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Womens Perception of Their Childbirth Experiences: An Integrated Literature Review

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WOMEN'S PERCEPTION OF THEIR CHILDBIRTH EXPERIENCES:
AN INTEGRATIVE REVIEW OF THE LITERATURE

by

NANCY M. FARMER

A thesis submitted in partial fulfillment of the requirements for the
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Abstract

Pregnancy and childbirth are a unique and sacred time in many women's lives and the process of giving birth often leaves women and families in a vulnerable position. This integrated literature review examined birthing experiences from the maternal perspective and focused on the short-term and long-term implications of negatively perceived maternal experiences. While there are several international studies, only a few have published studies from the United States. This integrated review showed a significant impact of provider-client communication and shared decision making on a woman's overall perception of her birthing experience. Reports of excess intervention, lack of informed consent, and a perceived disregard for embodied knowledge- all contribute to negative perception of the birthing women. It is important to better understand both the positive as well as negative maternal experiences in order for health care providers to effectively address quality of care issues. Implications for nursing education, practice, policy, and research are discussed in depth with a focus on improving maternal perception of the birth experience.

Dedication

To my four greatest blessings: Calista, Natalie, Amelia, and Ryan- whom I am lucky enough to lead as an example for. I hope this journey has shown you that you can do anything in the world you set your mind to! Every time I thought about quitting, I remembered you were watching. Thank you for being patient with me as I worked on this for many hours and for being my reason to push through! I am forever blessed to be your mom.

To my sweet husband David: you introduced me to the idea that childbirth can and should be different. I doubt you understand how grateful I am for your gifting my heart this passion. Thank you for continuing to support me through every step of this process and for encouraging my heart to dance on! I love you for always.

To my parents: There was never a moment in my life that you did not encourage me to jump in and tackle everything I set out to do. Your example and love have allowed me to blossom into a woman with passion and drive, who knows she can do anything she chooses. Thank you for supporting all of my choices for all of my years. I love you.

To my family and friends near and far: Thank you for constantly listening to me ramble on about this topic, my research, for encouraging me to push forward constantly, and for celebrating my success. I am better for having you on my team.

And finally, and perhaps most importantly, to the many women and families who have allowed me to share in their birth stories: it has been a privilege and an honor to serve you and to share in your most sacred moments. Thank you for trusting me with your hearts as you pour them out in the process of healing. Your stories will live with me and continue to push me every single day as I work to bring light to the challenges and to advocate for women everywhere.

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Introduction

Patient experiences and their perception of care quality has become a priority in all healthcare settings. The nationally recognized standard for measurement of patient perception of their experience with health care services is known officially as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). HCAHPS is a survey-based tool of which results are publicly reported, allowing comparisons of patient's experiences of care in hospitals and health care practices, at the local, regional, and national levels. Created as a collaboration between the Centers for Medicare and Medicaid Services (CMMS) and the HCAHPS Project Team, three goals were established as basis for the project. The first goal ensures the survey is designed to accurately produce data specific to the patient's perspective of care in a format that will allow comparison of hospitals on topics that are meaningful to consumers. Second, publicly reporting survey results creates a unique incentive for improvement of care in hospitals and among healthcare practices. Finally, HCAHPS increases transparency with public reporting; thus, increasing healthcare accountability.

HCAHPS is comprised of a 27-question, Likert scale, survey which discharged patients are asked to complete and evaluate their recent healthcare encounter in both acute and community-based facilities. Of the 27 questions, there are 18 core questions specific to communication, responsiveness, cleanliness, quietness, pain management, discharge information, overall rating, as well as would a patient recommend the hospital. The survey is administered to a random sample of adult patients from 48 hours to 6 weeks after discharge, using a variety of modes: electronically, telephone, mail, interactive voice recognition, or a combination of mail with follow up phone call, across a spectrum of medical conditions. HCAHPS administration

mandates specific protocol surrounding sampling, data collection, and coding. Acute care facilities, clinics, and health service venues must routinely and systematically collect data each month throughout the year. The organization may either utilize the services of an approved vendor or collect the data on their own (with prior approval from CMS).

HCAHPS scores are publicly reported on a quarterly basis, and four (4) consecutive reports are available at a given time. This allows consumers to fairly and objectively compare HCAHPS scores over time. Select factors are adjusted to ensure fair and accurate comparison by consumers that are beyond hospital control. Finally, to ensure quality and adequate oversight, the HCAHPS project team works to routinely inspect administration procedures, evaluate the statistical analysis process, and performs site visits to assure protocol adherence (HCAHPS, 2017). The focus of this integrative review is on women's negative childbirth experiences to inform health care providers in their efforts to improve quality of care in this specialty.

Purpose

The purpose of this integrative literature review is to examine the research focusing on women's negative childbirth experiences in facilities that provide obstetrical services in order to identify factors that impact the quality of maternal healthcare.

Problem Statement

What are women's perceived negative child birthing experiences and the subsequent short- and long-term impact?

Background

Currently, patient satisfaction is at the forefront of healthcare. Insight into the perceived expectations, perceptions associated with childbirth can be highly beneficial to understanding and promoting a positive experience for all women and their families. Statistics show that most women report a positive childbirth experience. However, that is not always the case. Several studies indicate, in some birthing facilities, not all women had a positive childbirth experience; or, met their perception of “quality care” with adequate professional accountability (Bohren, Vogel, Hunter, et al 2015). There is a body of qualitative research describing maternal perception of disrespectful or abusive care during labor and birth. This less than favorable information is essential in order to address the problem and institute standardized practices to address these issues in maternal care services.

Consequently, a 2015 statement from the World Health Organization recognizes maternal perceptions of trauma and disrespect during childbirth as a global issue. The official statement reads: “Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful healthcare.” (WHO, 2015, p.1). Following the lead of the WHO, the American College of Obstetricians and Gynecologists (ACOG, 2016) released the following official statement: “The autonomy of a woman, who is capable of making decisions the right to refuse treatment and discourages health care providers from the use of behaviors targeted to motivate a woman toward a specific clinical decision: these behaviors include: duress, manipulation, coercion, physical force, or threats” (ACOG, 2016 p.4).

Psychological research identifies long term implications of the childbirth experience on maternal mental health and family wellbeing. The birth experience, which extends from early onset of labor and includes postpartum recovery, can impact a woman and her families emotional

and mental health (Reed, Sharman, & Inglis 2017). Among others, trauma associated mental health issues during the postpartum period have been shown to lessen a woman's sense of self, and disrupt family relationships (Fenech, Thompson, 2014). Problems can arise with mother-baby bonding which contributes to increased stress, low self-esteem and other emotional problems. Maternal post-partum responses can also negatively influence a child's emotional, social, and mental development (O'Hara, Wenzel, & Kleiman, 2014). Therefore, the consequences of real or perceived traumatic experiences in childbirth can have far reaching consequences for the woman and her family.

