, and fear of childbirth (Bailham & Joseph, 2003; Iles & Pote, 2014). Similarly, evidence shows how women need to feel in control of their birthing experiences to enable positive birthing perceptions (Iles & Pote, 2014). Birth trauma perceptions after caesarean or instrumental delivery have also been linked to postnatal negative consequences such as ongoing pain and psychological distress on recollection of her birth (Elmir et al, 2010).

Women in this study reported there being no postnatal support provided by public hospitals, no debriefing provided or availability of discussing a woman’s birth with one of the midwives or obstetricians present at her birth. Even when women actively sought out this information and support (which with a newborn baby required a huge amount of time and energy, highlighting the importance of this to women) they were met with dismissal and frustrations by midwives and obstetricians who could not provide this service. Some of the women in this study avoided any contact with maternal and child health nurses and felt this care was not what they needed or sought out, rather they wanted to debrief the specifics of their birthing experiences with midwives and obstetricians who were at their births.
Current evidence shows that a lack of timely debriefing or support can heighten symptoms of trauma postnatally (Iles & Pote, 2014). From the findings in this study, women actively sought out and felt a deep sense of need to debrief their birthing experiences with midwives and obstetricians present at their births. When this service was rendered unavailable to women, women felt a deeper sense of aloneness and abandonment by publically funded maternity services. This not only deepened their distrust in public hospitals and midwives and obstetricians but also permeated into women’s feelings of trauma, enhancing negative feelings and pushing women further away from any possible resources to support them through their experiences of trauma and integrating life with a newborn baby. These findings support current knowledge of the importance of postnatal debriefing, how unavailable it is to women currently, and how by this unavailability to debrief women’s experiences of trauma are heightened.

The effects of trauma not only affected women, but also their families. Maternal relationships with other children, newborn babies, partners and immediate close family members were all affected by the women’s birth trauma and suffering postnatally. Again, a plethora of existing evidence supports how birth trauma has a huge disabling effect on women’s immediate relationships particularly those with her children, partner and family members (Bailham & Joseph, 2003; Boorman, et al. 2014; Iles & Pote, 2014; Nicholls & Ayers. 2007; Soet, et al. 2003; Thomson & Downe. 2008). This disabling effect has been found to extend to a woman’s plans for future family planning, to the extreme of women wishing to be sterilised in avoidance of any risk of future traumas or repeating her past birth trauma (Thomson & Downe, 2010). The findings from this study support this existing knowledge of women having severe disabling effects produced by their perceived birth traumas and affecting their bonding with new babies, relationships with other family members and partners.

Women also felt the hospital environment negatively impacted them postnatally. Women felt being at home in the immediate post-partum period would have been healthier and safer for them; with some women reporting abuse in the postnatal period by midwives and lactation consultants inside the hospital environment. While there already exists large volumes of data supporting the importance of the birthing environment and changes needing to be made to public hospital birthing environments to produce more positive perceptions of birth (Foureur,
Leap, Davis, Forbes & Homer, 2010; Lindsey, 2011; Page & McCandlish, 2006) this finding of women feeling the postnatal hospital environment as a source of contributing to women’s perceptions of trauma, is a new key finding.

Women felt hospital practices and attitudes of staff prevented them from bonding with their babies. That women were rushed out of birthing rooms or babies taken away for measuring weight and so forth with women feeling they were denied their time to bond as a new family. While current evidence shows how birth trauma can interrupt a woman and babies bonding experience (Bailham & Joseph, 2003; Iles & Pote, 2014) this is a new finding highlighting midwives and obstetrician’s treatment of women postnatally as insensitive and disruptive to bonding time for families based on pressures and time restrictions for staff. Current evidence shows the importance of bonding time between mothers and babies and the push to integrate into practice a minimum of 45 to 60 minutes of bonding time immediately postnatally provided there are no medical indications to alter this, (Young, 2013). This finding, however, shows for these women, this has yet to be integrated into clinical practice due to the lack of midwifery models of care.

Another important finding in this study which contributes to new knowledge is that women perceived midwives and obstetricians not only helped create the trauma, they failed in their role to acknowledge the women were traumatised. In addition, midwives and obstetricians have a tendency not to recognise traumatic obstetric actions as well as a pre conceived idea that women who have vaginal births would not experience birth trauma. Each of the women felt midwives and obstetricians would not be able to perceive these women as traumatised and were often met with a commonly shared response by midwives and obstetricians of ‘you have a healthy happy baby why would you be upset’. Women reported postnatally upon expressing their distress they were met with further dismissal and therefore became withdrawn and further distrusting of midwives and obstetricians. One mother even sought professional debriefing with the medical team present at her birth only to have her experiences dismissed and denied. Another mother sought out medical support post birth in her maternal and child health nurse only to again be further dismissed resulting in the mother’s complete withdrawal from any community or medical services that could support her. This is a new key finding to the current knowledge on birth trauma. The perceptions of staff generally only perceive birth trauma belonging to a group of women who have
experienced physical trauma or caesarean during labour. Perceptions of vaginal birth and associated birth trauma are non-existent (Thomson & Downe, 2007).

