

THE INFLUENCE OF ENVIRONMENTS ON FEAR OF CHILDBIRTH DURING
WOMEN'S INTRAPARTUM HOSPITAL STAYS

by

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

The Faculty of Graduate and Postdoctoral Studies

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

July, 2017

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Abstract

Differences in birthing environments and models of maternity care are contributing factors to women's fear of childbirth. British Columbia has higher rates of caesarean sections than the Canadian national average and provides women with a variety of maternity care models in hospitals. Studying British Columbian women's perspectives can increase our understanding of the influence of unique hospital birthing environments on women's childbirth fear. The study aimed to investigate women's perceptions of effects of hospital birth environments on their childbirth fear, following hospital-based labours and births. The study design was qualitative description. Over a five-month period, 15 women were interviewed individually. Inductive content analysis produced one major theme: Women's engagement with their labours and births; the major theme incorporated six sub-themes: Women's connection to their bodies; women's inclusion in decision-making processes; freedom to use the hospital space; feelings of trust toward professional caregivers; distractions from labour; and personalized care. Study participants linked being disengaged during their labours and births to feelings of uncertainty, fear of the unknown, and losing control while labouring and birthing in hospitals. The study findings point to the importance of professional caregivers incorporating women-centered care practices in maternity care. More investigation into barriers preventing professional caregivers in British Columbia from enacting women-centered care is warranted.

Lay Summary

Childbirth fear is a common experience for women who mostly labour and birth in hospitals. Women's childbirth fear has been linked to more interventionist birth outcomes (e.g. instrumental and surgical assisted births). The investigator interviewed fifteen women who shared their experiences of labouring and birthing in hospital and the impact of these environments on their childbirth fear. Study participants described being disengaged from their labour and birth experiences in hospital when they felt uncertainty, fear of the unknown and feelings of losing control. They indicated that childbirth fear made it difficult to stay connected to their bodies and their fear was enhanced by their lack of inclusion in decision-making processes, freedom to use the hospital space, feelings of trust toward professional caregivers, ability to focus on labour, and personalized care. The study results underline care providers' responsibilities to attend to women's needs for control and trust in the childbirth process.

Preface

This thesis represented a collaboration between myself and my supervisory committee. I completed the work of data collection, and data analysis with input from my primary supervisor. The writing of the thesis was completed with the guidance and input from all committee members including Dr. Wendy A. Hall, Dr. Jennifer Baumbusch, and Lily Lee.

This thesis project received ethics approval from the Human Ethics Board of UBC Research Ethics. The certificate number of this approval is H15-03097.

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Acknowledgements

I offer my immense gratitude to faculty, staff, and fellow students at UBC who have encouraged and inspired my work on this project. I want to give particular thanks to Dr. Wendy Hall who has supported and challenged me throughout the work on this thesis, without her commitment to quality and her gift of discernment I would not have been able to accomplish this work. I also want to thank my supportive and expert committee members whose patience throughout the process has given me stamina in order to develop my scholarly skills. I am forever grateful for to my entire committee for their expert and kind contributions to this project.

I am extremely grateful to Dr. Beverley O'Brien, as well as, the Midwifery and Nursing programs at UBC for awarding me the Strengthening Mothers through Perinatal Research award to support this thesis project. The award has given participants more opportunity for their voices to be heard, as well as providing potential for the study to have greater influence through dissemination of the results.

Special thanks are owed to my husband whose support and efforts have gone heavily toward my developing this project with success and quality, both morally and technically.

Dedication

I wish to dedicate this work to the women whose voices have not been considered over the course of their maternity care. I want to extend my immense gratitude to the study participants. Their commitment to and enthusiasm for telling their stories will be forever an inspiration to me, moving forward in my career.

I also wish to dedicate this work to my supervisor and committee, whose continual hard work stretches far beyond my master's project to many other avenues of nursing research, by informing the public and their caregivers to improve women's wellness and the quality of clinical practice. I only hope I can achieve as much in my career. This dedication is directed to Dr. Wendy Hall, Dr. Jennifer Baumbusch, and Lily Lee.

Further, I want to dedicate this work to my husband. Ben Auxier gave his time and energies in supporting me through this process. His support and excitement for my work continues to give me motivation. From his unique support I have a positive anticipation for what research can achieve for the wellness and safety of women being served by health care systems in British Columbia and around the world.

1: Introduction

1.1 Fear of Childbirth

Fear of childbirth has been described as an extreme fear of birth, a clinical condition known as tokophobia (Stoll & Hall, 2013a). The prevalence of pregnant women's fear of childbirth (FOC) in developed countries is estimated at 20% (Hall, Hauck, Carty, Hutton, Fenwick, & Stoll, 2009; Saisto & Halmesmäki, 2003). There is a range in the prevalence depending on the specific country, suggesting that birth environments may be a contributing factor to women's perceptions of FOC (Hall et al., 2009). FOC's nature, meanings, prevalence, risk factors, and associated outcomes have been studied internationally and in Canada. FOC has been associated with poor maternal outcomes, such as increased rates of emergency caesarean sections (Laursen, Johansen, & Hedegaard, 2009) and poor neonatal outcomes, e.g. low Apgar scores (Räisänen et al., 2014).

The influence of hospital birthing environments on FOC in labouring women has received limited attention. Differences in birthing environments and models of care internationally appear to result in varying manifestations of FOC and outcomes for labouring women (Cumberland, 2010; Nyman, Downe, & Berg, 2011; Taghizadeh, Arbabi, Kazemnejad, Irajpour, & Lopez, 2015). The variation across countries suggests that it is important to examine the influence of birth environments on women's perceptions of FOC. In this chapter, I will describe some aspects of FOC, explain the significance of studying this phenomenon in relation to hospital birth environments, and articulate the purpose of my study.

Pregnant women's FOC in late pregnancy can persist to the time of admission to labour wards, and to the birth of the infant and beyond; this is called the vicious circle of fear (Kjærgaard, Wijma, Dykes, & Alehagen, 2008). There is evidence that when FOC is present during labour and birth a physiological cascade of fear is initiated (Stenglin & Foureur, 2013). Stenglin and Foureur (2013) outlined the phenomenon of the fear cascade, which occurs when epinephrine is released during a fight or flight response. The release of epinephrine affects oxytocin uptake during labour leading to a slowing of labour progress and vasoconstriction throughout the body (Stenglin & Foureur, 2013). Vasoconstriction has been linked to ineffective perfusion of the placenta, prolonged labours, and fetal distress, which can lead to instrumental deliveries and emergency caesarean sections (Stenglin & Foureur, 2013). In cases in which this fear cascade becomes initialized, women's pre-existing fears about labour and birth can be enhanced if women experience persistent fear-inducing stimuli in the birth environment (Zar, Wijma, & Wijma, 2001).

Labouring women are particularly influenced by hospital birth environments that are dominated by the medical model and interventionist approaches to birth (Cumberland, 2010). The medical model, also termed the medical illness model, is an approach that portrays birth as risky and potentially dangerous (McCool & Simeone, 2002). The medical model approaches to birth utilize surveillance technologies, e.g. continuous electronic fetal monitoring, and interventions, e.g. oxytocin to control the progress of labour and birth (McCool & Simeone, 2002). These approaches to maternity care highlight the risks involved with labour and birth and influence labouring women's perceptions of their births, often giving them the sense that they can express limited

agency in the context of their births (Christiaens, Van De Velde, & Bracke, 2011; Cumberland, 2010).

Hospital birthing environments have been viewed as contributing to the vicious circle of fear (Kjærgaard et al., 2008). For example, women's heightened awareness of the increased caesarean section delivery rates in the United Kingdom has contributed to the increase of FOC in women there (Cumberland, 2010). As well, a study describing women's birth practices and preferences in the United States suggested that variation in women's attitudes and beliefs about modes of birth could derive from different sources of fear for each woman depending on her attitudes toward medical models of birth (Miller & Shriver, 2012). The variation in women's attitudes toward medical models of birth and the fact that some women are fearful of operative births suggest that predicting whether different hospital birth environments will influence labouring women's FOC positively or negatively is complex but important.

We know that some women who have high levels of FOC describe birth as "[losing] oneself as a woman into loneliness" (Nilsson & Lundgren, 2009, p. e4) "feeling invisible and out of control" (Elmir, Schmied, Wilkes, & Jackson, 2010, p. 2145) and "feeling trapped" (Elmir et al., 2010, p. 2142); all of these feelings can act as triggers for entering the fear cascade. Women, with such experiences, describe having deeply uncomfortable thoughts and feelings during labour and birth, resulting in efforts to find solace in expediting their births. In an Iranian study, 70.6% of women who chose caesarean section had FOC, whereas only 10.9% of women who chose vaginal delivery reported FOC (Matinnia et al., 2015). Some women who have high levels of FOC appear to be choosing to have higher interventions in labour and birth (Cumberland,

2010; Matinnia et al., 2015; Saisto & Halmesmäki, 2003; Serçekuş & Okumuş, 2009; Stoll & Hall, 2013b; Waldenstrom, Hildingsson, & Ryding, 2006); therefore, understanding how hospital environments might affect women's FOC is an important avenue for study.

Recent studies have identified the outcomes resulting from midwifery led care and medical models of care. In a current review examining the two models of care it was found that similar mortality and morbidity rates were associated with the midwifery care and medical care models (Sandall, Soltani, Gates, Shennan, & Devane, 2015); however, midwifery models of care were associated with cost benefits and more positive birth experiences (Soltani & Sandall, 2012). Medical models of birth have offered benefits in terms of women's and infants' life preservation and positive public health initiatives (McCool & Simeone, 2002). Because there are benefits to both the medical and midwifery models an important avenue for study exists in British Columbia where surgical intervention rates for birth have risen (Perinatal Services, 2011) and a variety of care models are being utilized in hospital birth environments (Perinatal Services, 2016).

During intrapartum hospital stays women often encounter care providers and institutional procedures that do not take into account their specific worries about their births (Nyman et al., 2011). Nyman and colleagues (2011) stated that this lack of attention leads to asymmetry between labouring women and hospitals as institutions. Such encounters demonstrate a pattern powered by professionals, which has been viewed as negatively influencing pregnant women's feelings of self-confidence, self-esteem, and self-efficacy (Nyman et al., 2011). A system that is powered by

professionals can be defined as a patriarchal system. A patriarchal system is one in which a powerful group of individuals, often adult men, lead the actions and practices of others, perceived as a less powerful, group of individuals (Muzaffar, 2011). In the case of medical models of birthing, patriarchal approaches have historically been enacted in hospital birth environments (McCool & Simeone, 2002). The landscape of maternity care is complex because some women who enter hospital environments find reassurance and a sense of control when they receive medically led care during their labours and births (Haines, Rubertsson, Pallant, & Hildingsson, 2012; Miller & Shriver, 2012). Nonetheless a willingness to surrender control has been linked to women acting as passive agents in their births (Luce et al., 2016).

Research situated in the western world has examined women's perceptions of their birth environments. Most findings report women's level of satisfaction with their birth experiences; some minor themes about fear during labour are reported but none of the studies have described an association between FOC and hospital birth environments (Bernhard, Zielinski, Ackerson, & English, 2014; Johnson, Callister, Freeborn, Beckstrand, & Huender, 2007; Nilsson & Lundgren, 2009; Rudman, El-Khouri, & Waldenström, 2007; Taghizadeh et al., 2015; Wu & Chung, 2003). Furthermore, studies have not focused on the influence of environments on FOC during women's intrapartum hospital stays in Canada.