Methodology

A comprehensive review of the literature was undertaken focusing on childbearing women and their overall perceptions of care in the childbirth setting. Databases searched included the Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus), Medline, Elton B. Stephens Co. (EBSCO), BioMed, and Directory of Open Access Journals.

Key search terms included: child birth experiences, quality obstetrical care, childbirth violence, disrespect and abuse in childbirth facilities, maternal health, maternity care, and prevention of, trauma, mistreatment, and promoting respect for maternal healthcare. Inclusion criteria included research published from 2007 to 2018, in peer-reviewed publications, and written in the English language. While the focus of this study is on practices in the United States, international studies were included. Exclusion criteria included research articles published in a language other than English and outside of the specified publication date.

Ten (N=10) studies were selected for this integrated review. Each was systematically analyzed. Subsequently, all were again reviewed for consistent and inconsistent findings. Gaps in the

research literature were also noted. (See Appendices: Figure 1 Selection Method of Literature; Table 1 Literature Search Strategy; Table 2; Evidence of Reviewed Articles).

Findings

Ten studies were selected for review per the inclusion criteria. Of the ten relevant articles included in the initial search, seven studies focused specifically on maternal perspective of the childbirth experience. Five of these focused primarily on the maternal (child-bearing woman) perception of the childbirth process and the remaining two studies included midwives/care provider's perspectives. Of the seven including maternal focus, six used qualitative methodologies and one used a mixed-method that included a qualitative component. All of the reviewed studies consisted of original research.

An additional three qualitative studies focused specifically on perceived maternal trauma during childbirth. Inclusion of the studies allowed for further examination of potential long-term effects associated with negatively perceived maternal birthing experiences.

One qualitative study estimated that of all women who have delivered in a health care facility, at least one third (33%) experienced some form of trauma while giving birth (Reed, Sharman, & Inglis, 2017). It is important to note that "trauma" is as unique as the person experiencing it. Therefore, qualitative studies can be an effective approach for exploring women's childbirth experiences both positive and negative. Perceived maternal birth trauma includes various experiences including; a healthcare professional challenging maternal autonomy in performing unconsented vaginal exams; force and manipulation in obtaining consent for a medical intervention; and, real or perceived bias in professional's presentation of facts when obtaining informed consent (Miller and Lalonde, 2015, p S50). Furthermore, provider communication and interactions can also influence a woman's perceptions of "trauma",

“disrespect”, and “abuse” in the childbearing setting (Reed et al., 2017). Finally, a woman’s perception of loss of control or lack of involvement in the decision making and overall birth process are often cited situations described as disrespectful or traumatic (Reed et al., 2017).

Bowser and Hill (2010) further identified seven categories describing perceived negative obstetrical experiences, specifically: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific attributes, abandonment/denial of care, and detention in a facility (Bowser and Hill, 2010). It is important to note these categories are based on women’s perceptions, and the authors do not provide precise definitions or behaviors for each concept.

Maternal Perspective

A recent large-scale (N=2787) cohort study of first-time mothers, evaluated the factors that influence women’s perception of shared decision-making during labor and delivery. The Delivery Decision Making Scale (DDMS), which included 6 questions, was used to measure women’s perceptions of involvement and satisfaction pertaining to the decision-making process to evaluate “inclusion in care” (Attanasia, Kozhimannil, Kjerulff, 2018).

The findings suggested the majority of women (64%) were satisfied with their inclusion in the decision-making process and their overall childbirth experience (Attanasia, et al., 2018). The results highlight a gap in satisfaction between mode of delivery and medical interventions; specifically, induced delivery (58% satisfaction) versus spontaneous delivery (67% satisfaction); and, cesarean delivery (51%) versus vaginal delivery (61%). Further analyses focused on demographic factors, i.e.: race, socioeconomic, education level. While most of the women in the study were satisfied with their inclusion in decision making, of those who were not satisfied most

demographically were in a “marginalized social group” (Attanasia, et al.,2018). The researches acknowledged that a disparity existed among women in marginalized social groups who did not feel they participated in the decision-making process during labor. The authors further note the disparity could be lessened with a culturally sensitive patient centered care model.

In an international qualitative study conducted in Ethiopia by Burrowes, Holcombe, Jara, Carter, and Smith (2017), both providers and patients were interviewed on their perspectives of disrespect and abuse during labor and delivery. Their study included N=45 participants in four (4) separate health facilities; they surveyed 23 childbearing women. Of these, 20 women delivered in a health care or birthing facility; the other three delivered at home.

The research examined women’s perspectives of their care including observation or personal experiences of disrespect, abuse and providers’ knowledge of patient rights. Verbal abuse was frequently reported (48%) with participant’s reports of being shouted at, mocked, or spoken to in a demeaning fashion (Burrowes, et al., 2017). Issues with autonomy was the most frequently noted by participants, specifically denial of the woman’s preferred birth position, denial of accompaniment during labor and/or deliver by a particular person, lack of privacy and breaks in confidentiality (Burrowes, et al., 2017). Personal reflections of participants are included in the report, vividly highlighting first-hand experiences of the women during labor and childbirth.

Increasingly, women in Ethiopia have been opting out of seeking medical care based on personal and others reported experiences. This choice puts women at a higher risk of complication by using less skilled birth attendants who often are unable to deal with life threatening situations of either the infant, the mother or both. Burrowes et al. discuss the need for

more comprehensive education of maternal care providers regarding the provision of respectful care including effective communication, counseling and rapport building skills (2017).

An international qualitative study in South Africa by Lambert, Etsane, Bergh, Pattison, and Broek (2018) explores the quality of care provided to women at birth incorporating feedback from (N=49) women who had given birth in the preceding twelve weeks. The purpose of the study was identification of the most vital and important aspects of care from maternal perspective. Eight themes emerged from their data: (1) Women [and healthcare providers] feel alone, exposed, and unsupported; (2) the mutual distrust between providers and women; (3) the lack of choice and inclusion in the decision making process; (4) a procedure-centered rather than patient-centered care; (5) the normalization of verbal abuse; (6) the dissonance between knowledge and practice; (7) a professional hierarchy; and (8) the ability to provide feedback (Lambert, Etsane, Bergh, et al., 2018).

Each of the eight themes were closely examined relative to the women's self-reports. The researchers noted it is vital to consider personal beliefs and attitudes as to how a person perceives the care they are receiving. Gaining insight into the history and experience of a person can better guide healthcare providers and facilities to more effectively meet the mental, physical, and emotional needs of childbearing women. Lambert et al. (2018) point out that the delivery of a message, such as the manner in which one speaks, and tone of voice relays one's attitude, may have a greater impact than what actually is stated (positive versus negative attitude); in turn, this can influence the perceptions of the women receiving care. The authors also recommend that organizational leaders provide ongoing training on effective communication techniques to improve the actual and perceived quality of care (Lambert et al., 2018).