The expectation that birth trauma includes only birth itself has been misleading. From the interviews in this study women reported post birth to also be a time of torment and trauma. The implications of trauma varied between women. They commonly included traumatic perceptions as a result of continuing medical intervention and physical limitations in the immediate post-partum period. Some of the participants felt midwives and obstetricians hindered their bonding processes, breastfeeding development and learning baby care. These findings showing that perceived traumas can be created in the immediate post-partum period as a result of midwives and obstetrician’s interventions or lack of care, is a new key finding contributing to knowledge.

These new findings lead to the recommendation that compulsory debriefing of all women’s birthing experiences with staff who were present at the birth to be offered as standard follow up care post birth. Further to this, that at least one member of the team present with each mother during her labour and birth provide this debriefing session, allowing space, time and discussion with women.

**Theme 9 I deserve a better birth**

This theme is where women described how they would do things again in the future, what they would do differently, or not. Women reported feeling overwhelmingly disappointed with their birthing experiences and stated they would never go back to the same hospital again. Some of the women stated they would go on to have a homebirth with an independent midwife. One mother stated she would employ a private obstetrician so she could have full control and have an elective caesarean. Finally, one mother stated she would never give birth again as the trauma was too severe for her to endure a second time.

Existing literature shows what women want for better birthing experiences (Bryant, 2009; Newburn, 2006; Page, 2008), that women want to have continuity of midwifery care through models such as caseload midwifery, they want better postnatal support, and most importantly they want to birth as naturally as they can (Bryant, 2009; Newburn, 2006; Page, 2008).
However, there is no current literature exploring the depth of perceived birth trauma for vaginal birthing mothers and how this has impacted on a woman’s family planning. This study highlights this as a new finding and leads to the recommendation for future research into the negative impact birth trauma has on family planning for women who birthed vaginally.

**Summary of findings**

Women could not adapt to changing situations during labour and felt unprepared to make choices in adverse circumstances. Obstetricians and midwives were not providing all of the information needed for women to feel informed and involved in their decision making. Women were left feeling uninformed, disrespected and with negative perceptions of their birthing experiences including that of the midwives and obstetricians who worked with them. Women experienced a poor mother-midwife relationship and felt their midwives did not understand nor support a normal physiological labour. Women also felt midwives and obstetricians lacked in respectful communication and did not involve mothers in decision making. Mothers also felt midwives and obstetricians used coercion and manipulation tactics to gain consent for procedures or medications and that they were controlled by obstetricians and midwives, loosing their sense of autonomy or even humanness. Women perceived an urgency to birth with a focus on their babies rather than on themselves. Furthermore, women were left deeply traumatised with varying degrees of negative impact on a woman’s personal, social, sexual and family life. In addition, women felt their postnatal care was lacking and often fuelled further traumatic perceptions due to the lack of support made available to them and the overall sense of dismissiveness by midwives and maternal and child health nurses, that their birth was traumatic to them.

**Summary**

This chapter has discussed each of the nine themes found within the study and how these themes relate to current literature on birth trauma. Each theme was explored in depth with further insights and touched on recommendations for future practice.
Chapter 7 - Recommendations and conclusion

Introduction

This chapter discusses the study’s findings, conclusions and implications, suggestions for future clinical, professional, personal and educational interventions that could lessen the experience of and impact of psychological and emotional birth trauma.

Recommendations and future research

Professionals: doctor/ midwives

The study found women reported feeling their antenatal classes inadequately prepared them for any adversity during labour and birth (Theme 1). Women reported classes only covered events for a normal physiological labour and birth with no mention of adversity or preparation for any emergency events. This lack of education left women feeling overwhelmed, ill prepared and shocked by events that unfolded during their birthing experiences. Most likely being a major cause of perceived trauma, this lack of education in the antenatal period needs addressing. Therefore, I recommend childbirth preparation classes run by public hospitals include more information and resources on coping strategies for women. This could be done by including more content into classes along with mindfulness, breathing techniques and coping strategies for couples to practice during pregnancy and use during labour. To evaluate the effectiveness of this recommendation women can complete a post birth survey indicating how prepared they did, or did not feel, for birth and rates of childbirth preparation class satisfaction would ideally increase.

Women included in the study reported feeling unimportant to staff, ignored, and that staff were ‘not telling me what they were doing’ (Theme 2). I recommend a checklist be created and introduced into midwifery education. This checklist would involve a series of questions and important information, with a women centric approach, to be used with women in labour under any particular introduced intervention or adversity. For example, if forceps were being discussed then a checklist of what information should be discussed with women and how
midwives should discuss this would be used. This is to enable women to feel this is a choice they have participated in and for. The checklist should also include a safe amount of time to leave couples to make this decision during labour being realistic about the circumstances. To evaluate the effectiveness to increase maternal satisfaction post birth, again would be through an evaluated post birth survey, reduced rates of post-traumatic stress and self-identified traumatic birth experiences.