Between 2006 and 2007, 97.9% of Canadian women gave birth in hospitals and/or clinics (Bartholomew & Public Health Agency of Canada, 2009). Canadian hospitals have higher rates of caesarean sections than many other publicly funded healthcare systems in the world, such as the Netherlands, Finland, and Norway (Soltani & Sandall,

2012). Canadian rates are closer to those of the United States, a country that predominately runs a for-profit healthcare system (Soltani & Sandall, 2012). British Columbia's caesarean section rate is 13% higher than the Canadian national average and has been trending upwards (Perinatal Services BC, 2011). These factors underscore the importance of studying the influence of British Columbian hospital birth environments' on women's FOC.

1.2 Significance of the Study

FOC has been associated with women choosing elective caesarean sections (Cumberland, 2010; Fenwick, Toohill, Creedy, Smith, & Gamble, 2015; Fisher, Hauck, & Fenwick, 2006; Haines et al., 2012; Hildingsson, 2014; Ryding et al., 2015; Stoll et al., 2009; Storksén, Eberhard-Gran, Garthus-Niegel, & Eskild, 2012; Tsui et al., 2007; Waldenstrom, Hildingsson, & Ryding, 2006). FOC can also increase women's risk for emergency caesarean sections, instrumental deliveries, postpartum depression (PPD), post-traumatic stress disorder (PTSD) (Fisher et al., 2006; Sluijs, Cleiren, Scherjon, & Wijma, 2012), and feelings of poor connectedness to their newborns (Fisher et al., 2006).

In a Perinatal Services BC Surveillance Special Report (2011) the rate of caesarean delivery in British Columbia was reported to be "one of the highest in Canada, and has [been] increasing steadily and significantly over the last decade from 27.1% in 2001/2002 to 31.0% in 2010/2011" (Perinatal Services BC, 2011). Furthermore, the rate of caesarean sections in BC was 13% higher than the national average in 2009/2010 (Perinatal Services BC, 2011). The rise in caesarean sections in British Columbia increases risks of complications for mothers and infants as well as cost

to the public and the use of resources (Perinatal Services BC, 2011). Because FOC appears to be a contributing factor to elective and emergency caesarean sections and the proportion of women experiencing caesarean births in British Columbia continues to rise, potential contributions of British Columbian hospital environments to this phenomenon require investigation. Exploring women's perceptions of hospital environments in relation to their FOC will inform healthcare providers about women's experiences of FOC in those settings.

Birthing environments and women's subjective experiences of birth are affected by the models of care being provided, whether interventionist or low intervention. Women's personalities, life experience, awareness of birth practices and birthing options available to them in their communities, and their potential interactions with particular models of care all contribute to their specific attitudes and beliefs about maternity models of care (Haines, et al., 2012). Therefore, women's subjective experiences provide important information. If women have poor experiences in their birth environments, poor outcomes can result (Simkin, 1991). When women perceive their birth experiences as negative they have been more likely to report PTSD (Ayers, 2014). A common theme in the literature situated in Western countries is that maternity care services should respond to women's desires about birth practices and care to prevent negative outcomes, such as PTSD and FOC (Ayers, 2014).

Researchers exploring causes of FOC have suggested that maternity care systems could be contributing to the problem (Eriksson, Westman, & Hamberg, 2006). Effects of hospital environments on FOC have not been examined extensively in the literature; however, seminal work has emphasized the importance of preventing poor

birth and labour experiences for women, which contribute to women's negative psychological status post birth (Simkin, 1991). Because poor labour and birth experiences can negatively influence mothers' abilities to preserve family wellness, resulting in ill effects for society (Simkin, 1991), it is important to understand the influence hospital birth environments have on women's perceptions of FOC.

Birth environments around the world influence women's perceptions of FOC differently depending on each setting and the care models implemented. Canadian women's perceptions of the influence of their birth environments on their FOC are important. Canada has a high rate of caesarean sections in comparison to other publicly-funded healthcare systems in the world, such as in the Netherlands, Finland, and Norway (Soltani & Sandall, 2012). Using British Columbia as the study setting provides access to different models of care being practiced within hospital birth environments, e.g. medical models and midwifery models of care (Perinatal Services BC, 2016), which could have implications for women's FOC.

1.3 Problem Statement and Purpose

A significant proportion of Canadian women (about one-quarter) report FOC (Hall et al., 2009). Having FOC has been associated with a preference for caesarean section as a birth modality (Haines, et al., 2012). Researchers have estimated that a significant proportion (20%) of women in developed countries report FOC (Saisto & Halmesmäki, 2003). The majority of Canadian women give birth in hospitals (Bartholomew & Public Health Agency of Canada, 2009). Evidence suggests that hospital birth environments play a role in women's perceptions of FOC; similar effects are likely in British Columbia. Studying hospital birth environments to identify how or whether cultural factors, stimuli,

and circumstances influence FOC is important to further our understanding of women's FOC. Therefore, this study aimed to explore women's perceptions of the effects of hospital birth environments on their FOC. My research question was: What are women's perceptions of the influence of environments on FOC during their intrapartum hospital stays?

1.4 Summary

In this chapter, I have explained relationships between women's FOC and hospital birth environments, as well as implicating the effects of the medicalization of birth for women's birth experiences. I have provided rationale for British Columbia being of particular interest for the study because of the high caesarean section rate. I have summarized my research problem and presented the purpose of the study. In the next chapter, I present the literature on childbirth fear and women's perceptions of their birth experiences and environments to illustrate the gap in the literature that necessitated the study.

2: Literature Review

2.1 Introduction

In this chapter, I synthesize and critically evaluate the literature to examine FOC in the context of women's birth experiences and environments and gaps in understanding about hospital birth environments' influence on FOC. I also explore potential effects of FOC. I begin the chapter with a description of my search methods, followed by a discussion of birth environment factors affecting FOC, relationships of media and birth depictions with FOC, and women's feelings and agency in birth associated with FOC. In the process of synthesizing the literature, I demonstrate gaps in understanding that point to the necessity of conducting a qualitative descriptive study about women's perceptions of the influence of environments on FOC during their intrapartum hospital stays.

2.2 Search Methods

My search method involved the use of the following keywords: Childbirth fear, childbirth, birth, parturition (MeSH term), maternity, intrapartum care, experiences, and perceptions in various combinations with the use of Boolean terms. I limited my search to include search terms, such as questionnaire, program evaluation, and interview and I accepted qualitative and quantitative studies. I included only literature pertaining to healthy childbearing women's perceptions of their birth experiences in their birth environments. I completed searches in the CINAHL and PubMed databases. My search activities yielded 54 studies. The total number of articles used for this literature review was 28 after using my exclusion criteria.

I excluded all peer-reviewed articles that referenced treatments and interventions for childbirth fear and fathers' FOC. I also excluded studies focusing on: Education techniques for professional caregivers and women about FOC; how FOC is understood in subgroups of women (i.e. lesbian women, women with high-risk pregnancies, and immigrant women); women's experiences of high-risk pregnancies or birth complications; and midwives' or nurses' perceptions of childbirth environments. I also excluded studies that were not published in English.

2.3 Elements of Childbirth Fear

The most widely used measure of childbirth fear is the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) (Wijma, Wijma, & Zar, 1998). The W-DEQ incorporates items capturing women's perceptions about past births or thoughts about possible future births in the form of expectations and subjective experiences (Wijma, Wijma, & Zar, 1998). A psychometric analysis of this tool was performed and several sub-factors of FOC were identified (Garthus-Niegel, Størksen, Torgersen, Von Soest, & Eberhard-Gran, 2011). These sub-factors included: Loneliness, lack of self-efficacy, lack of positive anticipation, and concern for a child's welfare (Garthus-Niegel, Størksen, Torgersen, Von Soest, & Eberhard-Gran, 2011).

In a four-factor measure of FOC developed from Lowe's (2000) Childbirth Attitudes Questionnaire (CAQ) Christiaens and colleagues (2011) framed FOC in a number of ways including women's perceptions of hospital birth environments. The factors included: "(1) Fear about the baby's well-being, (2) fear of labour pain and injuries, (3) personal control-related fear, and (4) fear of medical interventions and hospital care" (p.222). Christiaens and colleagues (2011) demonstrated the validity of their shortened

version of the Childbirth Attitudes Questionnaire by identifying that “its averaged total scores were significantly correlated ($r = 0.55$; $p < 0.001$) with the averaged total scores of the antenatal version of W-DEQ” (p.225). Although factors from these two measures of FOC have some overlap, the measures do not entirely account for experiences women have reported in circumstances where they are exposed to medical models (emphasis on risk and management of risk) of maternity care. The W-DEQ continues to measure women’s levels of FOC around the world (Pallant et al., 2016). Nonetheless, Christiaens' and colleagues' work suggested a link between hospital environments and FOC.

2.4 Birth Environments Affecting Childbirth Fear

My synthesis of the literature about fear related to hospital birth environments revealed that women’s subjective experiences about their labour and birth environments are situated in contexts that influence their perceptions of fear. For example, low-risk Chinese women described their fears about the childbirth process, problems with healthcare providers, and lack of control (Tsui et al., 2007). Furthermore, an English researcher identified common elements associated with women’s FOC including: The possibility of complications from birth, experiencing pain, having an emergent caesarean birth or interventions imposed on them, and encountering unequal power relations between themselves and healthcare professionals (Cumberland, 2010). Similarly, Iranian women described giving birth in highly medicalized hospital maternity services where they had psychological trauma associated with feelings of loneliness and less psychological support and alleviation of pain than they had expected (Taghizadeh et al., 2015). In Canada, where physicians continue to manage the

majority of births, women's fears about medical management, imposed interventions, and lack of control may be realized. Thus, it is important to explore Canadian women's perceptions of the influence of hospital environments on their childbirth fear.

2.4 Effects of Media and Personal Birth Depictions on Childbirth Fear

Women, even prior to pregnancy, are exposed to media images and stories from family and friends that affect their beliefs and attitudes about birth in ways that can diminish or enhance FOC (Stoll & Hall, 2013a). North American studies suggest that non-pregnant women who have high levels of FOC generated from media depictions of hospital birth often prefer elective caesarean section as a mode of delivery (Stoll, Edmonds, & Hall, 2015). Negative media depictions of birth can portray elements of the environments of hospital birthing areas that emphasize women's helplessness and need for interventions, thereby, acting as contributing factors to some women developing FOC (Morris & McInerney, 2010; Serçekuş, & Okumuş, 2009).

Women anticipating childbearing have also reported that their FOC was influenced by stories they had heard from family members or peers, particularly those portraying labour and birth as dramatic and risky (Fenwick et al., 2015; Stoll & Hall, 2013b; Tsui et al., 2007). Women who are pregnant for the first time and exposed to dramatic and perilous depictions of birth through family members or the media appear to worry about birthing (Fenwick et al., 2015; Morris & McInerney, 2010).

Depictions of birth portrayed by media present emergent and dramatic situations requiring intervention by healthcare providers as the norm (Stoll & Hall, 2013b). Such depictions can suggest to women that their own birth experiences could include some of these emergent and dramatic situations requiring pharmacological and medical

interventions (Stoll & Hall, 2013b). Birth constructions from media depictions of birth likely influence labouring women's perceptions of their encounters with hospital environments.