Another very recent qualitative study by Madula, Kalembo, Yu, and Kaminga (2018) focuses on provider-patient communication and the impact this has on a woman's perception of care in childbirth. Thirty women (N=30) were interviewed in six (6) facilities in Malawi maternity settings to identify barriers to effective communication (Madula, et al., 2018). An interview guide focused on communication, perception, and barriers to communication. All of the interviews were performed by the same individual to address interrater reliability to minimize differences in interview approach. A six-step process for thematic analysis was performed with the raw data.

Five themes were identified in this qualitative study, specifically, (1) effective healthcare provider- patient interaction; (2) verbal abuse and lack of respect; (3) failure of providers to entertain or answer questions; (4) linguistic barriers and lack of competency in alternative, non-verbal communication; and finally (5) discrimination related to status (Madula, et al., 2018). Madula et al., (2018) emphasized more obvious communication barriers included (real or perceived) disrespect, verbal abuse, language limitations, and notable discrimination related to social status. Furthermore, themes that were related to women's positive birth experience included good provider communication. The researchers recommend the need to develop and implement an intervention or program to improve provider communication skills along with patient centered health care behaviors (Madula, et al., 2018).

Miltenburg, Lambermon, Hamelink, and Meguid utilized focus groups to evaluate women's thoughts on maternity care and human rights (2016). They completed (N=36) interviews with 17 Tanzanian women who had given birth, between the ages of 31-63 to explore their experiences and perspectives of maternal health care. Their data analysis focused on four human rights principles: (1) dignity; (2) autonomy; (3) equality; and (4) safety (Miltenburg, et

al., 2016). The principle of dignity includes multiple dimensions (dignity in person, relation, and institution); and is categorized as “worthiness”. Autonomy included participation in decision making, right to choices, and informed consent. Equality specifically focused on fairness rather than sameness. Safety referred to protection from unintentional and intentional harm. The women’s negative perceptions related to a violation of one or more principles of human rights.

Positive experiences were reported events of being treated well and equal, feeling respected, and being given adequate, complete, and appropriate information pertaining to medical intervention and treatment (Miltenburg, et al., 2016). The researchers acknowledge the reported experiences suggested participants of the study were aware of the violation of human rights in their birthing experiences. The authors further analyzed the impact of perceived concerns for safety and respect in instances in which the participant may disagree with the mode of care by a healthcare provider (Miltenburg, et al., 2016). When asked if the knowledge of violation would affect the setting in which they chose to deliver, the women in this study reported preference to utilizing health facilities for childbirth based on possibility for complications in delivery (Miltenburg, et al., 2016). The authors also reflect on the potential impact of a woman’s previous experience and knowledge of rights as it affects her perception of her childbirth experience. The researchers found that improvement in communication and attitude was vital to improve perception of care by the laboring and birthing women. They further conclude that effective and respectful communication can have significant impact on improving perceptions of women experiencing care and reducing the perception of violation of human rights (Miltenburg, et al., 2016).

Women’s perception of obstetric violence was evaluated in a study performed in Brazil by Oliveira, Costa, Monte, Veras, and Rocha (2017). The researchers interviewed, twenty

women (N=20) between the ages of 15-49, in a public hospital. This qualitative study focused on evaluating, characterizing and exploring the experience of violence by women in the parturition process. Focus groups generated new and original ideas rather than categorize based on determined themes (Oliveira, et al., 2017). Frequent responses of neglect of care and verbal aggression emerged in the womens comments (Oliveira, et al., 2017). Examples of neglect of care included deprivation of care, but also withholding information from the women. Verbal aggression included lack of therapeutic communication and demeaning language (Oliveira, et al., 2017).

While the authors recognized that the term, “obstetric violence”, alludes to physical acts, their results suggest that poor communication was associated frequently with reported negative birth experiences (Oliveira, et al., 2017). The authors reflected that not all who experience “obstetric violence” recognize it as such. Strong emotions contribute to the likelihood of a woman just accepting what is happening to her, in fear or otherwise. The authors encourage health professionals, managers, and community members to engage in the discussion, development, and implementation of policies to ensure improvement in humanized obstetric care (Oliveira, et al., 2017).

A cross sectional study of N=1660 women giving birth in nine (9) facilities across eight (8) regions in Chile by Weeks, Pantoja, Ortiz, Foster, Cavafa, and Binfa (2016), sought to understand maternal satisfaction as it associates with medical intervention and accompaniment during labor among Chilean women. The study included 47.3% (n=790) nulliparous women, 40.9% (n=683) multiparous women, and 11.3% (n=187) with unknown parity. Mode of delivery was also broken down in which the majority (75.8%, n=1258) experiencing spontaneous vaginal delivery, 18% (n=313) delivering by cesarean section, just over 4% (n=70) delivering through

forceps assisted birth. The remaining 2% (n=19) mode of delivery was unknown (Weeks, Pantoja, Ortiz, et al., 2016). The intention of the study was to explore the effect medical procedures or interventions as it related to postpartum maternal satisfaction of care. Significant factors creating less than optimal satisfaction scores included cesarean birth, pharmacological pain management, continuous fetal monitoring, episiotomy, and nulliparity (Weeks, et al., 2016). Positive factors include accompaniment of a companion [of the subject's choice] (Weeks, et al., 2016). Their findings were consistent with the recommendation by the WHO regarding the routine use of medical intervention in laboring women. (Weeks, et al., 2016). The authors suggested improved health care provider education, training, protocols, and communication correspondingly improve perceived maternal experiences.

Finally, a global mixed method study captured both quantitative data and qualitative written comments from women reporting on their childbirth experiences (Reed, Sharman, & Inglis, 2017). A total of (N=943) participants, (n=748) surveys included qualitative questioning, and six phase inductive thematic analysis. The participants were from Australia and Oceania (36.8%), North America (34.2%), and Europe (25.5%). Also Included were a small sample of women from South America (2.1%), Asia (0.9%), South Africa (0.5%), and the Middle East (0.2%). In this study, four themes contributed to the perception of negative or traumatic experiences; (1) Prioritizing the care provider's agenda; (2) disregarding embodied knowledge; (3) lies and threats; and (4) violation. 66.7% identified caregiver actions and interactions that they perceived to be traumatic in nature (Reed, et al., 2017). The researchers described participant's perceived trauma that specified, excessive medical interventions (i.e. fetal monitoring, forced consent/non-consent intervention, loss of control, not being involved in the decision-making process related to vaginal versus cesarean delivery. Their report further

acknowledged that women noted their interaction either positive or negative with care providers. Communication was most significant in their perceived experiences related to the quality of care (Reed et al., 2017). Reed et al. recommend inclusion of more humanistic approaches in the practice of maternity care. Including the woman in the process can be beneficial in improving their overall childbirth experiences and reducing the real and perceived trauma.

Care Provider Perspective

Two studies examined in the patient perspective provided data relative to the healthcare provider perspective. In the qualitative study by Burrowes, Holcombe, Jara, Carter, & Smith (2017), four practicing midwives and fifteen third year bachelor's degree midwifery students were interviewed. The results from the interviews align with the reported data from the maternal participants. The healthcare providers recognized and reflected on the frequent use of verbal and (sometimes) physical abuse, as well as unconsented care (Burrowes, et al., 2017). The provider participants acknowledged the care they provided often was lacking in support for the woman in labor.