Women reported having a perception of panic and a need to rush and birth their babies projected from midwives and obstetricians. Women felt a deep sense of urgency as a result of midwives and obstetrician’s mannerisms and behaviours during labour. Women felt the staff were rushed and too busy to allow birth to proceed naturally, and as a result felt they were coerced, manipulated and pushed into procedures or interventions they may not have needed or did not want. These findings lead me to recommend that midwives and obstetricians are supplied with education on birth trauma and how to prevent this sense of urgency. That a clear delineation between medical emergency and hospital efficiency be made by midwives and obstetricians, and any medical emergency be communicated clearly with mothers, while hospital efficiency urgency be eliminated from the birth suite. Midwives and obstetricians receive education on the importance of telling women exact time intervals between their visits with her, any hospital expectations. For example, time of dilation how many centimetres per hour. Midwives and obstetricians can let women know they will be back in 30 minutes, five minutes and so forth. Midwives who are busy and rushing due to workload should communicate this with mothers letting them know their rushing is not related to the woman’s labour and any sense of urgency is not a sign of this mother’s birth. This exact information gives women a sense of how imminent things are progressing or not, and can relieve anxiety or undue stress. Structural influences to be lessened on a policy level for example, pressures of time and fear of litigation. Immediate postnatal care – midwives and obstetricians should leave the newborn with mother, seek permission to remove [assess newborn] and any urgency should be only when the situation is designated as an emergency. Midwives and obstetricians need to receive education around authoritarian personality styles and power roles inside hospitals between caregivers and the woman/patient. There should be professional debriefing for staff with a focus on institutional influences placing pressure on them and their capacity to work ‘with women’. This could be achieved again by in-service
education, published journal articles of this study and input into midwifery and obstetrician educational curriculum.

Women felt midwives lacked traditional midwifery skills, and were not working for a normal physiological labour with women, that midwives were not acting as midwives (Theme 5, *I know that is just what the system is like... they're hospital midwives...they're medical*). Also reported in the study’s findings were that women felt they deserve a better birth (Theme 9). In addition, the study’s findings identified that midwives and obstetricians lacked an awareness that a vaginal birth can indeed be perceived by women as emotionally and psychologically traumatic. Therefore, I recommend that in-service be offered to midwives and obstetricians on identifying and preventing emotional and psychological birth for all women including vaginal births. This education would include an emphasis on midwives and obstetricians’ perceptions of birth being normalised to one of a natural and normal physiological event. Obstetricians generally perceive birth as pathological, a medicalised model of care. Childbirth is natural and should be treated as such (unless something happens to put the mother and baby at risk).

Midwives and obstetricians need to de-jargonise the language they use in front of women and not use technical language in the presence of the mother. A reduction in women reporting birth as traumatic would be an ideal finding post implementation of this type of in-service, along with midwives evaluated capabilities to identify and prevent this type of birth trauma and implement this knowledge into all clinical birthing practice. It was found from the findings of this study that authoritarianism, patriarchy and power asymmetries are prevalent inside birthing hospitals and many midwives are oblivious to this on their behaviour (Themes 2, 5 & 6). Therefore, it is recommended that professional debriefing for staff with a focus on institutional influences placing pressure on them and their capacity to work ‘with women’ be implemented as routine professional development for midwives working in hospitals. Authoritarian and power needs to be reduced and a consultative and partnership (equal power) needs to be the focus – in this model, the guidelines associated with informed consent should be applied – plenty of information and work in partnership. The success of this recommendation could be evaluated by midwifery knowledge and work satisfaction being
identified by midwives. Implementation of more midwifery models of care would also be advantageous.

Women reported midwives were not working in partnership with women, lacked midwifery skills and did not understand normal physiological labour or how to work with a woman’s body to facilitate a vaginal birthing process (Theme 5). Women also reported that they were commonly not asked for their consent to certain procedures or practices and that they felt things were simply being done to them without their knowledge or consent (Theme 2). I therefore recommend as part of continuing professional development an inclusion of traditional midwifery skills education, that places emphasis on partnership models of care including the importance of informed consent and how through informed consent and communication models form a partnership. This education can either be done through an in-service from a professional midwife who specialises in vaginal birth, an online task that could be completed during work hours if time permits or by attending a short course or seminar on normal physiology of labour and birth and how midwives can best support women to achieve this. This program would also influence midwifery autonomy in clinical practice and allow for a deeper sense of work satisfaction. The evaluation for this type of implementation and recommendation would be in assessing midwifery knowledge and skill sets both by the implemented in-service or education process. For example, a short test at the end of the program to test for new knowledge. In addition, maternal feedback on positive midwife-mother partnership during labour, again this could be evaluated in a maternal post birth survey done prior to discharge.

Women throughout the study identified midwives and obstetricians used language that felt disempowering, abusive and derogatory to the women (Themes 2, 4, 5, 6 & 8). I recommend that a policy be developed specifically addressing the use of language or type of staff discussion in the presence of mothers, that when this policy is implemented a copy of it be delivered to all staff present for birthing women and are made aware of these changes. If needed again, an in-service on the power of language and conversation in the presence of birthing women be offered to midwives and obstetricians. Again, this can be evaluated by the use of a post birth survey for mothers to complete prior to discharge that asks specifically how women felt in the presence of midwives and doctors while they discussed the woman or
her baby. Ideally once this recommendation is implemented the rates of maternal distress over being spoken to, or communicated with in a negative manner would decrease.