If women have constructed emergent and dramatic births as the norm in hospitals, they may experience the initiation of the fear cascade when they enter hospital birth environments. Initiation of the fear cascade is said to occur when women feel that their worst fears are being realized; the stress response is proposed to affect both mother and fetus by prolonging labour and causing vasoconstriction in the mother's circulatory system which impacts placental perfusion, known as the fear cascade (Stenglin & Foureur, 2013; Zar, Wijma, & Wijma, 2001). These conditions can result in poor outcomes for the fetus, such as low Apgar scores (Räisänen et al., 2014)

2.5 Women's Feelings Associated with Labour and Birth

Between 5 and 20 percent of pregnant women in the western world report FOC (Adams et al., 2012; Fenwick et al., 2015; Greer & Dunne, 2014; Kjærgaard et al., 2008) with 6 to 10 percent of these pregnant women reporting disabling fear that affects their daily lives (Kjærgaard et al., 2008). In Australia and Sweden, women who describe high levels of FOC have reported more negative birth experiences and higher intensity of labour pain compared to women who describe having less or no FOC (Haines et al., 2012). As well, Kasai and colleagues (2010) suggested that ambivalent feelings about pregnancy and birth can lead to pregnancy-related FOC.

Much of the literature that explores women's perceptions of their birth experiences has revealed that women have experienced feelings of loss of control (Tsui et al., 2007), reduced self-efficacy (Nilsson & Lundgren, 2009), and loneliness (Nilsson

& Lundgren, 2009); all of those feelings have been viewed as important factors in understanding how FOC is linked to hospital environments (Garthus-Niegel et al., 2011). Women have reported being fearful of panicking from the experiences of pain during their labours (Melender, 2006) and interventions that they expected hospital caregivers to enact (Christiaens et al., 2011; Miller & Shriver, 2012), as well as effects of “fear-based” (Bernhard et al., 2014, p.162) perspectives of the professional caregivers on their labour experiences. Healthcare professionals have often provided care using a medical model that emphasizes risks of birth rather than focusing on some of the natural and normal components of the birth process (Cumberland, 2010). These environments have the potential to evoke feelings of loss of control (Tsui et al., 2007)

Depending on pregnant women’s attitudes toward labour practices and management, birth environments can affect their perceptions of FOC. There is a significant proportion of women who believe that the pain of labour is not something to be afraid of at all (Johnson et al., 2007), and that they are safe when experiencing the natural course of labour and feeling labour pain. Women in the Netherlands who delivered at home have described the environment as contributing to their ability to have agency over environmental factors associated with birth (Johnson et al., 2007).

Units in hospitals that are devoted to labour and birth are often environments that encourage relatively rapid completion of labour and eradication of pain (Christiaens et al., 2011; Janssen et al., 2002). Conflicts between women’s and healthcare providers’ approaches to birth may exist, which can create stress for the labouring women (Janssen et al., 2002; Johnson et al., 2007). Although hospital birth environments utilize medical models of birthing, there is variation in the healthcare providers that attend

births in hospitals; the physiologically-driven model of care is sometimes utilized in hospital birth environments, for example when registered midwives attend women and manage their births in hospitals (Perinatal Service BC, 2016). Because of the different models of care utilized in hospitals, there is likely variation in the experiences of women who are birthing in hospital environments both within their own countries and around the world.

The literature reveals that some women have described experiences of personal agency during their births. For example, women have described feelings of empowerment and pleasure in their freedom to choose where and when they carried out labour activities, i.e., moving, bathing, sleeping, and eating (Bernhard et al., 2014; Johnson et al., 2007; Melender, 2006). Findings from an American study investigating women's childbirth preferences and practices revealed a consistent theme of the need for agency during intrapartum care (Miller & Shriver, 2012). According to Miller and Shriver (2012) all women in their study would be acting with agency if their labour and birth experiences matched their expectations. They suggested that women who felt agentic during their labours and births appeared to feel a sense of accomplishment after giving birth in whatever setting.

When women in Western Sweden and their partners were asked about their first impressions upon entering hospital labour wards one woman described going to the labour ward for the first time as scary because she did not know what to expect (Nyman et al., 2011). In Iran pregnant women felt afraid when they saw hospital instruments during the course of their labours (Taghizadeh et al., 2015). Taghizadeh and colleagues (2015) also found that “all mothers in [their] study experienced fear in connection with

the physical structure of the delivery or operation rooms as they perceived these rooms as similar to mortuaries for dead people” (p.6). Although Iranian women’s perceptions about mortuaries are rather unique, it is clear that their impressions of their birth environments negatively affected their birth experiences. One of the Iranian participants also suggested that healthcare providers did not seem to place importance on the fear she had about her labour and delivery (Taghizadeh et al., 2015). The findings from this study are helpful for demonstrating links between birth environments and women’s subjective experiences of childbirth fear; however, they have limited generalizability because the researchers were investigating the perceptions of women who had experienced psychological birth trauma in Iran (Taghizadeh et al., 2015).

2.6 Women’s Sense of Agency in Birth Environments

Women’s perceptions of their capacity for personal agency during their labours and births has been a theme in the literature describing women’s fears about childbirth and their perceptions of their birth environments (Fisher et al., 2006; Nyman et al., 2011; Taghizadeh et al., 2015). Pregnant women’s reasons for having little to no capacity for agency during their labours and births include: Having limited information and knowledge about their births and labours (Fisher et al., 2006); receiving impersonal care from professional caregivers (Taghizadeh et al., 2015); and being socially placed in an inferior position in birthing environments, in particular, labour wards in hospitals (Nyman et al., 2011). Some women have been described in the literature as becoming so dissatisfied with their limited capacity for agency while in hospital birth environments that they chose a home birth for their next pregnancies because they felt these spaces

gave them more control over their labours and births (Bernhard et al., 2014; Johnson et al., 2007).

Fisher and colleagues (2006) explored birth environments affecting childbirth fear in contexts using medical models of maternity care. They argued that, because most women have no authoritative knowledge about childbirth, they give control of their birthing experiences to care providers thereby putting social control over childbirth in the hands of the healthcare professionals (Fisher et al., 2006). This can sometimes be due to their feelings of inadequacy, which are associated with their heightened fear of birth (Fisher et al., 2006).

Nyman and colleagues (2011) described how Swedish women perceived their level of agency over their birth environments in a study about women's first impressions of entering labour wards. Women in this study described feelings of being placed in inferior positions to the healthcare providers because they were made to wait for information for unspecified amounts of time (Nyman et al., 2011). Iranian women, in Taghizadeh's and colleagues' (2015) study, expressed frustration and disappointment with the maternity services they received, specifically due to the rules for the restriction of women's activities while in labour and limitations imposed on individuals wanting to support mothers. In that study, no support person was allowed to accompany the mothers during labour and that lack of support contributed to the women's fears (Taghizadeh et al., 2015).

Some women have chosen home birth after having hospital births; their reasons included: Avoiding experiences of personal dismissal by medical professionals; being given perceived choices but no real freedom to choose; being interrupted by many

healthcare providers; and being subjected to unwanted interventions (Bernhard et al., 2014). Bernhard and colleagues (2014) also found that women who chose home birth, after having experienced a hospital birth, expected to be “taking back control of their bodies and births” (p.162). The authors of this study argued that women who maintained control over their processes had affirming birth experiences regardless of the location of their births (Bernhard et al., 2014).

Women who have given birth in their home environments by choice have reported feelings of control during labour and birth (Johnson et al., 2007). In a study exploring decision-making and preferences of women who had experienced both hospital and home births, the women who gave birth at home described experiencing more control of birth and themselves (Bernhard et al., 2014). Complex factors in hospital environments appear to have contributed to women's beliefs that they had little control over what happened during their labours and births (Taghizadeh et al., 2015). In a study about Iranian women's perceptions of their birth environments, the women were particularly concerned about health care providers' communication with them and rules governing hospital environments; those elements seemed to be enacted in a way that emphasized risk management rather than addressing women's fears and unique needs (Taghizadeh et al., 2015). Women have expressed their desires to make birth uncomplicated, either through the bypassing of labour and receiving a surgical birth for non-medical reasons (Waldenstrom et al., 2006) or by avoiding all intervention in birth because they view birth as a natural process rather than an inherently risky one (Johnson et al., 2007).

Childbirth fear has been portrayed as prevalent in communities around the world (Hall et al., 2009; Kjærgaard et al., 2008). Pregnant women in a number of countries described negative birthing experiences in hospital environments where medicalized birth has been prominent, in part, related to their perceptions that these environments have contributed to them having limited capacity for agency during their labours and births (Fisher et al., 2006; Nyman et al., 2011; Taghizadeh et al., 2015). Canadian women's births are generally managed by physicians, at 84.2% (Bartholomew & Public Health Agency of Canada, 2009). Physicians' management of birth, including operative deliveries, affects the context of hospital birth. Canadian women's perceptions of the effects of hospital environments on their FOC may vary from those of women in other countries. It is possible that women who exposed to portrayals in the North American media of birth as risky and requiring management by physicians have differing perspectives about FOC. Therefore, an exploration of Canadian women's experiences of the influence of hospital environments on their FOC can contribute to the literature and our understanding of FOC.

2.7 Summary

This chapter has included a description of the search terms used to support my literature review, as well as the primary themes developed from my synthesis of the literature. The themes included: The nature of childbirth fear; environments affecting childbirth fear; effects of media and others' birth depictions on childbirth fear; women's feelings associated with childbirth fear; and women's sense of agency in birth environments. In the next chapter, I describe my study design and methods.

3: Methods

3.1 Introduction

In this chapter, I describe my study methods and design. I have included my procedural activities: Obtaining ethical approval, sampling techniques, data collection, and data analysis, as well as plans for dissemination of my study findings. I have described how the participants' semi-structured interviews led to the creation of probing questions that further developed interview topics and the process of analysis of participants' perceptions of their hospital birth environments, including details about my coding, categorizing and clustering of the raw data.

3.2 Study Design

I used a qualitative descriptive study design to investigate the influence of hospital birth environments on women's perceptions of FOC. Qualitative description is used to inquire about straight descriptions of events, (i.e. what, why, and who of events) (Sandelowski, 2000). My description of effects of the hospital environments on women's feelings and events during labour and birth is useful to answer the research question because it captured the phenomena that were meaningful for women's perceptions of their FOC.

3.3 Ethics

I applied for and received ethical approval from the UBC Office of Research Ethics Behavioural Research Ethics Board (BREB). To adhere to ethical standards, I incorporated the following elements in my study:

Participants received detailed information about what would be required of them prior to semi-structured interviews. The recruitment letter (Appendix A) included explicit

information about how to exit the study at any time during the process if the participants felt unable to continue, including after the interviews had been performed. Participants who agreed to take part in my study received a consent form (Appendix B) by email, which allowed them time to consider providing informed consent. They reviewed and signed the consent form prior to their interviews. Additionally, I provided participants with information about counselling and support services by email after the interviews had taken place in the event that any individuals were experiencing negative emotional reactions following their participation in the study.

3.4 Inclusion and Exclusion Criteria and Recruitment

My inclusion criteria comprised: (a) Women who had delivered only one child vaginally or by caesarean section in a hospital located in the lower mainland of British Columbia; (b) women who had delivered at least two months prior to the study; and (c) women who spoke English fluently. The rationale for including women who had both vaginal and caesarean deliveries was to gain a thorough understanding of women's perspectives arising from a variety of birth experiences.