Lambert, Etsane, Bergh, Pattison, and Broek (2018) reviewed the quality of care women receive at birth from both the woman's and provider's perspective. Their study included nurses, medical staff, and midwives (n=33) who participated in five focus group sessions and eighteen in depth personal interviews. Overwhelmingly, responses indicated that providers have insight and knowledge of what constitutes quality care but sometimes offered reasons for not providing it, such as staffing issues, supply shortage, physical environment limitations, and finally poor referral pathways (Lambert, et al., 2018). The data from the providers perspective reinforces the

importance of appropriate management, facility protocols, and improved interprofessional communication.

Long Term Consequences of Negative Birthing Experiences

Long term implications must consider that most women are emotionally and physically fatigued after delivering a baby. As physical healing begins in the new mother, and the family bonds with its newest member, the memory of the birthing process begins to fade. However, that may not be the case for a woman who perceives her childbirth experience negatively. The research focusing on women who describe their perceived birthing experience with emotional trauma, finds that subsequent mental health issues can impact the woman's long-term sense of self and even disrupt family relationships (Fenech, et al, 2014). Other studies show the correlation of maternal emotional effects on lack of successful mother-baby bonding, which may in turn negatively influence the child's emotional, social, and mental development (O'Hara, Wenzel, & Kleiman, 2014).

A qualitative study by Susan Ayers, (2007) included a sample of N=50 women: half (n=25) with the presence of post-traumatic stress (PTSD) symptoms, and half (n=25) without presenting symptoms of PTSD. The interviews examined maternal recall of emotions and thought during labor and birth, cognitive processing in the postpartum, and the recall of memories of birth associated with PTSD symptoms (Ayers, 2007).

Four distinct themes emerged; mental coping, desire for labor to end, poor understanding of on the events taking place and, mental defeat contributed to the negative experiences of women during childbirth and further to the development of PTSD symptoms (Ayers, 2007).

Women with the presence of PTSD symptoms also recalled feelings of panic, anger, defeat, dissociation, and thoughts of death during the birth process. Postpartum, these women had more difficulty staying present in the moment, with painful, intrusive memories, and ruminations. Ayers (2007) suggests acknowledgement of birth and postnatal processing may be beneficial for screening women at risk for development of post-traumatic stress disorder symptoms. More research is needed to direct the implementation and understanding of real or perceived birth trauma with associated PTSD symptoms.

A prospective cohort study by Schepper, Vercauteren, Tersago, Jacquemyn, Raes, and Franck (2016) utilized interviews to examine the prevalence of PTSD and risk factors associated with personal versus care provider influences in Flanders, Belgium. They included two separate interviews of women at week one (N=340) and week six (N=229) postpartum. After one week, the prevalence of PTSD symptoms in the women ranged from 22% to 24%; and, the follow-up (six week) interview ranged from 13% to 22% (Schepper, Vercauteren, Tersago, et al., 2016). Influencing factors included Islamic (religious) belief, traumatic childbirth experience, low socioeconomic status, psychological/psychiatric history, and complications in labor and birth. Factors which decreased the prevalence of PTSD symptoms include midwifery care, an opportunity to ask questions and clarify concerns during parturition, and a 'normal' physiologic birth (Schepper et al., 2016).

The findings of this study emphasize the importance of a woman feeling in control during the birth process. Ability to ask questions and feel included in decision making may help to increase maternal perception of control and therefore may decrease the incidence of post-traumatic stress symptoms. The authors express the need for further research in order to create a

fully comprehensive PTSD risk screening which will allow providers to best address the needs of the population (Schepper et al., 2016).

Another study included interviewing fourteen (14) women from New Zealand who described their birth experience as ‘traumatic’. Thomson and Downe (2008) initiated this research to explore the perceived experience and associated meaning to subjects reporting traumatic birth. Interpretive phenomenological theological approach was utilized to analyze the data; which offered a person-centered approach to explore the lived experience and meanings of reported trauma (Thomson & Downe, 2018). Their findings highlighted three main themes; disconnection; helplessness; and isolation (Thomson & Downe, 2018). Upon further exploration the authors concluded that the mode of birth was not a primary factor of associated trauma, but rather interpersonal relationships between the client and provider were more important in decreasing incidence of PTSD symptoms related to their birth experience. The authors noted that perceived or real traumatic birth stems from connection rather than the issue of ‘over-medicalization’ or mode of childbirth (Thomson & Downe, 2018).

Discussion of Findings

The purpose of this integrated literature review was to evaluate and explore the negative experiences of women in childbirth about the care they received. To understand how to better serve women and reduce the negative reported experiences, ten relevant research studies were reviewed and analyzed to gain a deeper understanding about the perception of negative childbirth experiences. This section will further discuss the findings of the literature.

Maternal Perspective

Seven articles focused on the maternal perspective of their childbirth experience. All seven used interviews and six of the seven identified common themes centering on a desire to be included in care, thorough patient education, and treated with basic human rights (i.e.: dignity and respect).

Perceived negative birth experiences (sometimes described as traumatic) generally were related to the care provider actions and ineffective communication (Reed, et al., 2017). A common perception that the healthcare provider prioritized their own agenda over the patients perceived best interest were mentioned in five of the seven studies. Most of the studies cited the women's perceptions that the care providers disregarded their embodied knowledge. The specific of mode of delivery and a woman's negative perceptions was rare. Rather, negative perceptions were associated with the approach of attaining consent for alternative modes of delivery, i.e., caesarean, forceps assisted, and augmentation. The results portray the importance of effective and sensitive communication between women and their healthcare providers during the childbirth process.

Communication includes one's perception of being "listened to" and having the ability to ask questions about the process or medical interventions. Women were less likely to report feelings of negativity toward their child's birth if they felt their basic needs were met. Negating a laboring woman's ability to make appropriate choices in parturition disregards human rights. Likewise, when women know their rights and options in childbirth, they can find a provider willing to meet their needs and preferences. However, it also is important initial birth plans regarding pregnancy, labor and delivery will need to be modified according to unanticipated events that can impact maternal and fetal safe outcomes

Physical violence and verbal abuse were reported on occasion in the studies. However, the recollections of the mothers (women) who did experience such behaviors remained vivid when it was reported weeks, months and sometimes years later. Reports by both women and confirmed by care providers included violation of a woman's choice to refuse (episiotomies, digital vaginal exams), avoidance of gaining informed consent, use of threats or fear tactics to obtain consent, 'slapping' a woman to get her to listen or do what the provider wanted. It is important to stress in the United States physical abuse of any type by a provider can lead to legal action and revocation of one's license. Improvements in communication training, informed consent protocols, and disallowing the mistreatment of women in facilities will go a long way to improve negatively perceived labor and birth experiences.

Care Provider Perspective

The term care provider in this discussion refers to nurses, midwives, birth attendants, and obstetricians. Management refers to personnel in administrative roles in a healthcare facility.

