

Women's traumatic childbirth experiences: Reflections and implications for practice

Yvonne Fontein-Kuipers^{1*}, Chantal Romijn¹, Elvira Sakko¹, Catelijne Stam¹, Nienke Steenhuis¹, Daniëlle de Vries¹, Ilze van Willigen¹, Diana Koster²

*Correspondence

j.a.c.a.fontein-kuipers@hr.nl

Yvonne Fontein-Kuipers

Rotterdam University of Applied Sciences School of Midwifery
Rochussenstraat 198
3015 EK Rotterdam, Netherlands
Tel: +33(0)10 79 46 166

¹Rotterdam University of Applied Sciences - School of Midwifery, Rotterdam, the Netherlands.

²Practice for coaching & counselling of women, The Hague, the Netherlands.

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Abstract

Objective: This study aims to explore women's traumatic childbirth experiences in order to make maternity care professionals more aware of women's intrapartum care needs to prevent traumatic experiences.

Methods: A qualitative exploratory study with a constant comparison/ grounded theory design was performed. Thirty-six interviews were conducted with women who had given birth in a Dutch birth setting.

Findings: Four themes, playing a profound role in the occurrence of traumatic birth experiences, emerged:

1. **Midwife-LED care** – Maternity care professionals' unilateral decision making during intrapartum care.
2. **Alienation** – Women's experiences of feeling distant and estranged from the childbirth event and the experience.
3. **Situatedness** – The difference of the impact of interventions in situations when complications or emergencies are present in contrast to when interventions are performed without an emergency reason.
4. **Discrepancies** - Paradoxes between expectations (ought self) and reality (actual self) - on an interpersonal (woman) and intrapersonal (woman-midwife) level.

Implications for practice: Intrapartum care needs to include informed-consent and shared-decision making. Practitioners need to continuously evaluate if the woman is consistently part of her own childbearing process. Practitioners need to provide personalised care, make an effort to explain (emergency) situations, be conscious of their non-verbal communication and maintain an ongoing dialogue with the woman.

Conclusion: Intrapartum care can be adapted, adopting a woman-centred approach, in order to prevent women's traumatic childbirth experiences. This study can serve as a valuable assistance for maternity services, midwifery practice, research and for developing guidance in the field of midwifery practitioners' education.

Keywords: Traumatic birth experience, Maternity care, Intrapartum care, Informed-consent, Shared-decision making, Woman-centred care, Qualitative research.

Introduction

Childbirth is a life-event being experienced as traumatic by nine to nearly 30% of childbearing women [1-3]. There is a wide variation in prevalences because no consistent definition of 'traumatic birth' exists. The definition of Beck [4] describing that "birth trauma is perceived in the eye of the beholder" - implying that only women themselves can identify the birth event as a traumatic experience - is most often referred to. The impact and effects of the traumatic birth experiences are widespread as these can lead to the avoidance of a future i.e. next pregnancy, fear of childbirth and to the wish for an elective caesarean section [5,6]. Other negative consequences are disrupted relationships with the partner or other children [6]. In addition, women who label their childbirth experience as traumatic are at higher risk to develop posttraumatic stress disorder (PTSD) [6].

There are various reasons that women have appointed as causes of a traumatic birth experience, such as: loss of control over the birthing experience; lack of information; fear for baby's health or life; not being included in the decision-making process and; discrepancy between expectations and reality [3,5,7]. Additionally, factors such as a lack of communication, a lack of emotional support and not being listened to have a great impact on the woman's experience of the childbirth event [7,8]. The effect of the attitude of the maternity care professional and the interactions between the woman and the care professional emphasise the profound supportive role of the maternity caregiver during the event of childbirth [2,7-9]. International organisations endorse the role of the maternity care professional, the midwife in particular, in their guidelines and strategy recommendations, enhancing the provision of respectful maternity care, effective communication between maternity care providers and women in labour and promoting companionship during labour and childbirth [10,11].

Despite current attention for women's traumatic birth experiences and PTSD and the ongoing debate regarding intrapartum care related to traumatic childbirth experiences [3,7,8], the incidence of traumatic childbirth experiences has remained static. Research, so far, has focused on women's

perceptions of traumatic birth or has provided quantitative measures on attributes and prevention of traumatic labour and birth experiences [5,7,8], resulting in an increased awareness about traumatic childbirth and its associated causes. However, no practical recommendations for maternity care professionals – based on women's experiences thus 'from the eye of the beholder' [4] - to contribute to the optimisation of women's childbirth experiences contributing to the prevention of traumatic childbirth, are yet available. This study therefore aimed to generate a theory leading to recommendations that are relevant for maternity healthcare professionals involved in the provision of intrapartum care. In order to achieve this, the impact of traumatic childbirth experiences as described by women themselves, needed to be explored to serve as the primary source of information.