Women in the study felt they were often not given enough time immediately post birth to bond with their babies as a family before they were moved, intervened with, partners asked to leave, or had their babies taken for measuring, weighing (Theme 7). These findings lead to the recommendation that through in-services, journal publications, conference presentations, midwifery and obstetrician education curriculum, and updated hospital policy and protocol, that midwives and obstetricians be educated in emotional and psychological birth trauma and how important it is that all women, regardless of her birthing experiences, be treated with the care needed to prevent this type of birth trauma. The evaluation for this recommendation could be seen by women’s reporting of satisfaction with their immediate post birth experience, as seen in the above suggested survey prior to maternal discharge.

**Organisational Structures: hospital**

Women reported a lack of rapport between midwives, doctors and themselves during labour, being spoken to poorly by midwives and obstetricians, and being uninformed about procedures. These women did not expect midwives inside hospitals to treat them poorly and without a woman-centred approach (Themes 2, 5 & 6). There is a need for obstetricians and midwives to get to know the mother as a person during labour, to bridge this gap of not knowing a woman, by enquiring into her as a person, her experiences and then her expectations. Midwives should be focusing on the women as an individual rather than on her baby or her labour. Therefore, I recommend a communication model to be implemented into clinical practice in intra-partum care that places the woman at the heart of labour. Some examples of these models might be non-violent communication (NVC) or a compassionate listening model as part of midwifery models of care. Midwives can be educated in these communication techniques through an in-service or professional development day at the hospital and the effectiveness can again be evaluated in a post birth survey offered to women prior to discharge. I also recommend that midwifery education programs include education for students in communication techniques and strategies to bridge relationship with women in labour. Finally, presentation of this study’s findings through conferences and publications would also boost this knowledge and skills. Ideally, a reduction in psychological and
emotional birth trauma would ensue and a higher level of satisfaction for mothers in their relationships with their midwives. Midwives would also report higher job satisfaction and fulfilment as the communication tool would bridge any emotional distance between midwives and women in labour.

Women felt a large negative gap and impact from not knowing their midwives prior to labour. With reports of personality clashes, differences in opinion and ideals for birth (between mothers and midwives) lack of information and partnership, and feeling unsupported by their midwives (Themes 2, 3, 4, 5 & 6). I recommend a midwifery communication tool to bridge the gap of unknown caregiver to women and improve maternal and midwife satisfaction. This communication model is to be trialed in large metropolitan hospitals in Melbourne. The aim of this model is to enable a deeper communication relationship between women and their care providers to enable a deeper sense of trust, companionship and what each individual woman might need to best birth her baby. This communication tool could be evaluated by maternal and midwifery satisfaction post birth, reduced rates of maternal dissatisfaction and reports of traumatic birth, midwifery job satisfaction and fulfillment increasing, and a decrease in complications during labour and birth.

**Personal/ family**

Women reported through the study that they felt their antenatal preparation both independently and from public hospitals, was inadequate in preparing them for any adversity during labour and birth (Theme 1). Women stated their antenatal classes did not include anything outside of a vaginal birth and left women reflecting on their classes and feeling they were poorly informed, ill informed or not informed at all about how to cope with any adversity. Therefore, I am recommending that public hospital run childbirth preparation classes include teaching women both problem solving and emotional coping strategies to help women cope under unexpected stress. Practices such as mindfulness, breathing techniques and other problem solving skills can be taught during these antenatal classes. To evaluate this strategy ideally women’s reports of traumatic birth would decrease and their experiences of feeling well prepared and empowered would increase. Childbirth educators could assess women’s class satisfaction through post-class evaluation tools already implemented in public hospitals along with post-birth surveys prior to discharge.
The study’s findings showed women felt their postnatal care was lacking, women felt alone and struggled to adapt to new motherhood with their reports of poor post birth care and support (Theme 8 & 9). Women felt there was little to no care postnatally offered by the hospital they birthed in. Women reported how they felt a debrief post birth would have improved their perceptions of birth and supported them in their new motherhood experiences while integrating their traumatic births. All women who participated in the study felt let down by the medical system in this lack of postnatal care, with some mothers stating how the care that was offered impacted them negatively and increase their traumatic perceptions rather than supporting them (Themes 4, 5, 8 & 9). I recommend that hospital policy be changed to include compulsory permission sought from mothers at any stage their babies are needed to be taken away. Compulsory debriefing of all women regarding their birthing experiences with staff who were present at the birth be offered as standard follow up care post birth. That at least one member of the hospital team present during her labour and birth provide this debriefing session, allowing space, time and discussion with women. This could also be achieved by sending mothers an online survey six months postpartum, allowing women time to reflect on their experiences. This tool would also work as an overall care evaluation tool for hospitals to assess their efficiency in providing adequate maternity care. Evaluation of the effectiveness of this strategy could involve a decrease in women’s perceived traumatic birthing experiences, improved mother infant bonding, lessened burden on the healthcare system for postnatal depression and trauma, higher maternal satisfaction and improved breastfeeding rates. An evaluation tool such as an online survey six months’ post-partum could provide easy access for new mothers to give feedback on the effectiveness of this debriefing session.