Two studies (Lambert et al., 2018; Burrowes et al., 2017) analyzed provider perspective and validated the maternal perspective related to the quality of care they received. Inadequate staffing patterns, the pressure to perform, and lack of resources left providers feeling inept at providing maternity care they described as high quality. High levels of acuity in health care facilities require rapid decision making on the part of the care provider. The sense of urgency combined with being overextended, often deterred providers from taking the time to adequately explain an interventions or procedures to a woman. Providers also acknowledge in the healthcare setting, if overseen by a supervisor who did not adhere to quality care standards, individuals under them would work at the same level.

Long Term Consequences of Negative Birthing Experiences

Three articles examined the long-term impact of a woman's negative birth experiences on the family unit (O'Hara, et al, 2014, Ayers, 2007, & Schepper et al., 2016). The researchers found that PTSD can be associated with a real or perceived traumatic birth experience, and providers should evaluate postpartum mothers for such researched symptoms. The researchers also pointed to the prevalence of risk factors which may predispose a woman to PTSD symptoms. Early identification allows for earlier interventions which can result in reduction of the long-term implications of traumatic birth on the process of maternal-infant bonding, and the child's long-term emotional health.

A woman's perceptions of disconnection, isolation, and helplessness further contribute to maternal related perceptions of trauma symptoms (Thomas & Downe, 2018). The researchers recommend healthcare providers create protocols and interventions to ensure women in labor and childbirth are not exposed to negative or emotionally damaging experiences, for example, allowing women to move while in labor, arranging for social support, and providing ongoing encouragement with frequent visits by the healthcare providers, can help to combat feelings of isolation. Finally, encouraging the women to ask questions, providing ongoing educating, and facilitating participation in the decision-making process related to their birthing process, can improve the overall perception of the childbirth experience in the post-partum environment.

Implications for Nursing

Based on the review of literature focusing on women's perceived negative experiences of childbirth, the next section highlights the implications for nursing practice, education, policy, and research, concluding with study limitations.

Practice

There is national emphasis on patient satisfaction with quality of care as put forth by HCAHPS (HCAHPS, 2017). In the maternity ward, a deeper and clearer understanding of women's perceptions of their childbirth experience is vital. Recognizing the significant impact care providers have on the perceptions of women and their birth experience is of value to improving mental health outcomes. Effective communication is a major aspect of the patient-caregiver relationship. It is vital for a woman in the parturition period to feel included, heard, valuable, and respected. Of the women who perceived neglect, disrespect, abuse, misconduct, trauma during childbirth, this was most often associated with ineffective provider communication. As advocates, nurses should plan and deliver individualized care to women during childbirth. Most important is including the woman as part of the care planning team which ultimately can also improve the overall patient experiences in childbirth facilities. Birthing choices are not a one size fits all model and educating and encouraging women to make informed decisions promotes feelings of trust and contribute to positive experiences.

Effort should be made to learn a woman's preconceived ideas of maternity care and the role the care providers have in assuring a safe and high-quality outcome. In turn, nurses can implement strategies to meet a woman's expectations for the childbirth experience. In situations

where goals are unlikely or unsafe, providing education and guidance to help reduce maternal stressors and feelings of being ignored or disrespected can improve the woman's perceptions of care. Improved interprofessional communication is essential to identify and deliver safe and effective care. Sharing insight, experiences, and information provided in patient satisfaction surveys, can serve as highly valuable tools to address demonstrations of improper care. Regular staff and interprofessional communication will also greatly impact the care given to patients.

Unit managers can recognize issues related to short staffing and do their part to address these concerns. Administrative oversight of protocols is also needed to ensure they are meeting the goals set forth by the WHO and ACOG. Implementation of maternal inclusion in care as well as procedure for full and complete informed consent should be initiated as a routine protocol in the childbirth setting. Ongoing feedback from childbearing women is essential to ensure the goals and preferences of this population are met. Including support persons and labor companions as part of the care team will also further the inclusion of maternal rights and relieve feelings of isolation in the childbearing process. Finally, busy maternity wards, perception of urgency, and discounting a woman's ability to understand information (based on education and socioeconomic status) may not be valid reasons to not provide adequate patient education and information for true informed consent.

Education

It became evident from maternal reports in the reviewed studies of negatively perceived birth experiences that there is an information gap in these types of facilities. While a great deal of nursing education focuses on therapeutic communication, there is an apparent failure of application in some childbirth settings. Facilities have the opportunity to adopt and educate about

a global initiative to ensure women have compassionate care, and an overall positive birth experience. The Mother Baby Friendly Birth Facility (MBFBF) initiative focuses on an official certification for birthing facilities (i.e., hospitals) that achieve the designation of Mother-baby friendly birth facility by meeting a criterion. This certification was created as a collaboration between the International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), the White Ribbon Alliance (WRA), World Health Organization (WHO), and the International Pediatrics Association (IPA). Health care providers in general, and nurses in particular can be educated about evidence-based standards of care that are equated with quality associated with pregnancy, childbirth and postpartum care. Quality indicators include assuring dignity, privacy, information on safe options for pain relief and choice of birth support/companions. Education of all providers who care for women during childbirth about effective ways to address human dimensions are imperative to favorably improve the experiences of women and their families during childbirth.

Policy

Implementing the initiatives set forth by the WHO and ACOG (WHO, 2015 & ACOG, 2016) discussed above, may prove effective and improving maternal perception of her birth experience. Facilities should do more to ensure adequate staffing and support for providers in order to repair damaged perceptions of laboring women. Policy protocols to ensure adequate staffing may help to decrease the stressors felt by care providers, allowing a higher quality of care. Finally, implementing research findings and including healthcare providers and community members in the process of policy creation may prove effective at reducing perception of negative birth experiences.

Research

There is a clear need for more research into women's perceptions of their birth experiences.

1. To improve patient satisfaction and quality, studies are needed to gain a better understanding of what women require feel supported, cared for, safe, and listened to during their childbirth experiences.
2. Studies should be undertaken focusing on the childbirth experiences of women in the United States, in particular those who are of minority ethnic and religious groups.
3. Research studies are needed examining nurses' roles on maternity care units in hospitals versus birthing centers in the community versus childbirth in home settings.

Study Limitations

Several limitations are noted for this integrative literature review focusing on the perceived negative experiences of women during childbirth. First, this review was limited to studies written in the English language, published from 2007 to 2018. Second, the majority were international studies, some of which were undertaken in developing nations. Consequently, the health care systems of those nations with different approaches to maternity care, consequently may not reflect care giving, quality standards and reimbursement practices of the US.