Methods

Design

This qualitative exploratory study used a constant comparison/grounded theory design utilising individual interviews. This course of action was taken to identify and explain the impact of women's experiences of traumatic childbirth, allowing to investigate the patterns of actions and interaction between the individual woman and her situation; ideally suited to explain the concerns and needs of women with traumatic childbirth experiences for midwifery purposes [12-13].

Participants

Women who had experienced a traumatic birth, whereby traumatic birth was defined by the woman herself, were eligible for the study. Women were included if they had a good proficiency of the Dutch language, were eighteen years of age, or older and had given birth in a Dutch birth setting no longer than three years ago at a gestational age of 37 weeks. Both primiparous and multiparous women were eligible, either receiving midwife-led care or obstetric-led care. Women who had experienced foetal or neonatal mortality were excluded.

Procedure

Participants were purposively recruited through a Facebook post, explaining the aim and

requirements of the study (interview). In total, 64 women responded of which 36 women could be included in the study. Women were excluded because they did not fit the inclusion criteria or when it was not possible to schedule an interview. The interviews were conducted between 12 March and 15 May 2016 at a time and place convenient to the participant. The six interviewers (CR, ES, CS, NS, DdV, IvW) were final-year midwifery students that were trained by a certified coach/ counsellor (DK) in (clinical) interview techniques, how to follow the path chartered by the participant, instead of using a pre-set list of questions. In line with classic grounded theory, the students, i.e. interviewers performed a literature review and they reflected on their own ideas and thoughts about the topic of study. These steps were taken to minimise the likelihood of observant-expectancy bias. None of the interviewers were personally or professionally related to the interviewees assuming the limitation to gratitude bias [12].

Ethical considerations

We adhered to the ethical principles of the Central Committee on Research Involving Human Subject because ethical approval was not required for this study according to Dutch rules of research ethics [14]. Written consent was obtained from all participants. Participation was anonymous. From an ethical perspective the researchers felt responsible to offer support to participants who might still be suffering from their traumatic experiences, being aware that the interviews could trigger thoughts or emotions, leaving women unsupported. Therefore, two certified counsellors were available post-interview for support if necessary. In this study, each participant was given a number and their identity was known only to the researchers, ensuring confidentiality and anonymity. The data were handled exclusively by the researchers and used for the sole purpose of the study. Information was given that findings would be published without identifiable information on the participants.

Data collection

We performed 36 face-to-face semi-structured interviews to gather in-depth information about the experience of the traumatic birth event. Women were invited to describe their birth experience in

detail followed by three questions: (i) how they had experienced the care they had received at the time of the traumatically experienced birth; (ii) if they thought aspects were lacking/ could have been different with regard to the care they had received, and if so what; and (iii) if they had any advice about which aspects could optimise (future) intrapartum care management, contributing to a better birth experience. This way, the 'how' and 'what' questions reflected clinical practice, connecting the students' clinical assessment competencies to their interview i.e. research skills [15,16]. Interviews were audio recorded for which consent was obtained prior to the interview. It was emphasised that there were no wrong answers and participants were encouraged to reveal anything they wanted to say about the topics addressed. Women were informed that they could refuse to answer questions and that they could withdraw from the interview at any moment without giving reason. The six interviewers (CR, ES, CS, NS, DdV, IvW) operated in pairs with alternating roles. Each interview was coordinated by one interviewer and one observer, who observed non-verbal communication (field notes). The interviews lasted between 45 to 90 minutes. Each duo conducted a pilot-interview before they started the interviews to collect the data for the study, to ascertain the interviews techniques were efficient.