**Role of the mother**

For women to feel empowered and contribute equally to a partnership model with their midwives and obstetricians, antenatal classes need to educate women on what they can do to take control of their emotional needs. Therefore, I recommend that during antenatal visits women need to be educated on the importance of attending antenatal classes and how this can have a huge impact of their birthing experiences. Antenatal classes need to focus on the importance of women feeling in control of their consent, and giving permission or not when
they choose it. Teaching women coping strategies to use during labour, strategies such as mindfulness techniques, breathing practices or meditative states to use during labour. Women also need to be educated on their own role in rapport building with midwives and obstetricians. For example, women can be educated on how to ask questions of enquiry in getting to know their midwife, and, how to be assertive in early labour. Women can also be reminded that if they are not happy with their midwives or obstetricians they can, and should, ask for someone else to work with them, that this is an option and a choice woman can make during labour. Teaching women assertiveness during pregnancy through antenatal education is crucial in developing empowering practices women can use to improve their birthing outcomes and perceptions.

**Role of partner/ other support person/s**

The role of support people or partners in labour comes into focus more so when a woman enters into deeper stages of labour and needs to focus internally on the birthing process. At this stage partners need to take over the assertion and act proactively in continuing on with a woman’s wishes and advocate for her needs and desires. During antenatal education partners and support people need to be educated on the importance of their role in advocating for women and how they can be the voice for her. For example, teaching partners and support people how to communicate assertively as a communication technique, how to ensure informed consent is being given, how to make requests of midwives and obstetricians during labour and seeking information if needed. These strategies are to be implemented into the above suggested recommendations for antenatal education classes.

**Postnatal care**

Also to be included in these antenatal classes is a focus on postnatal care needs. Educating women on how to ask for what they need or want from their midwives and maternal and child health nurses can help improve women’s postnatal care perceptions and reduce any anxiety during this period of new family development.

**Education**

Women reported midwives did not have traditional midwifery skills, lacked in communication skills, failed to recognise their vaginal birth could be traumatic and that
midwives acted in an authoritarian manner rather than a women centred feminist approach or working in partnership with women (Themes 2, 3, 5 & 6). Even with the current midwifery education programs in Australian universities focusing on this woman centred partnership model, this study found midwives are still not acting as midwives and are in fact contributing to perceptions of traumatic birth by working in a manner that left the participants of this study feeling disempowered and traumatised (Themes 4 & 6). Therefore, I am recommending that midwifery education programs include a guest presentation from an expert in traumatic birth on identifying, preventing and managing psychological and emotional birth. In addition, to be included into midwifery education curriculum is an emphasis on educating midwifery students about the hospital pressures and social pressures working in teams that can influence midwives away from working in a woman centred manner. Student needs to be educated on how, when in clinical practice, they will be pressured away from woman centred approaches and that they need to resist this pressure and remember to return to the evidence based knowledge they have on working in partnership with women. Midwifery education needs to touch on hospital culture and social pressures and equip students for this by practising observing these pressures during their time on placement. Midwifery educators inside their education institution should also ensure their attitudes in educating students includes a reality focus of how the student will be pressured to practice differently to what they are being taught, and to teach these students how to manage these pressures by being aware of these hospital and social pressures and always returning to evidence based practice. For evaluating this implemented strategy, midwifery students could be assessed during their exams for birth trauma awareness. Midwifery educators could receive and in-service on how to educate their students on the social and hospital pressures and education programs could include this focus as part of the student curriculum. A decrease in perceived traumas would likely follow with more educated and aware midwives working in the industry. Women’s satisfaction of their birth would increase and reports of an improved mother-midwife partnership would likely increase also.

Limitations and Future research

For this study I wanted to focus on an extreme group as I wanted to know the essence of women’s experiences and perceived traumas. However, this bias and the sample size may be seen as a limitation. Another limitation in this study is the possible recall distortion from
women given some of their interviews were recorded so long after their birthing experiences (all within 5 years). The study also could have included information and interviews done with women’s birthing partners or support people and midwives to be more objective from others perceptions that were involved.

For future research, a mixed methods approach that includes the quantitative elements of looking into how widespread the themes I have found in this study are. This research should include an explanation of how many women who do not self-identify as being traumatised, however still experience an emotional impact of trauma. However, the focus should remain on vaginal births as this type of trauma is not how midwives perceive birth trauma to be, but is how a significant number of women perceive it. Quantitative research is needed to see how big the impact of this type of birth trauma is. In addition, a future study is needed to form a model of care that encompasses the above-mentioned recommendations. This could then be trialled in metropolitan hospitals in Australia. All the above mentioned recommendations and evaluations would also be included in future research.

Summary

The results from this study identified nine themes which women experienced during their perceived birth traumas. These include; ‘I was determined to birth naturally’, ‘Not telling me what they were doing’, ‘I just had to force her to be born’, ‘I felt traumatised, it was really horrific’, ‘I know that is just what the system is like… they’re hospital midwives… they’re medical’, ‘I didn’t feel connected to them’, ‘She stood up for me’/ ‘I felt powerful’, ‘I deserve a better birth’, ‘After the birth, just horrible’/’Your stuck with the consequences’, ‘I deserve a better birth’. These themes each identified areas of deep distress for the women leading to perceived traumas.