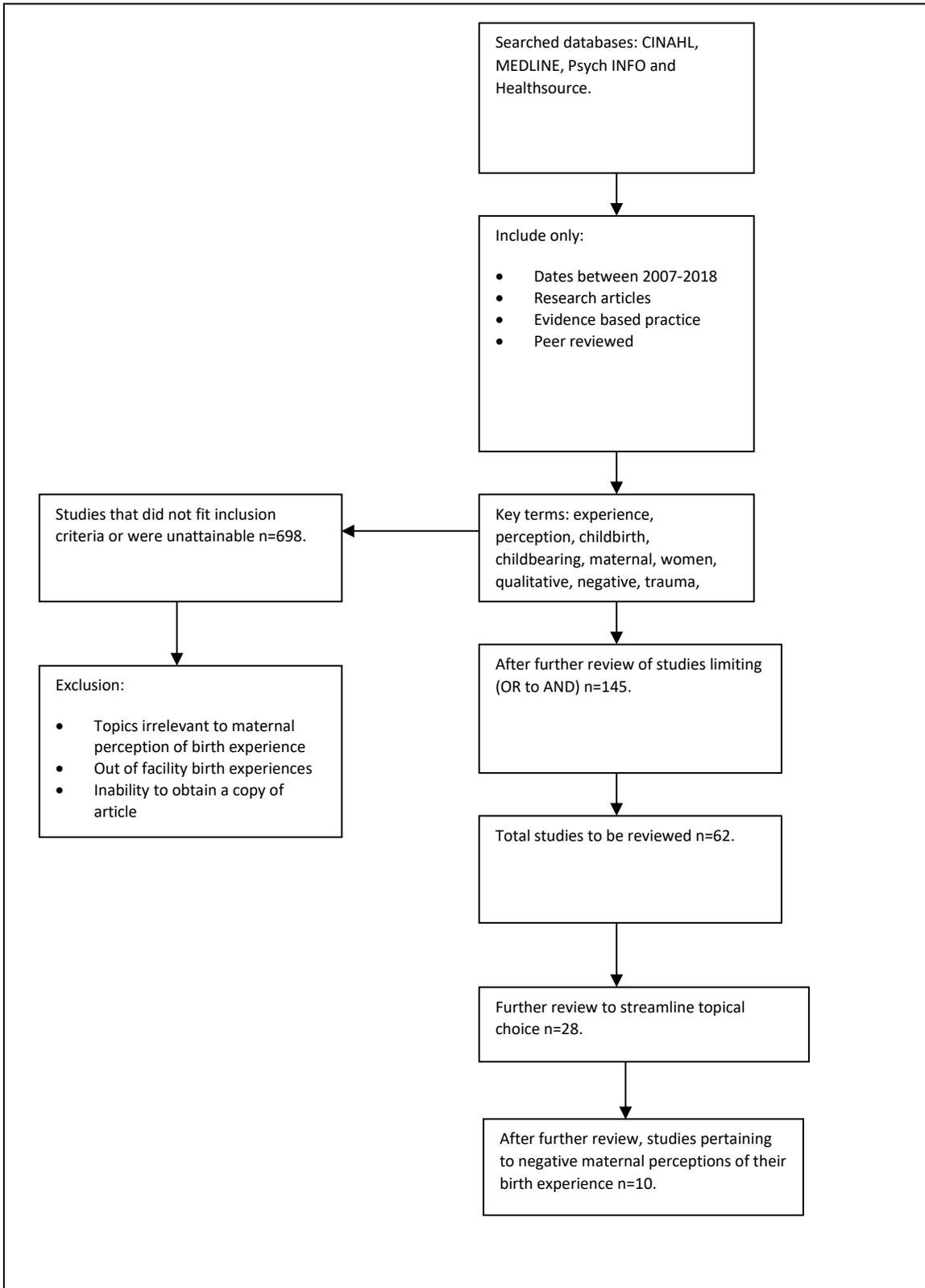
Summary

In summary, this integrated review of the literature focused on womens' perception of childbirth experiences. Of particular interest was the perception of negative experiences. This information is essential to address concerns and implement strategies to improve the perceived quality of care and maternal satisfaction.

Appendices

Appendix A

Figure 1: Selection Method of Literature



Appendix B

Appendix B

Table 1: Literature Search Strategy

Database	Date	Strategy	No. of Articles Found	No. of Relevant Articles
CINAHL plus With Full Text	9/2018	("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (negative)	158	23
		("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND qualitative AND (disrespect or abuse or trauma)	90	18
		Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (disrespect or abuse or trauma) AND (negative)	12	2
Medline	10/2018	("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (negative)	141	22
		("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND qualitative AND (disrespect or abuse or trauma)	81	16
		Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (disrespect or abuse or trauma) AND (negative)	13	6
PsycINFO	9/2018	("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (negative)	134	26
		("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women")	86	19

		AND qualitative AND (disrespect or abuse or trauma)		
		Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (disrespect or abuse or trauma) AND (negative)	7	1
Health Source	10/2018	("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (negative)	64	18
		("Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND qualitative AND (disrespect or abuse or trauma)	50	12
		Experiences" OR "Perception" or perceptions* or experience*) AND ("childbirth" OR "birth, childbearing*") AND ("Maternal" OR "Women") AND (qualitative) AND (disrespect or abuse or trauma) AND (negative)	7	0
Total			843	145

Table 2: Evidence Table of Reviewed Articles

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Attanasia, L., Kozhimannil, K., Kjerulff, K.	Factors influencing women's perceptions of shared decision-making during labor and delivery: Results from a large-scale cohort study of first childbirth <i>Patient Education and Counseling (2018) 101: p1130-1136</i>	Interview/ Data Review	Comparative: Logistic regression model	Women who gave birth to first, singleton baby in Pennsylvania between 2009-2011 (n=3006).	To examine the correlates of shared decision-making during labor and delivery and assess the relationship between delivery mode and subsequent childbearing.	Black women, women without college education, or without private insurance were less likely to report inclusion in shared decision making. Women who underwent labor induction (58% positive), assisted delivery (39% positive), and cesarean birth (49% positive) report lower perception of inclusion in decision making as well.	While the majority of women in this study (64%) reporting the highest possible score for perceived shared decision-making inclusion, a disproportionate gap exists with racial/ethnic minority groups, lower education level, lack of private insurance. Marginalized groups are less likely to be involved in shared decision making.	Strategies with a focus on improvement of the quality of patient-provider communication, information sharing, and shared decision making are necessary to reduce the disparities seen in these marginalized groups.	Shared decision making, maternity care, disparities, patient-centered care, cesarean delivery