Analysis

The recorded interviews were described verbatim and field notes were added to the transcripts to aid interpretation of the data. The transcripts were anonymised. We utilised a process of open coding, creating categories and abstraction. We collected the labels, clustered them in preliminary categories and ordered similar categories into core themes [12,13,17]. Meaningful sections of transcripts were highlighted and discussed in order to propose ideas about the meaning and to consider what stood out in the transcripts. Peer students were asked to validate thoughts and ideas that emerged from the analysis. All these measures were taken to allow a broader interpretive process. After analysing 32 interviews, we recognised that no additional information about the topic of interest was being discovered and repetition was occurring when data collected from participants did not develop new properties within the already established categories

and we were empirically confident that the categories were saturated [17]. To write this paper, the 32-item checklist consolidated criteria for reporting qualitative studies (COREQ) was used [18].

Findings

Participants

Characteristics and obstetric details of the participants are presented in Table 1 and Figure 1. The traumatic births that women referred to had taken place between three months to three years before the time of the interview and included births of first as well as of subsequent children.

Table 1. Characteristics participants (n = 36)

	Mean (SD; range)	N / %
Age	29.4 (0.9; 19-41)	
Primiparous		32 / 89
Multiparous		4 / 11
Obstetric-led care		8 / 22
Transfer of care during pregnancy*		15 / 42
Transfer of care during labour* 10 / 28		10 / 28
Counselling/ therapy resulting from the traumatic birth		7 / 19
Freebirths after traumatic birth experience		3 / 8

* Transfer from midwife-led to obstetric-led care because of antenatal or intrapartum complications during pregnancy and/or labour (In the Netherlands low-risk women receive midwife-led (primary care), including home birth; when complications arise, women are referred to secondary, i.e. obstetric-led care).

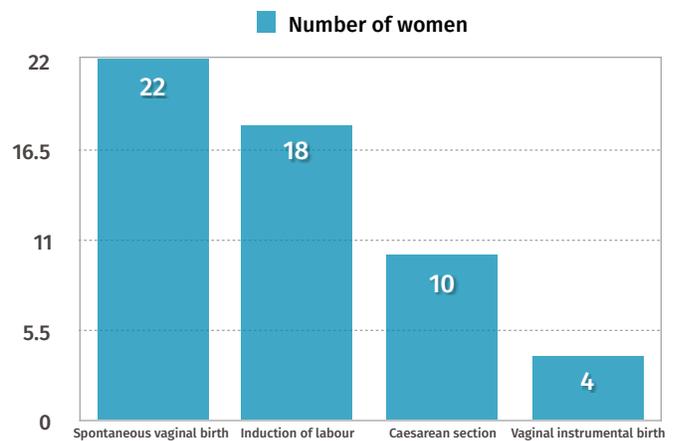


Figure 1. Obstetric details

Themes and practical implications

Four themes emerged: Midwife-LED care, Alienation, Situatedness and Discrepancies. Quotes were added to illustrate the findings. Following on from the themes, we combined our findings with literature, focusing on the optimisation of care, describing practical implications for maternity care professionals that can possibly contribute to prevention of traumatic childbirth from the perspectives of women [19].

Theme 1. Midwife-LED care

Many participants experienced unilateral decision-making of the midwife or obstetrician with regard to care management. Women expressed that it was the professional who decided which policies and interventions were needed and executed, without being informed or granting consent. Women experienced the care provider as being 'in the lead' and not being informative about what was happening. Interventions came as a surprise and sometimes as a shock.

'She [midwife] just did her thing, decided what to do and did it. She didn't tell. It was shocking. I had no control. I did not consent. I had no power, no say in the matter. It felt as if somebody else controlled the birth and it sure wasn't me (...) There was no room for me'

Women felt uninformed about the nature of interventions and the decisions underpinning the performance of the interventions. The women in our study felt that necessary information was not provided. The women in our study wanted to have a care professional who supported their autonomy,

respected their values and met their expectations. One participant described about not being informed and being surprised about the administration of Oxytocin post-delivery:

'All of sudden I got this injection right after the baby was born, I didn't know what it was, nobody had told me or asked me, they just did (...) afterwards it turned out to be synthetic Oxytocin, something I did not want (...). I wanted the placenta to be born naturally, do it myself. It was important to me. I was overruled (...) Shocking, unbelievable... could not believe it they just did that'

For another participant the decision to perform an episiotomy came as a shock. She described that she could not understand the reason for this decision, but she did not have the courage to speak up for herself:

'Then she [midwife] said: I am going to cut you now (...) That came as a complete and utter shock to my system", somebody deciding for me (...) she did not ask... she should have asked (...) it was in my birth plan (...) I felt ignored, patronised and numbed, she did not understand how important it was to me'