My exclusion criteria encompassed: (a) Women with any chronic medical or mental illnesses; (b) women who had delivered preterm infants or infants with congenital anomalies; and (c) women who served as healthcare professionals in direct care provision for labouring women (i.e. obstetricians, anesthesiologists, nurses, midwives, and doulas). I excluded healthcare providers from the sample to ensure that I captured perceptions of women who had not been embedded in the cultural nuances of hospital birth in British Columbia.

I recruited participants by posting the recruitment letter (Appendix A) on the VancouverMom's community group Facebook page, Kijiji®, and Craigslist®. I also posted the recruitment letter around the UBC campus and community recreational centres.

3.5 Sample Selection

The participants in my study represented a sample of convenience; however, I used a purposive approach (Thorne, 2008). Purposive sampling relies on participants who can help us better understand the areas of inquiry (Thorne, 2008). The women varied in terms of the nature of their primary care providers, models of maternity care received while in hospital, and their values and attitudes about the medical model of maternity care. Although, the women were a demographically homogeneous group, the participants consisted of phenomenally diverse cases (Sandelowski, 2000); phenomenally diverse cases represent differences in the women's birth and labour experiences which provide opportunities to learn about how the women perceived their birth environments under different circumstances (i.e. birth mode, emergent circumstances, and epidural insertions). I sampled women who had given birth in a variety of hospitals from the lower mainland, a region that holds 54% of British Columbia's population (Environmental Reporting BC, 2016).

After interviewing fifteen women, I achieved data redundancy. This was the point at which I obtained critical mass of data from my interviews that yielded no new information from further interviews related to my identified themes (Polit & Beck, 2012). According to my study procedures, I performed data analysis from the inception of my data collection. Concurrent data collection and analysis enabled me to compare and

contrast interviews to identify the salient themes and evaluate data redundancy (Elo et al., 2014).

3.6 Data Collection

Demographic data were collected after the interviews were completed using my demographic questionnaire (Appendix C). I collected information about participants' education level, occupation, age, mode of birth, newborn gender and health status, the presence of a live-in partner, and the average family income.

I collected qualitative data using semi-structured interviews with a series of open-ended questions from my interview guide (Appendix D). I asked questions that encouraged participants to describe what they perceived as the effects of their birth environments on their perceptions of FOC. I followed the participants' lead if they introduced information that was not part of the semi-structured interview but was relevant to the study aim. Based on my early analysis of some interviews, I used probing questions to guide participants to share in-depth information about their birth experiences. Examples of my early probing questions included: Did you enter the hospital prior to arriving during your intrapartum stay?; Did you attend a hospital tour?; What were your perceptions of the events that led to the progression of pain management plans, or of labour progression plans?; If an emergency moment occurred, what was decided for management of this plan and how was it decided?; What were the effects of these decisions and how this planning occurred?; and How did the decision-making processes influence your feelings of safety, comfort, or fear? My modified interview guide was developed and used in subsequent interviews as I created the major themes. I have included an example (Appendix E).

I performed the interviews at least 6 weeks after the women had delivered their newborns. The literature supports my approach, by indicating that a six-to-eight week period after birth is an appropriate time frame to wait before interviewing women who have given birth (Martin & Fleming, 2011). Martin and Fleming argued that women require time to physically heal from birth and to reflect on their birth experiences. The time from the participants' births to the timing of interviews ranged from six weeks to three years. I included some participants who were three years beyond their births because they were very anxious to talk about the effects of hospital births on their birth experiences and it is clear from the literature that women have vivid memories of their birth experiences, even years after the events occur (Simkin, 1991).

All of the interviews were digitally-recorded. I interviewed all of the participants in a location of their choice. Some women chose to meet in their homes, while others preferred to meet in coffee shops of their own choosing. In addition, some women brought their children to the interviews. The transcribed data and recorded information were stored in files on an encrypted memory stick and any hard copies were stored in a locked cupboard in the principal investigator's (PI) office. All identifying elements within the data set were removed and pseudonyms were applied to preserve confidentiality for participants.

3.7 Data Analysis

Data analysis consisted of concurrent inductive content analysis; inductive analysis enabled me to construct patterns and themes from the data (Sandelowski, 2000). I achieved thematic development by immersion in the data (transcripts and reflexive notes). I read the interviews numerous times and identified codes that represented participants' comments in the data set (Sandelowski, 2000). This process is

highly iterative. Because I was conducting concurrent inductive analysis I initiated the process during the early stages of data collection.

I documented coding procedures by using memos and reflective notes. Because the coding was performed in conjunction with the data collection phase I was able to develop probing questions for subsequent interviews. I used memos to describe the codes and cluster them into common categories (Appendix F & Appendix G). After I created the categories, I compared and contrasted the categories to develop themes and specify their relationships. Those activities captured hospital environmental factors affecting women's perceptions of FOC. I kept an organized and coherent record of interview data. Because I transcribed all of the interviews I was very familiar with the interview content which aided my systematic thematic development (Sandelowski, 2000).

The early codes that I developed were closely linked to the descriptions women provided in the interview data. They comprised foreign and unfamiliar beginnings, pain management plans, continuously present expert caregiver, hospital rooms and equipment, uncertainty, and attitudes about intrapartum care models relating to fear. I clustered the codes into broader categories, which included: Foreign and unfamiliar clinical procedures and processes, women's expectations influencing their feelings of affinity towards hospital birth environments, emergency procedures influencing feelings of fear, feelings of helplessness resulting from times of uncertainty and loss of control, and times of uncertainty influencing feelings of fear. I described those categories in my second memo, Parts 1 and 2 (Appendix F & Appendix G).

Finally, I clustered the categories and examined links between them to construct the major theme and six subthemes. The major theme was women's engagement in their labours and births. The six subthemes, which supported the major theme, were: Women's connections to their bodies, women's inclusion in decision-making processes, freedom to use the hospital space, feelings of trust toward professional caregivers, distractions from labour, and personalized care.

3.8 Rigor

I prepared a thorough audit trail, which is a "systematic collection of materials and documentation that allow[s] an independent auditor to come to conclusions about the data" (Polit & Beck, 2012, p.591). To achieve this, I compiled all raw data, analysis products, process notes, materials about my intentions and dispositions, and drafts of the chapters (Polit & Beck, 2012). A clear decision trail illustrating my study plans and practices including interview procedures, as well as data analysis plans and actions were created in the form of memos (Appendix F & Appendix G) and reflective notes (one example of a reflective note can be referred to in Appendix H).

I obtained thick descriptions from all of study participants through the semi-structured interviews, so that I and my supervisor could derive relevant code clusters and categories from the data to assist in answering our research question. By collecting information from women who had a variety of experiences during their intrapartum hospital stays, I was able to increase the variability of the data available for analysis.

The transferability of findings is demonstrated by the shared experiences and messages of each participant and is useful to other users and health care providers of local maternity services. Hospital birth environments here are of a specific user context

and the stories and subsequent themes that were constructed speak to that context (Sandelowski, 2004).

Observer bias is an element of the research process that requires enactment of reflexivity. Observer biases often occur if emotions, prejudices, and values of observers result in faulty inference (Polit & Beck, 2012). I made reflexive notes (Appendix H) during data collection and analysis to identify my biases as they occurred. For example, I heard one participant discuss what it was like to interact with a pre-op nurse and an anesthesiologist when deciding if extra support persons could come into the operating room during her caesarean section. The nurse told the woman that she could not have two family members in the operating room. Subsequently, the anesthesiologist said it was okay. I reflected on what she had said and realized that I was not comfortable hearing about this interaction. I think my impulse was to take sides with the nurses for some unknown reason. However, at the same time, my compassionate side understood that the woman was sharing a deep need she had regarding the course of her care and support in the operating room. I reflected on the focus of that interview data being about how the woman felt as a result of the interactions, she felt afraid, and “ready for a fight” (P 5). Realizing this made it less important for me to be concerned about whose side I would be inclined to take, if I had been present and more concerned with the woman’s perception during that interaction. I also later reflected on the effects of my biases in my interpretation of the data. It was necessary to reflect on my experience as a labour and delivery nurse so that I did not apply it to the woman’s experiences. I prevented observer bias by digitally recording all interviews and transcribing them verbatim so that representations of the interviews were available for data analysis. During interviews, I

did not attempt to correct or change meaning for participants if I was surprised or disbelieving about their labour and birth events. My supervisor reviewed the interview transcripts and assisted in identifying relevant codes and categories which reduced the influence of my emotions, prejudices and values in the final interpretation of the data. I avoided imposing my own perceptions of hospital birth environments on their stories. By carrying out the previous activities, I worked towards reducing the influence of my emotions, prejudices, and values on the interpretation of the raw data for analysis.

3.9 Dissemination

I intend to disseminate the findings from my study through parent groups, healthcare professional presentations, and a peer-reviewed publication. I will also distribute a summary of findings to all participants in the study along with a thank you letter (Appendix I) for participating in my study.

3.10 Summary

My use of a qualitative descriptive study design aligned with the aim of my study: To investigate women's perceptions about effects of hospital environments on their perceptions of FOC during their labours and births. I outlined the process of obtaining ethics approval. I described my inclusion and exclusion criteria, sample selection, data collection procedures, and data analysis. The methods chapter included my attention to rigor and my plans for dissemination of the study findings. In the next chapter, I present the study findings.

4: Findings

4.1 Introduction

In this chapter, I begin by describing the participants demographic characteristics. I then present my findings, beginning with my major theme: Women's engagement with their labours and births. Following that section, I introduce my subthemes: Women's connections to their bodies; women's inclusion in decision making processes; freedom to use the hospital space; feelings of trust toward professional caregivers; distractions from labour, and personalized care. The links between the major theme and the subthemes are illustrated throughout the chapter.

4.2 Sample Characteristics

My study participants consisted of 15 women who were between the ages of 28 and 38; their average age was 34 (See Table 1). All women had given birth to only one child in a hospital. Forty percent (N=6) of the participants delivered by caesarean section; the other sixty percent delivered vaginally. One woman gave birth via an instrumental vaginal delivery. Forty-six percent (N=7) of the participants had been receiving care from a midwife during their pregnancies but required a consult for care from an obstetrician while in hospital. Twenty percent (N=3) of the women received midwifery care and the support of a doula while in hospital without an obstetric consult. In addition, twenty percent (N=3) of the participants had an obstetrician as their primary care provider for labour and birth, and thirteen percent (N=2) of the women were receiving care from a general practitioner. Seventy-three percent (N=11) of the participants reported their yearly household incomes as equal to or above \$90,000 a year. The majority, ninety-three percent (N=14), of study participants reported living with

a partner. This sample of women included generally highly educated women with all achieving a college diploma or university degree.

**Table 4.1
Sample Demographics**

Demographic Variables	% (n)
Maternal Age	
25-30	20 (3)
31-35	40 (6)
36-40	40 (6)
Household income	
\$20, 000-34, 999	6.7 (1)
\$35, 000-49, 999	0(0)
\$50, 000-74, 999	6.7 (1)
\$75, 000-89, 999	13.3 (2)
≥\$90, 000	73.3(11)
Maternal Education	
Diploma	13.3 (2)
Degree	46.7 (7)
Masters	33.3 (5)
Doctorate	6.7 (1)
Mode of delivery	
Vaginal birth	53.3 (8)
Instrumental Vaginal birth	6.7 (1)
Elective caesarean section birth	6.7 (1)
Emergent caesarean section birth	40 (6)
Living situation	
Lives with partner	93.3 (14)
Lives as single parent	6.7 (1)

4.3 Women’s Engagement with Their Labours and Births

The major theme constructed from the data is entitled: Women’s engagement with their labours and births. Women’s engagement with their labours and births in hospital was linked to their feelings of fear; their sense of fear was enhanced when they

felt disengaged throughout their experiences. This was because some women felt fear of the unknown when they did not feel engaged with, connected, or included in the hospital processes surrounding their labours and births.