Key findings included the new discovery that birth trauma perceptions are not limited to actual obstetrical acts during labour and birth, but also include vaginal births. These vaginal births can hold equally as much of a traumatic impact than for example, a caesarean or emergency forceps birth.
These themes and findings informed recommendations for improving maternity services for women through antenatal education, midwifery education programs, and areas needing improvement in midwifery and obstetrical provisions. Antenatal classes need to educate women on how to be assertive, mindfulness techniques and breathing practices to use for coping with intense emotion, and how important these tools are in optimising their birthing experiences. Midwifery education is to include a communication model that encompasses informed consent, women centred approaches, assertiveness on social and hospital pressures and education on psychological and emotional birth trauma. Hospital policy is to include more time provisions for women. The implementation of a communication model between midwives and women aimed at bridging the familiarity gap and using techniques such as compassionate listening and non-violent communication is crucial in developing more enriching partnerships during labour and increasing positive birthing perceptions. Midwifery models of care would incorporate this.

**Conclusion**

Contemporary birthing practices inside metropolitan public maternity hospitals within Victoria pose significant risk of psychological and emotional trauma to mothers experiencing vaginal births. Power asymmetries and hegemony inside the birthing room were commonly reported throughout the study and midwives were found to not be performing as midwives. Instead midwives were acting in an authoritarian manner that left women feeling disempowered and objectified. The fetocentric model of care used by midwives and obstetricians further enabled feelings of dissociation, disrespect, distrust and trauma for the birthing women. The impact of this trauma was long term for some of these women.

In order to lessen the risk of psychological and emotional birth trauma, midwifery models of care such as caseload midwifery, midwifery led care, and one to one staff ratios during labour, need to become standard practice in public maternity hospitals. Midwives and obstetricians need to be educated in preventing this type of trauma by addressing systemic pressures, attitudes, perceptions, the use of language around mothers and communication strategies to build rapport and connection with women during labour. Antenatal education programs need to equip mothers with coping strategies to manage intense emotion and problem solve, such as mindfulness or other breathing/coping techniques. Women need to be
better educated during their antenatal classes on how to be more assertive in asking for what they want or do not want during labour, advocating for themselves and using permission giving when and if they choose. These antenatal classes also need to include emphasis on empowering women to know if they do not like a midwife or obstetrician they can request a change of staff, that this is an option for them during labour.

Midwifery education programs across Australia need to include comprehensive education on building resilience and assertiveness for midwives to manage the social pressure and hospital hierarchical approaches that leads midwives away from their evidence based woman centred practice. Obstetricians need to be educated on their attitudes and perceptions of a medicalised model of birth and understand the importance of perceiving birth as a normal physiological life event that does not necessarily require medication.

Future research needs to include the development and implementation of a model of care that encompasses all above-mentioned recommendations for improving women’s experiences and perceptions of birth. This model then needs to be trialled in major metropolitan hospitals across Australia and evaluated.

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Press.


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Appendices

Appendix A – Poster and Flyer
Appendix B – Interview Guide
Appendix C - Demographics
Appendix D – Information and Consent form
Appendix E – Letter of support from MCHN centres
Appendix F – Department of Education and Education ethics approval notice
Appendix G – RMIT University Human Research Ethics Committee ethics approval notice
Volunteers Needed

APPENDIX A
Women’s Experiences of Birth Trauma.

- Did you experience a difficult birth?
- Felt emotionally distressed after birth?

RMIT University is conducting a study of women’s experiences of a difficult and emotionally traumatic birth.

If you are a first time mother who has given birth within the last year and felt distressed by your birth, you may be eligible to participate in this study.

We need to talk with women who
- Are a first time mum
- Had a vaginal birth (not a caesarean) and
- Live in the northern suburbs of Melbourne in the Darebin, Whittlesea or Moreland Councils.

Interested and eligible women will be invited to attend an interview with the Midwife/Postgraduate Student after an initial telephone assessment.

Interviews will generally be between 40 and 60 minutes’ duration and be conducted in a private environment of your choice.

♦ To find out more phone Midwife and Post Graduate Student Arimaya Yates on
♦ Email:

This study has been approved by RMIT University ethics committee and the Department of Education & Education.
APPENDIX B

Title -

Interview Guide

• Please tell me about your experience of giving birth and your feelings/perceptions towards this experience?

• What happened during labour that made you feel you were cared for or not cared for?

• Did you have a birth plan? Why? Who helped you write it?

• Did you feel you were able to make your own decisions in labour and birth? Why? Please describe

• How would you describe the communication, hearing and being listened to, the ability to ask questions et cetera. between yourself and your healthcare provider?

• Could you describe anything you perceived as a barrier to feeling in control of your labour and birth?

• Could you describe anything you felt enhanced or helped you to feel in control of your labour?

• How did your birth experience leave you feeling when you went home from hospital? And later on?
• If you were to birth again, would you do anything differently? If so, what?

• Is there anything else you would like to add?
APPENDIX C


PARTICIPANT PROFILE  Participant: _____________________________
                      Unique identifier

SEMI STRUCTURED INTERVIEW NUMBER: _____________________________

Thank you for indicating you are willing to be interviewed about your experience of birth trauma. Your details will not be revealed to anyone else, but will be aggregated to give an overview of the background of the participants of this study.

(a) I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
(b) The project is for the purpose of research. It may not be of direct benefit to me.
(c) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
(d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will form part of a submission for the award of Bachelor of Science - Nursing at RMIT University. Any information which will identify me will not be used.
Outcomes of this research will be presented in publications, presentations at public/professional seminars and conferences.