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Ayers, S.	Thoughts and emotions during traumatic birth: A qualitative study <i>Birth (2007) 34:3 p.253-263.</i>	Interview	Qualitative	50 women: (n=25) women with the presence of post-traumatic stress symptoms (n=25) women without the presence of post-traumatic stress symptoms.	Examine thoughts and emotions during birth, cognitive processing after birth, and memories of birth that may affect the development of PTSD symptoms.	Themes for all women: mental coping, desire for labor to end, poor understanding of what was going on, mental defeat. Negative themes > positive during birth. Women with PTSD symptoms- more panic, anger, thoughts of death, mental defeat, and dissociation during birth. After birth: fewer stay present strategies, more painful memories, intrusive	Insight toward identifying aspects of birth and postnatal processing that may determine whether women develop PTSD symptoms following birth.	More research is needed in order to implement this possible insight into the practice setting.	Posttraumatic stress disorder, birth, thoughts, cognition, emotion

						memories, and ruminations.			
Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Boucher, D., Bennett, C., McFarlin, B., Freeze, R.	Staying home to give birth: Why women in the United States choose home birth <i>Journal of Midwifery & Women's Health (2009) p. 119-126.</i>	Online Survey	Qualitative descriptive secondary analysis	160 U.S. women who planned a homebirth at least once. 82% (n=132) planned a homebirth within the past 5 years.	Examine to understand why women in the US choose homebirth.	26 common themes emerged from the question "why did you choose home birth?". Most commonly: (n=38) safety; (n=38) avoidance of unnecessary medical interventions common in hospital birth; (n=37) previous negative hospital experience; (n=35) more control; (n=30) comfortable, familiar environment; (n=25) innate trust in the birth process.	Survey responses illustrate the acknowledgment and desire for safety and the desire for a natural birth without medical intervention and the desire for perception of control.	Understanding the responses allows facilities to adapt standards of care to promote patient when appropriate.	Choice of birth settings, health policy, homebirth, home birth, home childbirth, home delivery, out-of-hospital birth, out-of-hospital deliveries, qualitative descriptive study

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Burrowes, S., Holcombe, S., Jara, D., Carter, D., Smith, K.	Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study <i>BMC Pregnancy and Childbirth (2017) 17:263</i>	Interview /Survey	Qualitative	45 interviews in 4 health facilities SURVEY: 2 populations: Provider and patient 23 women over age 20 who had given birth in a facility; 3 women who had given birth at home. 4 practicing midwives; 15 third year bachelor's degree midwifery students	Perceived and reported disrespect and abuse of women during labor and delivery is increasingly recognized as a violation of women's rights and acts as a deterrent for the utilization of facility-based, skilled attendant based childbirth services. Lack of utilization may be increasing the risk to those choosing to opt out of care.	Frequent verbal and physical abuse (primarily unintentional) were reported by both midwives and patients. Reports of non-consented care were also frequent.	Women recognize violation of rights and opt to deliver in other facilities or at home when compared to facilities with reputations for poor care.	Increased and strengthened training on respectful care should be adopted. Improved counseling skills and rapport building should be a primary focus.	Midwives, respectful maternity care, disrespect and abuse, maternity care, quality, patients' rights, women-centered care.

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Creedy, D., Shochet, I., Horsfall, J.	Childbirth and the development of acute trauma symptoms: Incidence and contributing factors BIRTH, 2000. 27:2. P.104-111	Interview	Prospective, longitudinal design.	499 women recruited in their last trimester from 4 public hospital antenatal clinics. Interviews conducted 4-6 weeks PP.	TO determine the incidence of acute trauma symptoms and PTSD in women resulting from labor/birth experiences. To Identify factors contributing to women's psychological distress.	One in three (33%) of women identified a traumatic event with identification of at least three trauma symptoms. 28 (5.6%) met DSM-IV criteria for PTSD. 113/499 reported some trauma symptoms. Acute trauma symptoms associated with level of obstetric intervention and perception of inadequate	Obstetric intervention and poor care were most frequently identified with connection to trauma symptoms. Women are more likely to experience psychological morbidity in the postpartum period as a result of adverse birth experiences.	Continued review of invasive obstetric interventions is needed. Improved communication and preparation of what to expect may help lessen traumatic experiences. Assessment of trauma symptoms in the postpartum period is vital to assure adequate mental wellbeing. Maternity staff should promote debriefing of birth	Acute trauma, childbirth, intervention, post-traumatic stress syndrome.

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Lambert, J., Etsane, E., Bergh, A., Pattison, R., Broek, N.	'I thought they were going to handle me like a queen, but they didn't': A qualitative study exploring the quality of care provided to women at the time of birth <i>Midwifery, 2018. 62: p. 256-263.</i>	Interview	Descriptive phenomenological approach	Birth in preceding 12 weeks: 49 women 7 focus discussion groups, 23 in depth interviews. Healthcare workers: 33 nurses, medical staff, midwives, 5 focus discussion groups, 18 in depth interviews. 10 Key Informant interviews with managers and policy makers.	To explore experiences of care during labor and birth from perspectives of both women receiving care and healthcare providers. To inform recommendations for the monitoring and improvement in quality of care, and to identify the most important aspects of care to women.	Both women and healthcare providers feel alone and unsupported. Prioritization of procedure over patient centered care contribute to negative childbirth experiences. A lack of belief in a woman's ability to make appropriate choices often negates choice and consent.	Main themes identified are applicable in both urban and rural settings. Women want to feel safe, welcomes, cared for, and supported according to their needs. Perception of how a healthcare provider's attitude presents and how they talk affect a woman's perception of her experience greatly.	experience to promote healing and understanding . Renewed focus is necessary to ensure a companionship approach during labor and birth. Training must prioritize and facilitate caring and supportive leadership.	Respectful care, maternity care, person-centered care, experience of care, disrespect and abuse.

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Madula, P., Kalembo, F., Yu, H., & Kaminga, A.	Healthcare provider-patient communication : a qualitative study of women's perceptions during childbirth. <i>Reproductive Health, 2018, 15:135.</i>	qualitative	Descriptive study with thematic approach for data analysis	30 interviews from 6 facilities from three regions in Malawi	To examine the nature of communication in the maternity ward, identify facilitators and barriers to healthcare provider-patient communication and understand how they affect maternal healthcare.	Main themes that emerged regarding the nature of communication : 1) good healthcare provider-patient interaction; 2) verbal abuse and lack of respect; 3) failure by healthcare providers to answer or entertain questions; 4) linguistic barriers to communication and lack of competency in non-verbal communication ; & 5) discrimination	The existence of communicative barriers such as disrespecting and verbally abusing pregnant women, language limitations, and discrimination r/t status affect maternal service delivery. Pregnant women who are happy with healthcare provider communication better receive delivering at facility.	Necessity to develop and intervention to help improve healthcare provider communication.	Maternal mortality, communication, pregnant women, traditional birth attendants, skilled birth attendant, health facility

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Miltenburg, A., Lambermon, F., Hamelink, C., Meguid, T.	Maternity care and human rights: what do women think? <i>BMC International Health and Human Rights (2016) 16(17)</i>	Interview/ Focus group discussion	Qualitative Data analysis→ coding scheme based on four human rights principles: dignity, autonomy, equality, and safety.	In depth interviews(n=36) with 17 women between ages 31-63. 1 focus group session.	Explore women's perspectives and experiences of maternal health services through a human rights perspective in Magu District, Tanzania.	Substandard care factors relate to the violation of multiple principles of human rights. Main themes: 'being treated well and equal', 'being respected', and 'being given the appropriate information and medical treatment.	This population of women in rural Tanzania are aware of violations to their basic rights.	Improvements in attitude and communicatio n is vital to improve perceptions of substandard care and perceived violation of human rights.	Human rights, maternal health, dignity