Participants linked their difficulty with being engaged in their labours and births to particular conditions during their hospital births. They described conditions that decreased their feelings of control and connection to their bodies, which contributed to feeling disengaged from their labours and births. When they regarded the care they received as impersonal and they felt that they were being excluded from the process by the professional caregivers the women indicated they disengaged.

All of the information he was giving me about the emergency c-section...he was across the room and it was like he was speaking over a couple of nurses, kind of thing...and telling the nurses what they were going to do, not us. (P 8)

The women described mistrust toward their caregivers, which contributed to feelings of fear, if caregivers' models of care did not align with their personal preferences for labour and birth, and if the caregivers did not include them in discussions about plans for labour management. The women described feeling unsafe or anxious in those circumstances.

But they wanted me to like sit on it on the bed, and I was like, I am way too high, like I don't feel safe so I'll do this on the ground but I'm not doing this on the bed, like you wouldn't let a child do this, why would you let me do this... I remember thinking like this is not safe...like maybe this is your better view of the baby if it comes out and I'm up here but like I'm like closer to the ceiling than I am to the floor. (P 4)

[There was] a bit of anxiety and sadness around the fact that when he emerged into the world neither of us were really there, like I was there but not... (P 8)

The women depicted fear, helplessness, disappointment, defeat, discouragement, loneliness and lack of positive anticipation for their births when they disengaged during their labours.

The participants indicated that they had challenges engaging with their labours and births when they felt disconnected from their bodies. They felt disconnected from their bodies when people in the environment distracted them from their labours, environmental circumstances disrupted their concentration, or they described being overcome by worries about the unknown. Their sense of disconnection occurred during events when they were being distracted by the presence of strangers, had minimal accommodation for their privacy, felt as though they weren't being told what was going on with their fetus or themselves, and experienced minimal tranquility in hospital spaces. When the women felt unwelcomed in hospital spaces and had to wait for staff to welcome them as guests into the environments they become distracted from their labours and lost touch with their bodies, which contributed to their feelings of fear, helpless, discouragement, and loneliness.

The women described feeling disengaged during their labours and births when they felt they were being done to rather than being able to participate in their care and/or that the care they received was procedural rather than considering their personal expectations. When the surroundings and care the women received seemed oblivious to their states (i.e. mental, emotional, and physical) participants described feeling uneasy, helpless, and disengaged from their labours and births; these feelings resulted in fear for many of the participants.

The women who experienced childbirth fear described not being included in decision-making during their labours and births in hospital. They were fearful when they felt inhibited from fully engaging with their labours and births because professional caregivers used their professional power to act on them without including their perspectives. The caregivers' knowledge about the hospital environments and clinical procedures, and their power to decide on care plans without consistently collaborating with the women or putting them at the centre of their births increased the women's fear and reduced their abilities to engage with their labours and births.

The doctor came in...and checked me, um and the baby's heart rate was going back up, and she said okay I want to break your waters so you can have stronger contractions, well, [I said] there's nothing I've read that tells me that's a thing that happens [the doctor said] I don't understand why you're fighting with me, you might as well benefit from stronger contractions while you're here, okay, so she broke my water. (P 15)

When participants felt constrained in their use of hospital space they felt uneasy and helpless which reduced their abilities to engage in their labours and births. All of the women in my study described their hospital environments as being controlled by professionals, which contributed to them feeling that they needed to wait to be given suggestions and offers about using the space, which reduced the women's feelings of control. Whether participants felt professionals held the control was not related to who their primary care giver was (i.e. midwife, general practitioner, or obstetrician); it was related to whether health care providers listened to them. If the women's wishes were ignored (impersonal care) they felt helpless and lacking control from the time they entered the hospital, which contributed to their fear.

But it...nobody suggested it and [it] seemed like I couldn't [get out of bed and use the exercise ball]...I don't know exactly why, like I didn't feel like I had the freedom to do it, like uh...almost like the permission to do it. (P 7)

When participants expressed mistrust towards care providers they regarded the environments as being controlled by the professionals, with professionals acting out plans or making decisions where the women had no control. Those conditions not only inhibited participants from being engaged with their labours and births but also increased their uncertainty and fear. They linked their fear and concern to the professionals failing to give adequate explanations or to conduct follow-up discussions with them after the births of their babies. They also described feeling fear and concern during instances when professional caregivers appeared to have made a mistake. Some participants said this made them feel like they were being acted on rather than having others collaborate with them around their labours and births. Their perceptions of lack of collaboration provoked feelings of fear for their safety and of possible upcoming discomfort or pain related to labour and birth or interventions.

I was watching her and I was like oh god it is taking her forever to get to the door, it was like, literally the door...um she marched, she didn't say anything, but she didn't look distressed or anything she just sort of got up and walked out...I'm like there's gotta be an emergency button on the outside of that door, she walked out, she walked back in I don't think she said anything, she came and she sat down beside me, and then in like 20 seconds there were like 8 people in the room. (P 9)

Participants who felt that they were not receiving personalized care felt disconnected from the environments. In those instances, the women described the care providers' approach to their work in hospitals as not incorporating the women as the focus of the care. Participants who were uneasy, anxious, and fearful received a clear message from professional caregivers that the environment was oriented towards the

caregivers' directives and tasks for managing labours and births safely without attending to the women's experience. When participants described care providers' failures to take their experiences into account they felt slotted in like someone waiting in line at a delicatessen. The women indicated that this contributed to them feeling isolated and that they were insignificant, which created doubts about what would happen during their labours and births.

I just felt like maybe that step could have been done at a different time, maybe, maybe if the different policies and procedures, get upstairs, get settled...I don't know maybe your midwife can help facilitate the check in, but yes, it did seem impersonal but that's why I said like maybe the receptionist is doing this all day so your just another person walking through the door...um... it's not a super warm fuzzy welcoming certainly... (P 10)

Caregivers' focus on control, directives, and tasks for managing the women's labours and births safely, but not in a personalized way, contributed to the women's feelings of mistrust toward caregivers. Without trust for caregivers, the women indicated they could not engage with their labours and births because they believed that their expectations for their births might be violated; risks of violating expectations made them feel fearful and defensive. The women indicated that when they had a sense that their expectations did not matter to the caregivers they felt less security and more fear.

So I was afraid about...having to have an unplanned section, because they said at that hospital the recovery is separate, so you can't be with your newborn, and they said in some hospitals you can... that made me afraid, because I wanted a certain kind of like... I was planning for an intervention free delivery and...I didn't want to have to have um a section and especially there because then I knew I would be away and not have skin-to-skin for they said two to four hours so that's what I was afraid of. (P 4)

When the women described feeling disengaged from their labours and births, they depicted feelings of fear, defeat, helplessness, disappointment, discouragement,

loneliness, and a lack of positive anticipation for their labours and births. They regarded their expectations for their labours and births as being violated; in what follows, I describe each sub-theme, beginning with the women's connection to their bodies.

4.3.1 Women's Connections to Their Bodies

The women felt disconnected from their bodies and fearful when they could not focus on what their bodies had the capacity to withstand in regards to labour pain and physical stamina. Without opportunities to become familiar with the sensations they were feeling throughout labour the women indicated that they lacked control and engagement during their labours and births. In cases when this occurred, some participants mentioned that their caregivers did not acknowledge that they had unique preferences about how they would perform birth. They depicted being fearful when particular phenomena arouse, when they were not given the opportunity to appreciate what the sensations in their bodies were signaling to them, and their feelings related to the ultimate delivery of their babies were not respected.

I remember being stressed out about my own contractions but then the sound,...that was one thing that really added to my stress like hearing someone [in] like full blown active labour as I was trying to sort of work through my own pain and knowing like I am already in a lot of pain at this point and like that's what's coming, even though the nurse was like trying to reassure me that that was probably something kind of special because they were having an extremely fast labour but the fact that I could hear someone else giving birth ya. (P 2)

When elements of the hospital birth environment distracted the women from their foci they felt more restless and anxious which contributed to their fear. Their restlessness distracted participants from the bodily sensations that they were having which they linked to feeling disconnected from their bodies. These circumstances arose

at times when they did not receive explicit reassurances about the successful delivery of their infants from their caregivers.

Everyone you see who is in charge, the nurses, the midwife, are all telling me I can't do it...Like so frustrating...[it] didn't add any value [sighs in awe] ...to my ability to deal with it, being told you can't do it is just so discouraging. (P 1)

Participants described what it was like to move from circumstances at home where they were comfortable and coping in their familiar spaces to the hospitals where they encountered foreign elements of the physical space. In hospital spaces, especially in the triage areas, the women experienced barriers to being comfortable and able to cope, the women described feeling disoriented and having things done to them that reduced their feelings of control and increased their fear.

When somebody is coming to put a blood pressure cuff on you, [are]...physically anchored to a spot and...I had to have my blood sugar tested repeatedly because I had Gestational Diabetes....so when people are constantly coming to do these, um, small tests on you it feels like, like you almost have to ask permission to get up...can I move, but if you've already lost...the feeling of control... (P 7)

Fearful participants linked their difficulties staying connected to their bodies to unfamiliar spaces and structures that did not fit with their personal physical needs. Participants who described health care providers orchestrating where and how they would be during their labours and births felt more fearful particularly when health care providers expressed needs to closely monitor them. Some participants described feeling stuck in the spaces, nervous, and unsettled by their surroundings.

I didn't know who I was spending time with, and the staff are very, you know they're not engaged at a personal level at all, it's very clearly just their job, and they have no other concern other than doing their job. (P 13)

Participants who felt disconnected from their bodies described difficulty articulating what they needed from their professional caregivers. They found it hard to decide if they should speak up about particular discomforts or personal preferences because they became uncertain about the legitimacy of what they needed and felt out of control and lonely. Under circumstances where professional caregivers were leading the course of care and seemed to take ownership of the women's bodies they described feeling less connected to their bodies and fearful.

Um I felt very much not heard, um I felt very disregarded um...and I do not like that [nurse], I've never seen her since, but I have very negative feelings toward her, it just felt like she didn't trust me to know what was going on with my body. (P 15)

Participants gave examples of their caregivers not allowing them to listen to their bodies; because it seemed to them that caregivers did not trust the women's bodies. In these cases, they felt more fearful and lost confidence in themselves.

I didn't like the contraption in my mouth [Nitrous Oxide] [R: Hmm] um and I remember a different nurse came in and she almost forced it on me the second time, she was like no, I think you really need to try it as I was going through the contractions, and um...I tried it again I don't know why I kind of let her...kind of push me into it. (P 14)

The women indicated that they were disconnected from their bodies and felt fear when they were experiencing suffering with their pain and could not focus inwardly to cope with the pain of contractions. Their suffering and fear were enhanced by the failure of professional caregivers to acknowledge their abilities to cope. For example, one woman said that she experienced very constant pain in her back that did not diminish between contractions. She indicated that she was fearful, ashamed, and felt out of

control because she did not know why her body was experiencing labour this way; she received little acknowledgement from staff members about her experience:

[It enhanced my sense of fear] ...I felt like I was behind a veil like, I am having all these huge emotions and I'm terrified and then you're so calm it makes me feel like I should be ashamed of feeling so out of control...I think I would have felt better if someone [would] have just went holy shit this is hard, you are in pain this is so hard for you. (P 1)

When a woman was experiencing labour pains and realized that nothing could have prepared her for the pain she was experiencing she indicated that her feelings of loss of control, connection to her body, and fear were reduced when her nurse validated that her labour was very strong.