The data will be used by myself as part of my Masters in Science – Nursing at RMIT University and will form the basis of my further study into a PhD.

Participants are entitled to withdraw from the research at any time and that they can request that their information (data) be destroyed or otherwise withdrawn from the research data collected.

Please circle the most correct answer for each of the following:

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<th>25 to 29 years</th>
<th>30 to 34 years</th>
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<td>Partnered/De Facto</td>
<td>Married</td>
<td>Separated</td>
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</thead>
<tbody>
<tr>
<td>Support person in labour</td>
<td>Partner</td>
<td>Friend</td>
<td>Mother or mother in law</td>
<td>Family member</td>
<td>Doula</td>
<td>No-one</td>
</tr>
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</tr>
<tr>
<td>Type of delivery</td>
<td>Vaginal</td>
<td>Assisted vaginal forceps</td>
<td>Assisted vaginal Vacuum</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwives and obstetricians present at birth</td>
<td>Midwife</td>
<td>Doctor</td>
<td>Obstetrician</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known medical complications with pregnancy or birth?</td>
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<td></td>
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<td>Average household income Annually</td>
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<td>$46,000 to $56,000</td>
<td>$57,000 to $67,000</td>
<td>$68,000 to $75,000</td>
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</table>
Participant Information and Consent Form

Exploring women’s perceptions of a traumatic birth in Victorian maternity settings: An ethnographic approach

PARTICIPANT CONSENT

Dear ______________________

You are invited to take part in a small research study that aims to understand your experiences of birth trauma in Victorian maternity settings. The information provided explains what is involved and will help you decide if you want to take part in the research. Please read this information carefully.

The research
You will be asked to share your experiences of birth trauma, your feelings and emotions and your capacity to express your desired outcomes in birth.

If you consent you will be asked to undertake a private and confidential face to face interview which will last for approximately 20 to 40 mins. The interview will be audio recorded only with your permission. If you do not agree to this, please tell the researcher prior to signing this consent form.

You will be asked to provide basic demographic information such as age and gender and type of birth.

You will not be paid for your participation in this research.

Who is involved in this project? Why is it being conducted?
The project is part of main researcher Arimaya Yates’ Master of Science – Nursing degree. The degree is being undertaken as a research degree with a focus on this qualitative project.
Senior Supervisor: Eleanor Holroyd (Professor Asian and Gender Studies, RMIT)

Student Researcher: Arimaya Yates (Midwife and Masters Student, RMIT)

Co-Supervisor Dr Leanne Sheeran (Coordinator, Child and Family Health Nursing, RMIT)

The project has been approved by RMIT Human Research Ethics Committee

**What are the possible risks or disadvantages?**

There are no potential perceived risks to this project for you other than the inconveniences of having to make time and present yourself for an interview. However, it cannot be completely ruled out that some participants may feel vulnerable or distressed depending on their personal experiences of birth. In the event of such distress, you have the choice to take a break, not do the interview, or postpone to another date. Should you wish, you will be offered immediate referral to professional and free services to help you.

**What are the benefits associated with participation?**

You will be contributing to the exploration of women’s experiences of birth trauma, the findings from the interviews in this project will potentially be used to help make necessary changes to hospital practice to improve relationships between women and their care providers.

You may also find the re-telling of your birth story may be a healing experience.

**Do I have to take part in this research project?**

No, participation in any research project is voluntary. If you do not wish to take part, you don’t have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Participants are entitled to withdraw from the research at any time and that they can request that their information (data) be destroyed or otherwise withdrawn from the research data collected.

**What if I withdraw from this research project?**

If you decide to withdraw, please notify a member of the research team before you withdraw. If you decide to leave the project, the researchers would like to keep the information you provided to them. This is to help them make sure that the results of the research can be measured properly. If you do not want them to do this, you must tell them before you join the research project. Please be advised that if you decline or withdraw from the research you will not be disadvantaged.
How will I be informed of the results of this research project?
On request you will be provided a letter detailing the outcomes of this study on the completion of the study.

What will happen to information about me?
Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law.

In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. A number coding system will be used to ensure confidentiality. You will be allocated a five-digit participant number by the researchers. Any data collected in this study will be kept in a locked and secure location for the duration of the study. Only the researchers will have access to this information for the duration of the study. Any electronic files will be password protected. All data collected in this study will be securely stored at RMIT University for a period of seven years post the completion of this study. Information collected as part of this study will not be used for other study’s.

The findings in this study will be published and disseminated in the thesis, seminar/conference papers, journal/book publications, and/or student reports. Your anonymity will be maintained in any form of dissemination.

How can I access my information?
In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information, with which you disagree, be corrected. Please contact one of the researchers named at the beginning of this document if you would like to access your information.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research study’s. Details of the demographic that will be collected from participants will be provided. Demographic sheet attached.
Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read or heard
- Consent to take part in the research project;
- Consent to participate in the research processes that are described;
- Consent to the use of your personal information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

Consent

I have read, or have had read to me in a language that I understand, this document and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described.

I understand that I will be given a signed copy of this document to keep.

I request a letter detailing the outcomes of this study on the completion of the study.

Yes or No

Participant’s name (printed) .................................................................