The findings show that informed-consent is not daily routine of maternity care professionals, making women feel undermined and excluded as an informed individual [3,8]. Informed-consent should therefore be practised routinely [20], as suggested by our participants. A unilateral care management approach of care professionals is one of the reasons why women feel 'out of control', an important factor related to traumatic childbirth [7]. To optimise care, maternity care professionals need to critically reflect if and how they obtain informed-consent and whether they utilise the steps of shared-decision making during their practice [21]. In addition, reflection is needed on the way care professionals communicate, explain and provide emotional and practical support during labour [7,10,11]. Woman-Centred Care is a model of care that is based on cohumanity and recognises the importance of the dialogue between the woman and the midwife as well as the value and importance of women's experiences during childbearing [22].

Theme 2. Alienation

An immediate effect of midwife-LED care was that women felt emotionally distant and estranged from

the childbirth event, the birth environment and from their own emotions. In other words, women felt alienated.

'When [name daughter] was born the only thing that I felt was immense relief (...) that it was all over, the tugging, pulling and prodding had finally stopped. I did not realise I had become a mother until I heard [name daughter] cry... somewhere in the distance. It wasn't me who had given birth, it was somebody else. I should have been happy, I wanted to be happy (...) I felt left out, let [name partner] take her off me, hold her [daughter]. How I missed that moment afterwards'

Women missed the support how to cope with changes and events during the birth process. No professional information was given about management of care or what the expected course of labour was. Perceived lack of information enhanced the passive role of women, because sense of empowerment to take an active role was inhibited. One of the participants described that she distanced herself of the birth when several interventions followed one after the other in a very short time; interventions she had disagreed with on forehand. She felt that her wishes were no longer met. She described that she surrendered to the situation and adopted a passive role. It felt as if the birth of her child no longer belonged to herself but was taken over by the maternity care professionals:

'I wanted to have a natural birth really (...) She [midwife] wanted to rupture the membranes. She didn't say why. She ruptured the membranes, a wire was attached to the baby's head, I got a drip, a contraction monitor strapped to my stomach ... it all happened faster than I could say: 'Jack the Ripper'. I didn't want this, it was in my birth plan that I didn't want all of that (...) I let it happen (...), what else could I do? Protocols were thrown at me, so to speak. They took over the birth of my baby, my child, instead of supporting me in the process (...) I could not cope, did not know what to do, I was left to my own devices (...) no support whatsoever. And what did I do? I did nothing'

Many women in our study described that often interventions were performed hastily or in a rushed manner, creating ambiguity, fear and the sense that they were not part of the moment. Instead the maternity care professional owned the process and

decided what was needed and made the birth process an impersonal and de-humanised event.

'I went in [labour ward], I can't recall it exactly but there were people everywhere, doing all sorts of different things to me, taking bloods, doing an internal examination, putting up a drip, all at the same time.' Am I dying? I am having contractions here. Give me space! Steady on'. But no, it just went on and on. It was really stressful (...) I had rolled onto an assembly line... I asked them to give me some space to recollect myself, but this was ignored and they carried on. I was only a number, a body, just a womb (...) not a human being at all... not a woman having a baby, becoming a mother'

Based on the findings, it seems that alienation is associated to a cascade and/or a chain of events/interventions. Because of unilateral decision making, reactions and demeanour of the maternity care professionals, lack of transparency and the absence of the feeling being empowered or involved, women experience loss of control, describing a context of an impersonal system of non-individualised care [3]. Medicalised procedures can contribute to the sense of 'being out of control', this being regarded as one of the main causes of a traumatic and dehumanised birth [7]. Therefore, midwives and other maternity care professionals need to continuously reflect on whether the woman is consistently and constantly part of her own birthing process and experience. Critical reflection on shared decision-making and optimal interaction between health care providers and the woman is required [21]. Reflection on the way the woman is being empowered and involved, explanation of policies and a stepped approach in application of policies are important factors to involve women in the birthing process [23]. Individualised personalised care will contribute to quality of care, opposed to protocolised care [24,25] but above all, a birth where compassion and co-humanity should be at the heart of the care for childbearing women [26].