Uh decreased [fear]...acknowledgement from my nurse...that... I had progressed quickly and severely and... that was acknowledged from her that she didn't dismiss that, that I wasn't just being a baby and that she uh acknowledged that I was in distress and not coping well. (P 3)

Participants who felt uncomfortable being disconnected from their bodies during labour and birth expressed feeling uneasy, which contributed to their fear. The women explained how hospital procedures and practices drove them to feeling disconnected from their bodies because they felt their bodies were out of their control. When the women indicated they did not receive options for coping with the pain and intensity of their labours, they felt jarred and disassociated from their bodies.

They took the nitrous away which was very sad because [laughs] I found it extremely useful um...it was kind of like, a bit jarring to have to like actually deal with the contractions...[that] made it even a little bit more like...I was a little bit outside of myself. (P 6)

Having things done to them and their bodies by professional caregivers made the women feel afraid of what was going to happen next, which they linked to their deep uncertainty.

Initially when I was um...labouring on all fours I felt very comfortable, and they had kind of asked that I change positions um more to on my side or on my back so that...that made me fearful, because of things that I had heard, um you know I did a prenatal class and I had friends that said like, don't push on your back, or don't push on your side cuz you'll tear, and da da da..so I became ya nervous and a bit fearful of that I kind of thought no no no I shouldn't, I shouldn't be on my back, that's not going to work. (P 12)

A participant who had been receiving care from a midwife, and subsequently received consult care from an obstetrician for complications related to prodromal labour described things being done to her that reduced her feelings of agency. She felt what was being done 'to her body' disconnected her from it. She was particularly fearful about not being told results of exams, or why her blood pressure was being checked.

I mean I know when my blood pressure's being taken but they're not always explaining what exactly is going on and...when they assess how far dilated [you] are...so that's when it starts to feel uh confusing, and like, almost more like you're being acted on than in control of the situation. (P 7)

Under circumstances where the women felt disconnected from their bodies the women depicted increased feelings of uncertainty about their labours and births, which made them feel afraid. They described being afraid that they could not cope during their labours and births, further increasing their sense of disconnection and feelings of fear. They indicated that fear could be reduced by information and suggestions about care from their caregivers, which helped them feel more connected and better able to cope with their labours as their pain increased and their experiences intensified.

4.3.2 Women's Inclusion in Decision-making Processes

The women indicated that they felt fearful during their labours and births when they were excluded from decision-making processes; they felt that they were losing control over their births, which made them fear the unknown. Participants' limited inclusion in decision-making processes and heightened fear reduced their engagement with their labours and births. They described many times when the health care providers made decisions about the courses of their care in hospital and they felt that their autonomy was undermined because they had no understanding of events, or were not included in decisions.

So...that was my my initial fear...I was so already heavily into it that I wasn't processing to ask the question like how long am I going to be alone for, when are you coming back? What happens from here?...I found myself alone in the [hospital] room like sitting on the toilet, throwing up into a bucket and just being afraid. (P 3)

Participants experienced fear and concern when they perceived independent decision-making by health care professionals as the professionals' use of power over them. The women indicated unhappiness about professional caregivers making decisions about elements of their labours and births that they regarded as being within their own realm of their understanding. Participants who felt well informed believed that they should have been included in decision making processes. The participants became very alarmed when professional caregivers gave them the impression that they were not welcome to participate in decision-making processes.

My doctor won't allow me to go past 39 weeks, and I'm like that's not his decision obviously he knows more about medical stuff than you do so like, talk to him, but there's no such thing as won't allow you to...it's your body, so when she said you know once you check in here you are on our timeline, that was...partly scary in terms of knowing that I was going to be pushed in certain directions. (P 15)

The participants also regarded abuse of power as occurring when professional caregivers carried on conversations about them and possible labour and birth management techniques without including them in their conversations. Those actions enhanced their feelings of loss of control. In particular, some participants described professional caregivers making decisions about what positions they should be in, which non-pharmacological labour interventions were available, which individuals would be present during their labours and births, and which methods of augmentation would be used (e.g. nipple stimulation vs. intravenous oxytocin).

I said okay what are my options and she said well we can hook you up to a breast pump to try and get some of this stimulations going. And I was like oh okay, cuz that's not a clinical intervention so okay. And she said or we can give you an epidural to help move things along, and...[I] don't remember thinking at the time...but that's not the way I wanted my birth plan to go and I wasn't with it enough to say you know, "come on are there any other options?", but in that state of mind it's very hard to advocate for yourself. (P 11)

The participants described feeling out of control, fearful and disengaged from their births when caregivers imposed limitations on their involvement in decision-making by having technical conversations that excluded them. No opportunities for them to discuss options, with professionals taking over decision-making and enacting clinical interventions, made the women feel fearful and anxious. They described caregivers' communication as short, repeated, unfeeling positive words for example, "everything's going to be fine" (P 8), "the machine is just giving us trouble. Everything is fine" (P 8). Those forms of communication contributed to the women feeling uncertain and afraid of the unknown.

I don't [know what] vaso vagal episode is [laughing] and they seemed really really concerned about that and uh if they hadn't used the jargon I could have said that honestly that does happen to me quite often...I wasn't particularly concerned at all but they were hugely concerned about it so then they dropped me back down to laying down...had me push that way but it was a really unproductive way to push, and once again nobody had ever suggested any other positions. (P 7)

The women linked times where the professional caregivers glossed over complex decisions by providing bias-laden suggestions and comments to their feelings of lack of trust, lack of power, and being out of control, which interfered with their abilities to stay connected to their bodies and engage with their labours and births. They described being afraid of the unknown. Having professional caregivers make what the women regarded as leading or suggestive comments gave them the impression that the caregivers were imposing their care preferences on them. Caregivers' impositions undermined the women's feelings of trust.

The women linked care being imposed on them to feeling disengaged from their births and defeated and fearful about possible bad outcomes resulting from imposed labour management decisions (e.g. purple pushing, or pushing in uncomfortable positions).

The participants indicated that a common decision over which professional caregivers had control was the timing of their admission to hospital, which occurred after the women came in for their initial assessments. The women who arrived at the hospital in early labour and expected to be admitted described feeling fearful and panicked during the car ride to the hospital. They indicated that, if they went home, they would have to do that car ride at least two more times, which they found difficult to face. The participants described the caregivers' decisions to send them home as daunting

and creating panic (e.g. due to traffic delays and concerns of them not being able to get comfortable in the car while experiencing contractions). One woman said:

I didn't want to be in the car having contractions, stuck there, out of control don't know what I'm doing, maybe it's just me and my husband, so that was a...level of anxiety that I'd had...but I still was a bit nervous that I wasn't going to be 4 cm and then what, what happens, do I drive all the way back home? (P 11)

Some participants described their feelings that their caregivers were 'closing ranks' or ganging up on them to take the power for making decisions about their labours and births. Under those conditions, they indicated that they lost connection to their labouring bodies, trust for their caregivers, and sense of engagement with their labours and birth. They described their expectations of their births slipping away. When professional caregivers made many decisions without taking the women's preferences into account, the women were more likely to depict fear, discouragement, defeat, and helplessness.

When you're faced with this...wall of people who have made it clear that they don't think you can do it...because they don't think statistically that you can do it, that...they don't support you in trying to keep doing it...so when you're faced with a wall of people who aren't going to help you do the thing that you came there to do I mean you just have to surrender in defeat...and these terms being used that created an atmosphere of fear, you know, stress on the baby. (P 7)

4.3.3 Freedom to use the Hospital Space

The participants described their fears that they were losing control when professional caregivers rather than the women had the power to control how the women used the hospital space. The women linked loss of control to reductions in their levels of engagement with their labours and births.

They were also still having trouble keeping the IV in place like when I was moving around...um and I think...also I had to have a ...like a monitor, and so there were

certain positions, and ya actually with the first nurse I remember her being much more prescriptive in like the positions that I...I...could be in, um she's like, "oh I can't read the baby as well in that position, you can't do that" and I was like... "ohhh". um and I didn't feel as much that she was suggesting other positions. (P 12)

Being exposed to procedures and processes in the hospital birth environment was often represented by the women as their loss of freedom to engage with or control the space associated with their labours and births. Participants depicted their limited freedom in hospital spaces when student doctors and nurses imposed clinical acts on them. They indicated that they were often made to wait in public spaces while trying to cope with their labour contractions. They described being restricted from getting out of bed or using the toilet while they were using an epidural. Participants also linked loss of freedom to being restricted in their pushing positions and locations during the second stage of labour. One woman described fear-inducing feelings from not having freedom to move:

I thought it was terrible. The bench was very uncomfortable...I felt like I didn't feel anxious at all until I got to that point...like having no idea, kinda what was happening next...and it was really uncomfortable like, I'm 9 months pregnant my back is already killing me and to sit on that that wooden bench...um so I found ya I got more and more irritated and anxious and kind of on edge the longer I sat there...(P 5)

When the women linked professional caregivers' clinical procedures and restrictions to solely risk-oriented and medically based approaches, they regarded their power to act in the process of labouring and giving birth as limited, which made them fearful. They described the environment as under the power of professionals. The participants indicated that they felt like guests with limited freedom to use the space and equipment. The women felt acted upon when they were expected to participate in

clinical procedures that restricted their freedom and their ability to have control over their situations. Feeling like passive participants contributed to their fear. As passive participants, the women perceived their labours and births as uncertain or disorganized. They described a sense of chaos and feelings of distrust that made them fearful and disconnected from their bodies and disengaged from their births.

Because you are arriving somewhere where you are going to put your trust in...medical professionals who are going to help you with this difficult thing so then on the other hand um it's a very cramped, chaotic space and you're kind of being forced into this um cramped physical space and in uncomfortable ways.
(P 7)

The women linked feeling less fearful and viewing hospital environments more favorably to their abilities to control using the beds and birthing balls and nitrous oxide. When they exerted that control they felt that those tools supported them in connecting with their bodies and engaging with their labours and births. They were more likely to express trust in their caregivers. One woman described her situation and how she appreciated being able to use the hospital space for her labour,

They gave me the nitrous oxide,...I thought man if I had to labour through that...to be standing up for every contraction or getting up out of bed every contraction I would had like been really really exhausted...so [it]...was great cuz then I was able to just kind of lay down and breath through the contractions. (P 6)

When the women described powerlessness because professional caregivers took control of their labours and births they felt less freedom to act and to use the hospital space. Feeling like strangers in a strange land resulted in participants feeling disconnected from their bodies and unable to engage in their labours and births. Their senses of disconnection and disengagement increased their anxiety, helplessness, and fear.