Signature

Date

Name of witness to participant’s signature (printed) ........................................
Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the consent section must date their own signature.

If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University, GPO Box 2476V VIC 3001. Tel: (03) 9925 2251 or email human.ethics@rmit.edu.au

List of resources:

FREE TELEPHONE COUNSELLING AND ADVICE/ REFERRALS

• Post and Antenatal Depression Society (PANDA) 1300 726 306
• Maternal and child health line 13 22 29
• Parent Line 13 22 89
• Beyond Blue 1300 224 636
• Lifeline 13 11 14

WEBSITES

• http://www.birthtraumaassociation.org.uk/
• http://birthtalk.org/
• https://www.facebook.com/BirthTraumaAustralia
• http://www.birthtraumaaustralia.com/services.html
APPENDIX E

Letter of Support

RMIT research project - ‘Exploring women’s perceptions of a traumatic birth in Victorian maternity settings: An ethnographic approach’.
I have discussed the above project with Arimaya Yates, postgraduate student at RMIT University. Arimaya has outlined the purpose of the study and any involvement of our Maternal and Child Health Centre for the purposes of recruiting participants for interviews about birth trauma.
This letter confirms that our service agrees to display the recruitment advertising poster and distribute flyers through the Maternal and Child Health Centre.

Signed

Name

Position

Organisation

Address

Email

Phone
Dear Ms Yates

Thank you for your application of 7 July 2015 in which you request permission to conduct research in Victorian early childhood settings titled Women’s experiences of birth trauma in Australian maternity setting: An ethnographic approach.

I am pleased to advise that on the basis of the information you have provided your research proposal is approved in principle subject to the conditions detailed below.

1. The research is conducted in accordance with the final documentation you provided to the Department of Education and Training.

2. Separate approval for the research needs to be sought from centre directors. This is to be supported by the Department of Education and Training approved documentation and, if applicable, the letter of approval from a relevant and formally constituted Human Research Ethics Committee.

3. The project is commenced within 12 months of this approval letter and any extensions or variations to your study, including those requested by an ethics committee must be submitted to the Department of Education and Training for its consideration before you proceed.

4. As a matter of courtesy, you advise the relevant Regional Director of the schools or governing body of the early childhood settings that you intend to approach. An outline of your research and a copy of this letter should be provided to the Regional Director or governing body.

5. You acknowledge the support of the Department of Education and Training in any publications arising from the research.

6. The Research Agreement conditions, which include the reporting requirements at the conclusion of your study, are upheld. A reminder will be sent for reports not submitted by the study's indicative completion date.
APPENDIX G

Notice of Approval

Date: 14 August 2015

Project number: 19428

Project title: Women's experiences of emotionally traumatic birth in Australian maternity settings: An ethnographic approach

Risk classification: More than low risk

Chief investigator: Prof Eleanor Holroyd

Status: Approved

Approval period: From 14 August 2015 To 31 December 2015

The following documents have been reviewed and approved:

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<td>14 August 2015</td>
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<td></td>
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<tr>
<td>Appendix A – Poster and Flyer</td>
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<tr>
<td>Appendix B – Interview Guide</td>
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<td>Appendix C – Demographics</td>
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<td>Appendix D – Information and Consent form</td>
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<td>Appendix E – Letter of support from MCHN centres</td>
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<td>Appendix F – Referral list of services</td>
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<td>Appendix G – Reference List</td>
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<tr>
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The following documents have been noted:

<table>
<thead>
<tr>
<th>Title</th>
<th>Version</th>
<th>Date</th>
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<tbody>
<tr>
<td>Yates short biography</td>
<td></td>
<td>14 August 2015</td>
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The above application has been approved by the RMIT University HREC as it meets the requirements of the National statement on ethical conduct in human research (NH&MRC, 2007).

Terms of approval:

1. Responsibilities of chief investigator
   It is the responsibility of the above chief investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by HREC. Approval is valid only whilst the chief investigator holds a position at RMIT University.

2. Amendments
   Approval must be sought from HREC to amend any aspect of a project. To apply for an amendment use the request for amendment form, which is available on the HREC website and submitted to the HREC secretary. Amendments must not be implemented without first gaining approval from HREC.

3. Adverse events
   You should notify the HREC immediately (within 24 hours) of any serious or unanticipated adverse effects of the research on participants, and unforeseen events that might affect the ethical acceptability of the project.

4. Annual reports
   Continued approval of this project is dependent on the submission of an annual report. Annual reports must be submitted by the anniversary of approval (14 August) of the project for each full year of the project. If the project is of less than 12 months duration then a final report only is required.
5. **Final report**
   A final report must be provided within six months of the end of the project. HREC must be notified if the project is discontinued before the expected date of completion.

6. **Monitoring**
   Projects may be subject to an audit or any other form of monitoring by the HREC at any time.

7. **Retention and storage of data**
   The investigator is responsible for the storage and retention of original data according to the requirements of the Australian code for the responsible conduct of research (section 2) and relevant RMIT policies.

8. **Special conditions of approval**
   Nil.

In any future correspondence please quote the project number and project title above.

A/Prof Barbara Polus  
Chairperson  
RMIT HREC

cc: Dr Peter Burke (Ethics Officer/HREC secretary), Ms Arimaya Yates (student researcher).