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Oliveira, T., Costa, R., Monte, N., Veras, J., Rocha, M.	Women's perception on obstetric violence <i>Journal of Nursing (2017) 11(1): 40-46</i>	Interview	Descriptive, exploratory, qualitative	20 women from public hospital in Teresina, Brazil.	To characterize obstetric violence experienced by women during the parturition process.	Two main categories emerged: negligence in care and verbal aggression.	Perceptions of violence can be characterized in a variety of ways, ranging from neglect of care, denial of rights and clarifying diagnostic information, to verbal assaults at the time of childbirth.	Mangers, health professionals, and the community must choose to implement public policies to ensure the perception of more humanized care.	Violence, obstetric, women's health

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Reed, R., Sharman, R., & Inglis, C.	Women's descriptions of childbirth trauma relating to care provider actions and interactions.	Online Survey-	Mixed method Qualitative-with six phase inductive thematic analysis process	943 women-survey 748 women survey with qualitative questioning.	Understanding the influence of interpersonal factors on a woman's experience of trauma allows for the development of care promoting optimal psychosocial outcomes. Perceptions of traumatic birth can impact postnatal health and family relationships.	Four themes identified: prioritizing the care provider's agenda; disregarding embodied knowledge; lies and threats; and violation. (66.7 %) described care provider actions and interactions as the traumatic element in their experience. {Care providers include OB's, midwives, and nurses}.	Interpersonal birth trauma is an increasingly recognized global issue. Care providers actions and interactions influence a woman's experience of trauma during birth.	Addressing interpersonal birth trauma must be done on all levels. Recommendations include inclusion of holistic and humanistic approaches in maternity care delivery. Utilization of the WHO five actions should remain forefront with process of developing provisions.	Childbirth, trauma, maternity care

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Schepper, s., Vercauteren, T., Tersago, J., Jacquemyn, Y., Raes, F., Franck, E.	Post- Traumatic Stress Disorder after childbirth and the influence of maternity team care during labor and birth: A cohort study. <i>Midwifery (2016) 32 p.87-92.</i>	Interview/ Data collection	Prospective cohort study	Two interviews postpartum (1 week and 6 weeks). 1 week (n=340) 6 weeks (n=229)	To examine the prevalence of PTSD and the role of risk factors (personal and obstetric) as well as midwifery team care factors in Flemish women.	PTSD factor prevalence 1 week after childbirth range: 22%-24%. PTSD factor prevalence 6 weeks after childbirth range: 13%-20%. Influencing factors: Islamic belief, traumatic childbirth experience, low family income, history of psychological/psychiatric conditions, complicated labor and birth. Positive Influencing factors (lower incidence of PTSD symptoms) include: care from midwifery team, opportunity to ask questions, a "normal" birth.	There is an importance of women feeling in control during the birth process. The ability to ask questions increases perception of control.	Further research is needed to develop a comprehensive PTSD risk factor screening. With deeper understanding , providers will be able to best address the treatment needs of a vulnerable population.	Post-Traumatic stress disorder, Postpartum, midwifery team, risk factors

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Thomson, G., Downe, S.	Widening the trauma discourse: the link between childbirth and experiences of abuse <i>Journal of Psychosomatic Obstetrics & Gynecology (2018). 29(4): 268-273</i>	Interview	Interpretive phenomenological approach.	14 women who had experienced a self-defined traumatic birth.	To explore to understand the lived experience of and personal meanings attributed to a traumatic birth.	Trauma was not related to the mode of birth, but to interpersonal relationships between client and caregiver. Emerging themes: 'disconnected', 'helpless', and 'isolated'.	Childbirth is not only a public health concern, but also a moral and ethical concern as well. The issues are far deeper than perceived 'over-medicalization' of childbirth and extends beyond mode of birth or outcomes.	Childbirth experience has far-reaching implications on the family unit. Raising awareness for all staff interacting with the mother is vital.	Trauma, childbirth, victims, abuse, violence, interpretive phenomenology

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Weeks, F., Pantoja, L., Ortiz, J., Foster, J., Cavafa, G., Binfa, L.	Labor and Birth Care Satisfaction Associated with Medical Interventions and Accompaniment During Labor Among Chilean Women <i>Journal of Midwifery and Women's Health (2017). 62: 196-203</i>	Qualitative - Interview/Survey Quantitative - Chart Review	Cross Sectional	1660 women giving birth in Chilean public hospital facilities between 2012-2013. 9 Hospitals in 8 regions. 47.3% (n=790) nulliparous 40.9 % (n=683) multiparous 11.3% (n=187) unknown parity Mode: n= 1258 SVD n= 313 CSD n= 70 FAB n=19 unknown	To explore birth procedures related to postpartum maternal satisfaction with care.	Satisfaction scores 66- 210. 49.4%- optimal satisfaction 28.6%- adequate satisfaction 22.0%- minimal satisfaction. Correlation between negative birth experience and medical interventions. The more educated women reported less satisfaction. Multiparous women reported more satisfaction.	Improving birth experiences related to focus on improving interpersonal interaction and reduced unnecessary intervention use.	Potential to improve experience of laboring women exists. Less intervention changes of training protocols, improved communication can all contribute to improvement.	Childbirth, Chile, Latin America, obstetric labor, quality of health care, intrapartum care, patient satisfaction.

Author(s)	Title/Source	Method	Study Design	Sample	Purpose	Results	Conclusion	Implications	Key Words
Vedam, S., Stoll, K., Rubashkin, N., Martin, K., Miller-Vedam, Z., Hayes-Klein, H., Jolicoeur, G., & the CCinBC Steering Council.	The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. <i>SSM: Population Health 3, 2017, p. 201-210</i>	Survey	Cross Sectional	1672 women sharing 2514 experiences. Including women from diverse communities across British Columbia. 3 samples to test for reliability and consistency: s1-s2 (n=2271). S3 (n=1613).	Systemic review across 34 countries by the WHO on the treatment of women during childbirth found no global consensus on the measurement of disrespectful maternity care. The creation of a survey tool by a community led action research team in British Columbia allows for a streamline approach for measuring and assessing a woman's experiences with maternity care-including discrimination and disrespect.	1 in 10 women reported feeling coerced into accepting options suggested by their care providers. 10.5% (s1) and 6.4% (s2) reported poor treatment r/t difference in opinion. Low MORi scores reported 3.6% of midwifery clients, 15.3% family physicians, 21.6% OBGYN.	The MORi allows for authentic insight on assessment of women's experiences of respect and ability for self-determination in maternity care.	If used consistently, the MORi can provide assistance to institutions and providers to evaluate the informed consent process as well as insight to patient's perceptions of experienced discrimination and poor treatment. It may also be useful in the educational setting, in patient centered care research, and to improve quality in practices.	Childbirth, human rights, participatory research, psychometrics, scale development, respectful maternity care, survey research, provider-patient communication

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