4.3.4 Feelings of Trust Toward Professional Caregivers

The women described feelings of disappointment and fear when their caregivers did not include them in decision-making. They depicted caregivers as appearing to ignore their opinions or preferences. Such actions were associated with participants reporting mistrust toward their professional caregivers. Lacking trust toward professional caregivers contributed to the women having difficulty connecting with their bodies and engaging in their labours and births. It made them fearful. Participants described feeling that they had to be on the defensive with their caregivers, fighting for validation of their preferences and values, or fighting for control over their labours and births, which left them worried and unsettled. One woman described her thinking as she navigated conversations with her primary caregiver for whom she felt mistrust:

So just sort of anticipating, uncomfortable and kind of tedious conversations, trying to figure out when to push back, and when to be like that sounds like a great idea, or can you give me more information about that suggestion, as if really these are really like calm civilized conversations that you're having while you are in labour. (P 15)

Another woman explained what it was like for her to navigate communication with her caregivers prior to her caesarean section:

If he wants my blood pressure to be a 170 over 100 then leave my mom out of that room. She was like well you'll have to talk to the anesthesiologist...And I was like, bring him on in. So I'm at this point a little pissed so I felt like I kind of got set up at this point...I felt like I was immediately shut down when I said I wanted my mom and my husband in that room as a support system you know, first time mom, never had surgery, never had a baby...Like my support system is very important to me and...she set me up to be more nervous to be even more anxious to ask the anesthesiologist. (P 5)

Lack of trust, usually around the participants' lack of inclusion in decision-making and using space, increased their feelings of uncertainty and their fear of the unknown.

In particular, when healthcare providers talked about the women in their presence but not to the women or when care providers left the room to talk about the women and returned without clarifying the conversation the participants indicated that their trust diminished and their uncertainty increased.

She literally just assessed me and then left the room, and then my doula left too for a moment, I guess to talk to her. They work together. They know each other they're part of the birth program so that doula has worked with that midwife a number of times um, and that was it like and then she was gone. (P 1)

The women described enhanced feelings of mistrust when caregivers performed assessments and tests, without discussing the rationale for the tests, or their results. The participants also depicted less trust for caregivers in situations where the healthcare providers neglected to identify themselves before providing care. The women indicated that encounters with healthcare providers who performed vaginal exams and then left the room without telling them their findings undermined their feelings of trust and reduced their sense of agency and control. Participants depicted the combination of decreased trust and increased feelings of lack of control of events as interfering with their abilities to stay connected with their bodies and engage in their labours and births.

So when nobody at any point ever says okay we're done all the tests we need to do, we're done. You don't know if you can just do your own thing or not, and if you already felt like you lost control like I did um then it's hard to kinda like, and you're in a lot of pain too. It's hard to kinda regain that agency. It's hard to kind of regain your voice and have that moment of clarity, because...it's hard to focus on anything when you're in severe pain. (P 7)

Being unable to trust their professional caregivers to listen to them undermined the women's resolve and motivation to speak. The women indicated that when they were unable to speak about their feelings and preferences they used a passive

approach to their labours and births. They lost their connections to their bodies. The participants also described professional caregivers coming to look at the machines in their birthing rooms without speaking to them which made them feel like objects rather than active participants who were engaged in their labours and births. One woman indicated that a professional caregiver had not introduced themselves before acting on her. Some participants described consenting to a major procedure, like an epidural insertion or an emergency caesarean section, where professional caregivers would begin prepping them without actually explaining what they were doing. When participants were prodded and pulled at in various ways, without being informed about what was happening, they viewed their caregivers as untrustworthy and undermining their efforts to express personal agency.

...The admitting nurse was there, and it was the nurse who did the assessment and I assume she was a nurse. It's just like somebody just comes in and like woop, [they perform a vaginal exam], I don't...it could have been like, if somebody in scrubs showed up, I would have just been like okay. I guess you're going to [do this exam] so anyway part of it too is you're not in your right mind either to like be asking oh, and who are you? (P 7)

One woman described her uncertainty about most of the professional caregivers' procedures and activities because she was not included in any discussions about what was happening to her fetus. She described a particular moment when many health care providers were staring at the fetal heart rate monitor and not saying anything. Everyone was just listening to the drop in fetal heart rate and monitoring the situation without a word.

The digital monitor of his heart rate cuz at one point this was kind of a weird point, the OBGYN and staff was there and the midwife and [nurse] and everybody. Like nothing was happening...Everyone was like in a semi-circle and everyone looking at the little monitor as it dropped from like, 100, 98, 95, and

everyone just sort of watching, and I remember being like, I don't think this is good. (P 9)

After interactions with professional caregivers where the women felt dismissed they depicted increased feelings of mistrust, which contributed to their feelings of fear and loss of control, and in some cases anger. For example, some participants described professional caregivers disregarding their opinions, telling them that a procedure did not hurt when in fact it did, or prescribing activities to them in very forceful ways. One woman gave an account of this:

She gave me an IV in my hand, and sort of jabbed me a little bit crooked and I bled and said 'oh' when she jabbed me and she was like it doesn't hurt, I'm like no it does I'm bleeding... (P 15)

When caregiver team members asked questions in leading ways, which did not seem directed at the women's actual experiences, participants felt that caregivers were making assumptions. In other words, the women indicated that whatever caregivers thought was happening was accepted as true, which undermined their trust in their providers and excluded them from decision-making. Some participants stated that when they told care providers that their epidurals were not working or that they began feeling contractions again members of the team repeatedly asked them to retake the test without looking for a problem or re-assessing the epidural. The women described feeling pressured to answer questions in certain ways even if they did not actually think that the answer was true. If they remained unsure about where they felt the cold for an ice sensation test or if their epidurals were effective they indicated that their uncertainty was dismissed. Encounters where the women felt caregivers were disconnected from

their experiences decreased the women's feelings of trust, increased their anxiety and fear, and interfered with their abilities to engage in their labours and births.

You walk through the two front doors and you check in at that first uh counter there where...it feels like such a casual environment and you're like whhhaaa like I'm out of control I'm not coping I am not doing well and then you feel so ashamed for feeling that way. (P 1)

The women linked their loss of trust and their feelings that others were taking control to a failure to view them as autonomous human beings with valid opinions and preferences. When they felt disregarded it was difficult for them to stay engaged with their labours and births, and the participants felt fear because of their uncertainty.

The women expressed feelings of mistrust towards their professional caregivers when they regarded their caregivers as not giving clear information about their actions or types of assessments. Although participants indicated being grateful for the life-saving skills of their professional caregivers, their feelings of gratitude were tempered by feelings of loneliness and fear based on their lack of trust. Their feelings were engendered by the failure of professionals to inform them about the rationale for clinical interventions or assessments and to share decision-making. Some participants described not receiving debriefing about the details about emergencies. They questioned whether the primary care provider was truly dealing with an emergency or if they were acting to avoid liabilities. When their care providers failed to communicate with them the women described feeling fearful, disconnected from their bodies, and disengaged from their labours and births.

I just remember, looking around and everyone was busy with their job, they whisked the baby away and I [remember]...not knowing if I wanted my husband to stay with me or to go with the baby, because they had to... take her away really quickly...I mean she was only five feet across the room...but I was so scared in that time and...no one was walking me through what was

happening...it's just such a surreal experience, you just had a baby, um and then...it gets messy and I felt like my biggest fear was coming true...(P 10)

Participants who expressed expectations about being heard and made a part of their labour and births felt helpless, out of control, and dismissed when no conversations occurred between their care providers and them about plans of care and the uncertain circumstances of their labours and births. When the women noticed a limited amount of disclosure from professional caregivers about possible risks or dangerous circumstances, they experienced more fear of the unknown and lack of control over their own bodies and births and the safety of their unborn babies.

So yes, lost, lost...I kind of just gave up. Just stopped and went okay, but the funny thing is in my mind she said let's give you an epidural...At that point, I wasn't you know when you're not on your game and tired, I should have known better. And I remember they gave me the epidural and laid me down they put a drip in my arm and the Pitocin monitor came out and I went... [expresses frustrations] like now I'm on Pitocin...But ya it was a place where I didn't want to end up. (P 11)

When the women described their experiences of hospital birthing environments as purely clinical and producing the sense that the women in labour were sick or in need of some kind of fix from medical professionals they indicated that they felt less trust, less at ease, and more anxious. Some participants indicated that their preferences to view birth as a healthy event rather than a state of being ill or a situation needing to be fixed might be ignored by caregivers who recommended clinical interventions that they would not want and might be unnecessary. They reported feeling lack of trust and being afraid of the unknown.

When obstetric emergencies occurred and the women did not receive a complete explanation, they were uncertain about what was happening, or sensed that something

dangerous was happening, and became very afraid. In many cases, the women described feeling lonely and abandoned by caregivers. Such circumstances increased participant's mistrust toward their professional caregivers.

I know that the OB stuck her hand inside of me to pull the placenta out but she never told [me]... I really would have maybe been less fearful if she had said like...but you know okay I'm just going to stick my hand in and get this out, oh look I got it out, um the bleeding slowing down...just walking me through. (P 10)

When the women felt alone with no sense of shared decision-making and power they described feelings of being outside their bodies, losing a sense of themselves, deep feelings of fear, and a disconnection from their experiences. All of those feelings contributed to them disengaging during their labours and births in hospital.

So ya I'd say that was a pretty scary time and I just remember there was, ya, the button got pressed, lots of people came in, no one was kind of talking to my husband or I anymore, um and ya and we just like weren't sure kind of how serious it [was]. (P 12)

The participants who lacked involvement in joint decision-making with their health care providers had limited feelings of trust toward their professional caregivers. They indicated their doubts that their personal preferences and expectations would receive consideration. The women who lacked trust were more likely to express disappointment that their professional caregivers would not validate their opinions or emotions. They lost confidence in their caregivers. Participants said that lack of confidence contributed to their uncertainty, fear, and disengagement from their labours and births.

4.3.5 Distractions from Labour

Many of the participants described the distracting elements of the hospital environments as including processes of registration, admission to triage and their labour

rooms, and occasional transfers between spaces (e.g. from the labour suite to the operating room and from there to the recovery room). It was distracting for some participants to re-orient themselves continually to new spaces in foreign environments of hospitals. They often found these environments more distracting than their home environments. In some cases, unfamiliar and distracting environments created a sense of uncertainty, which contributed to the women's feelings of fear or anxiety.

They put me into the tub...I felt like I'm in the tub and everyone is just staring at me, I'm like this is not...where am I, it's all new, and bath,...new, and the temperature is too hot, it's not the way I want it, everyone is looking at me expectant waiting and I can't make anything happen and then my labour stalled, stopped dead. (P 11)

Some participants expected that the spaces and rooms in the hospital birth environments would be foreign to them, so they were not surprised about expending effort to focus on settling into the hospital spaces rather than their labouring bodies when they entered them. However, many participants who found the environments busy, distracting, and lacking in privacy viewed their birth experiences as chaotic, which increased their uncertainty and loss of control. Those feelings reduced their sense of connection to their bodies and their abilities to focus inwardly. Participants who found their environments distracting described feeling afraid of the unknown. They wondered whether they would be able to handle labour and birth because they were feeling disconnected from their bodies and disengaged from their labours. The women's thoughts of how their labours were not meeting their expectations of being intimate and tranquil distracted them.

It just and then... and the bathroom was open like it had an obviously for ease of nursing and care. But it's like, it's just a curtain and you know, like you're so beyond it you feel like you, you're so engrossed in being in there. So you don't

think about saying can you close the curtain or whatever? Because you kind of want their help but at the same time as a first....if...if I would have another baby I would do it differently I think. (P 11)

The participants linked distractions in the hospital birth environments to their increased feelings of panic because they worried that they would not be able to cope with labour after losing their foci, connections to their bodies, and their engagement with their labours. They described feeling that everything was out of their control. Under those circumstances, the women became fearful about possible interventions they might require if they could not refocus after becoming distracted.