Theme 3. Situatedness

We observed a difference in women's traumatic birth experiences with regard to complications. When labour and/or birth had become critical, interventions were very rarely mentioned or assigned as the cause of the traumatic childbirth. Instead, the emergency or life-threatening aspect

dominated the overall birth experience. Few women had severe complications during labour, for example a haemorrhage postpartum:

'I noticed because of the rush, things were serious (...) They were constantly trying to stop the bleeding. Things were not going right at all (...) I was petrified (...) will I live, will I come out alright? Will the baby be okay... my husband? The whole thing was terrifying, mind blowing, horrific, traumatic'

In contrast, when there were no (severe) complications present but nonetheless interventions were performed and when women experienced the focus was on the interventions, they appointed the interventions and the respective procedure as an important factor of their traumatic childbirth.

'Another vaginal examination, being stuck to the CTG and the drip (...) I couldn't move, was stuck to the bed. One thing after the other... processing interventions (...) my needs and personality were subsumed by protocols. It was all so impersonal, lacking humanity or genuine care. All these things made it a horrible experience, I was on a conveyor belt. Yes, I had a healthy baby, yes, but at what cost emotionally, personally?'

Due to the lack of transparency about what was going on in case of an emergency or in case of a cascade of interventions, women were oblivious what was happening and felt uncertain and anxious. Carers' non-verbal communication such as 'concerned looks' or 'rushed actions' enhanced women's feelings of anxiety and concern.

'The baby's heart rate dropped and nobody spoke. It was distressing. They [professionals] were exchanging glances but did not look at me or speak to me (...) their body language... That made me think whether the baby was alright or not and what was going on (...) I was so worried and so stressed'

In addition to the earlier identified topics for reflection, these experiences of women – regardless situations are emergency situations, there must be an ongoing dialogue between the woman and her caregiver and time must be taken to explain and inform women what is happening. [7,26]. Because of women's sensory awareness during labour, professionals must be conscious of their non-verbal communication. The way health professionals look, walk, stand, gesture conveys much about

circumstances to women, sometimes evoking considerable fear and uncertainty. This is why it is extremely important for care professionals to stay in control of non-verbal messages and interactions.

Theme 4. Discrepancies

Discrepancies between the actual self and the ought self – between expectations and reality - occurred on an interpersonal and intrapersonal level. Discrepancies between ideologies of the woman and the caregiver; medicalised versus physiological birth, caused interpersonal conflicts. Discrepancies between women's expectations of labour and birth and reality had an immense emotional impact. Women who had experienced discrepancies between the actual self (reality) and the ought self (expected to be) described feelings of sadness, lowered self-esteem but also of uncertainty and incomprehension. The discrepancies between wishes and actual outcomes had a great impact on women's mindset and emotions. One participant described that she had wanted to give vaginally but had a caesarean section instead:

'In the end I had a caesarean (...) I had not at all expected that to happen, it was so not what I had envisaged or wanted. I had wanted a homebirth or at least wanted to have given birth vaginally. The only thing I could think of afterwards was to become pregnant again and to give birth again. Then I realised I didn't want to have another child (...) I just wanted another chance to do it right as I felt so bad (...) I felt like a failure, an unfit woman and mother. The first weeks I could only cry (...) I was depressed and a lousy wife'

Discrepancies between the expectations of the maternity care professional and the expectations of the women in labour had negative effects on the woman's childbirth experience - the caregiver and the woman having different perceptions on the process and progress of labour - both expecting different outcomes or course of progress. Because of paradoxical expectations of the woman and the practitioner these women experienced losing connection with the maternity care professional. One participant described the experience of having less dilatation than expected:

'I had been in labour the previous night and all day. At eight p.m. the midwife came in and she said

casually: "Great, you are six centimetres dilated, what a surprise" (...) I thought it was ten! It should at least have been nine and a half (...) The way she said it, so easily and uncaring... rude... as if it was not a big deal (...) as if I was unable to do it [give birth], it was insensitive (...) she didn't notice I was disappointed and hurt. I did not want her there at the birth, someone uncaring and unkind being present at a such an important moment in my life... no. I was glad her shift was over'

Maternity healthcare professionals have an important role in communication and to frame messages in a way that enables the woman to think about her situation and if and how she wants to proceed, including manageability, comprehensibility and meaningfulness of the situation at hand [23,27,28].

Discussion

This study explored the subjective experiences of Dutch women who self-identified the birth of their child as a traumatic event. The reasons that our participants described as contributing factors to their traumatic birth experiences, were similar to those mentioned in other studies [2,3,5,7-9]. We, however, attempted to better understand these experiences and their causes to articulate suggestions and recommendations to optimise midwifery care, aiming to facilitate optimal births and to prevent traumatic ones to happen. We have chosen to focus on care during labour and birth, as we believe this is the first relevant focus when optimising maternity care to prevent negative and traumatic birthing experiences. We hope to have made healthcare professionals who provide midwifery care for childbearing women more aware of the supportive needs that women have, resulting from traumatic childbirth experiences. We do not intend to point a finger towards maternity care professionals but only want to articulate and highlight women's experiences, hoping to learn from the accounts given by the participants in our study to allow maternity care providers to understand women's subjective experiences to enable them to respond appropriately and accordingly to their needs. The findings of our study articulate the core issues in midwifery care [10,11]. The suggestions and recommendations on their own, none of them are sufficient; all suggestions are intertwined and reflect the nature of woman-

centred care [22]; necessary for providing optimal care in childbirth.

Implications for practice

Recommendations and suggestions originated directly from the data, combined with earlier research on the topic of study. Women's experiences can help maternity care professionals to be aware of their practice, attitude and (care) behaviour. Optimal care can be achieved when maternity care professionals critically evaluate and reflect on the intrapartum care they give, their overall attitude, counselling competencies, their views on the woman-midwife relationship and on communication and shared-decision making processes [21,22,26]. Topics for evaluation are: being aware and checking with each individual woman whether informed-consent procedures have been applied [20,21] how they interact and communicate with the woman [23], if they provide transparent care and information [3] and allow themselves to involve and empower the woman [24,25]. Reflection of the health care professional on whether the woman is part of her own birthing process and experience seems a major issue [7]. To prevent unnecessary stress and negative emotions among women, maternity care professionals should take time, independent of the situation, to explain to the woman what is happening, taking a stepped approach in the application of policies and interventions [26]. In order to prevent or deal with discrepancies between expectations and reality, the woman should be supported to evaluate and reflect on the situation and if or how she wants to proceed, strengthening the individual woman's own resources and her sense of coherence and her involvement in the childbirth process [26-28]. These practical aspects suggest to reduce the risk that women feel out of control, overruled and disempowered and experience a traumatic childbirth. Hence, maternity care professionals should seriously consider how they can implement woman-centred care, because this care model agrees with the intrapartum needs of the woman [22]. Education about and critical reflection on the topic of study should also be implemented in the curricula of education programmes of the relevant healthcare professionals and of lifelong learning of maternity care professionals, to make them aware

of the factors that contribute to an optimal childbirth. Dissemination of the facts of women's traumatic birth experiences and guidance of the prevention of these experiences in education and in practice, will contribute to the professional development of a self-conscious and woman-centred maternity care professional.

Strengths and limitations

A number of limitations are apparent in this study. Our participants were all from the Netherlands and the stories they told were shared within the context of the Dutch maternity system, affecting transferability [12,13]. Our analysis relied on women's memories of their experiences and might have caused recall bias as some women spoke of births that had occurred two or three years before. However, women generally recall labour and the birth of their children accurately, even three years after the event has taken place [29]. The self-selective nature of our study might have led to sampling bias and we might have included women with strong opinions about mismanagement of their birth event. It is likely that women with insufficient proficiency of the Dutch language, with a severe depression or who feel ashamed or embarrassed about their traumatic birth did not respond to the call for this study [30]. Therefore, more research is needed to reach and include these women and increase transferability of the study results. The interviewers had extensive midwifery knowledge and clinical experience that possibly could have influenced the execution and outcomes of the study [15,16]. We assured that the interviewers' role including biases, beliefs, and values up-front were adequately addressed through instruction and support during the data collection process. To ensure that interpretations were valid and grounded in reality, the researchers engaged in continuous self-reflection and self-scrutiny and analysis took place in collaboration [30].

Conclusion

The findings of this study can serve as a powerful message for healthcare professionals who are involved with childbearing women. Maternity care can be adapted, in order to prevent women's traumatic childbirth experiences. Our study emphasises that the best scenario is to facilitate a

positive birth, where the woman feels in control, feels respected in her choices and in her being. Based on the experiences of our participants, woman-centred care should be considered as a preferred model of care within midwifery teams and maternity care units. The findings and implications for practice can serve as valuable assistance for maternity services, midwifery practice, research and developing guidance in the field of midwifery education. Continued investigation of the topic of traumatic birth experiences would be of merit.

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