They're starting to tell me...[if you]...don't get this baby out in the next ten minutes...we're going to have an OB come in...to assess and like we're going to have to use forceps...And I didn't want any interventions so maybe they told me that to motivate me...I was so out of control because I didn't know when to push. I had people telling me. I had people holding my legs. I had no idea at that point. I was starting to get scared like the baby is not going to come out it's going to be stuck here forever. (P 1)

The presence of strangers distracted some of the participants. They described coming into contact with bystanders in hospital spaces during what they regarded as one of the most life changing and ideally intimate experiences of their lives. The women indicated that being in the presence of strangers reduced their feelings of comfort and safety, which reduced their connections to their bodies and their abilities to stay engaged with the rhythms of their labours. "So I...tried to stay out of that room as much as I could cuz they [unfamiliar healthcare providers] couldn't fit into the shower...um, So I used the space, [shower], as a way to keep them out as much as I could" (P 1).

Many participants linked the lack of privacy in the hospital birth environments to feeling uneasy, frustrated, and distracted which contributed to their feelings of fear. The women indicated that when students were part of the caregiver team but not really

introduced to them they regarded students as distracting strangers. Some participants mentioned that being distracted by other women vocalizing in labour. In one case a woman witnessed the delivery of a baby from behind the next curtain. Witnessing the birth resulted in her first impressions of the hospital space as being distracting, public, and not intimate which produced ambivalent feelings. She had curiosity and amazement about the other woman's birth but discomfort because the woman did not have privacy.

In the situations when some of the women described encountering invasions of their privacy (e.g. having healthcare professionals present for vaginal exams, and during epidurals being inserted) they indicated that the group surrounding them did not have familiarity with them but knew a lot about them. That combination of lack of familiarity and high levels of knowledge reduced their sense of intimacy. They linked losing intimacy to losing their connection to their labouring bodies and a sense of control. One woman described the distraction from a patient in the next triage bed beside her taking her out of her own experience:

All I remember...I remember hearing her moaning and thinking oh god that's going to be me because hers' were a lot worse...she was screaming obviously she was about to have a baby, and I remember thinking oh my god that is what's coming. Like it's going to get way worse than where I am now. (P 11)

Encountering clinical equipment throughout the hospital spaces and on the walls of the hospital rooms created reduced feelings of safety for some of the women who had anticipated letting their labours take their natural courses. The visible equipment increased their fears that their births would take on a clinical flavor with equipment involved. For example, one woman said:

We did a hospital tour before obviously D day. And it...and it heightened my fear. it just became very real and it became uh um... the the tools that I was shown that were to be used at my disposal um like the bar on the bed and the bath and

and stuff like that all heightened my anxiety towards the fear that I was going to...ah the pain that I was going to experience during childbirth. (P 3)

4.3.6 Personalized Care

Participants became more fearful when they described the impersonal care being given in hospital. Impersonal care undermined the women's trust in their care providers, engagement in shared decision-making, ease in hospital environments, and abilities to stay connected to their bodies and engaged with their labours and births.

When the women detected an impersonal tone in the courses of their care, they described feeling less engaged with their labours and births because they did not feel comfortable in the hospital environment. They indicated that the place and the people failed to regard them and their births as individual and special.

I was a temporary resident and...the staff treated you that way because the next person was going to come in after you. That's not a negative comment in the way that they were mean...but it would be very hard to switch that mentality off as a caregiver. Because you're going to have your baby, I'm going to see you and in 24 hours I'm going to be back here in exactly same room with somebody else. (P 11)

Under the conditions where the participants viewed the hospital environments and birthing rooms as impersonal and sterile and not fitting with their expectations about the special event of labour and birth they felt ill at ease. They regarded their care as lacking personalization. For example, a woman described this setting in this way:

Day in and day out they've done it for years. They've seen it all. They've seen the tragedy. They've seen the joy. They've seen everything so when you walk in so you know you are just kind of another number you're going through this incredibly life changing moment [and] they're at work doing their everyday. (P 1)

When some participants described professional caregivers as performing assessments and tests, without orienting them to the test, asking permission, identifying themselves during the procedure, or updating them on the results or outcomes of the assessments and tests, they viewed their care as impersonal. They described decreased trust in their professional caregivers, and having their circumstances feel clinical, decreasing their sense of control, and increasing their sense of disengagement with their births and disconnection to their bodies.

Participants indicated that they wanted personalized care in relation to their choice of pain management treatments. The women who wanted an epidural would often want that treatment used in a unique way that suited their preferences. For example, some participants, who requested and received an epidural, were comforted and reassured by their ability to rest for a time while still having contractions. Other participants wanted to use the epidural to take the edge off their contraction pain while they walked around, and moved in and out of their beds to labour in different locations and positions. Some participants viewed their lack of opportunity to choose what type of epidural they received as emblematic of lack of personalized care.

I remember saying is this going to be a walking epidural? [the midwife] was like, nope...I think maybe that...There's this game of deferral so the midwife might have said,...we'll see if we can get you one, but the best might be...to get this labour moving again, which she knew is what I wanted...[and that] a full epidural...would be the best, but she said, you know what I'll defer to the anesthesiologist...(P 11)

When the participants felt that the courses of their care were impersonal they were more likely to feel frightened, disappointed, disengaged, and to have a lack of positive anticipation for their births and labours.

But you're still scared of the unknown, having a baby is going into the unknown, and the women that see it every day, the doctors, the nurses, the admitting people, it's all normal to them. And it's not normal to the patient, and that's a hard thing I think that they might forget that actually she's really scared and she's really anxious, and she's afraid, and we need to help her along the way. (P 11)

Participants mentioned that they wanted decisions about their care based on their unique cases, rather than on rules and regulations or on particular statistics. Some participants mentioned that they were given recommendations from professional caregivers that were based on population statistics which they found undermined their sense of trust and their views about the personalization of their care. One woman described a conversation that she had with her primary care provider about when to begin induction.

I was being given information about a broad swath of women who maybe didn't have prenatal care, or um you know 48 year olds, and 14 year olds. You know I very much wanted to get information about what would be a recommendation in my case rather than this is our standard practice we want you to do it. (P 15)

While many of the women were content to have care that was described as evidence-based, they wanted the care recommendations they were receiving about labour and birth to be personalized. Some participants felt that just using evidence did not take into account their personal and unique circumstances. They described reacting to these types of interactions with staff as having feelings of deep fear about the direction of events they experienced from the care providers' interventions. In one woman's case, this manifested as the care provider physically coaxing her to move from the triage room to the outside, which she did not want to do. This woman linked the care provider's failure to see how her circumstances were affecting her willingness to enact

evidenced-based labour care plans to a lack of personalized care to feeling unsafe. This woman said that she felt unsafe when the following events occurred:

I didn't feel like I had any internal resources to deal with the pain. I had no break between the contractions and so that made it worse for me that I was being physically coaxed to get outside and so I... I did because the rational part of me that was left knew that that was good idea to get movement. Like I did know that so I, I did it but not without.. like great discomfort. (P 1).

In another situation, a woman's husband advocated strongly with her midwife for his wife to stay in hospital. His advocacy helped this woman feel secure, because of her fear of being sent home. The participant pointed out that her increased security did not arise from an opportunity to choose her time of admission coming from professional caregivers but from a personalized approach directed by her advocate.

Some participants reacted to caregivers' suggestions that appeared to lack acknowledgement of their individual circumstances by presenting a helpless plea to them. Circumstances where professional caregivers failed to personalize their care undermined the women's sense of control and agency. "Well, yes please I do want to stay. I don't think I can do that car ride again" (P 7).

Some of the participants described the failure of registration and admission processes in the hospitals to align with their immediate concerns as disrupting their sense of engagement with their labours. When they lost touch with their bodies it created more anxiety and unease. They indicated that all of the admission information could have been collected during the prenatal period rather than at the time of admission for labour. One woman indicated that forcibly completing the same paper work twice during different outpatient assessments increased her frustration. Her contemplation of filling this paper work out a third time prevented her from wanting to

return home while in early labour. Lack of personalized care during the participants' initial intake procedures (e.g. filling out paperwork and answering questions related to registration, and waiting in public hallways and vestibules) could induce fear. Other participants linked their lack of personalized care during admission to feeling frustrated. Many participants described feeling a lack of freedom and power to act in the ways they preferred because health care professionals used a non-personalized and risk-oriented approach to clinical management of labour, which contributed to their feelings of frustration, uncertainty, and fear.

Caregivers made some of the women very aware of the guidelines and policies they expected them to follow. The participants gave examples of these as being charting all of the events and observations associated with their labours and births, and following prescribed frequencies of fetal monitoring and other assessments. For some participants, unquestioning adherence by professional caregivers to institutional guidelines and policies contributed to their perspectives about a lack of personalized care and their sense of powerlessness to act during their labours. Receiving institutional and medically recommended monitoring and treatments that the women indicated gave them no personal involvement in decision-making resulted in them losing trust in their care providers, their connections to their bodies, and their abilities to engage with their labours and births and feeling fearful about the outcomes.

Participants reported other instances where they lost their freedom to choose and power to act (e.g. using scented lotions and taking a particular position during labour) due to the directives of specific professional caregivers who failed to account for their personal situations. These circumstances illustrated how the women felt the

courses of their care were sometimes institution-focused rather than client-focused. Therefore, they perceived limited personalized care which affected their abilities to engage with their labours and births.

4.4 Summary

Participants described their feelings of fear during their hospital birth experiences when they received no support to engage in their labours and births. Participants' collective perspectives identified experiences in which they often did not receive care that incorporated teamwork and collaboration with them. When the women's care did not include them and enable them to act as active participants in their labours and births, they described feeling uneasy, anxious, and fearful. The participants who were fearful were unable to focus during their labours and engage with their labours and births while staying connected to their bodies. Under conditions where the women felt disconnected from their bodies, excluded from decision-making processes, restricted in their use of hospital space, reduced trust towards their professional caregivers, distracted from their labours and births by environmental features, and in receipt of impersonal care, they reported having difficulties engaging with their labours and births and more feelings of fear, anxiety, helplessness. The participants had a lack of positive anticipation of their births in these cases.

In the next chapter, I place my findings in the context of current research in the field of childbirth fear, refer to the significance and contributions of my thesis research, and comment on the strengths and limitations of my research. I then describe the

nursing implications in the areas of practice, administration, education and research that arise from my findings.

5: Discussion of Findings, and Implications

5.1 Introduction

I begin this chapter with a summary of the study findings. Following this, I describe how the study findings extend, refute, or fit with current literature on women's perceptions of hospital birth environments and their influence on women's FOC. I also make recommendations from the study findings for clinical practice, education, and research.

5.2 Summary of Study

The study sample comprised fifteen participants who had given birth to one child within a period of two months to three years prior to participating in the study. Whether the women had the opportunities to feel engaged with their births influenced their feelings of comfort or fear during the course of their care in hospital birthing environments.

Many of the participants experienced fear and difficulty engaging with their labours and births due to factors relating to the hospital birth environments. The major theme capturing the data was: Women's engagement with their labours and births. The theme incorporated six sub-themes: Women's connections to their bodies; women's inclusion in decision-making processes; freedom to use the hospital space; feelings of trust toward professional caregivers; distractions from labour; and personalized care. When the participants described having their connections to their bodies (inward focus) disrupted, being left out of decision-making processes about their bodies and births, being distracted from their labours by situations around them, and being restricted in their use of hospital space, they experienced more fear and anxiety. Erosions in their

feelings of trust and sense of personalized care contributed to their fear, helplessness, discouragement, and loneliness. The women described a failure to have their labour and birth preferences and expectations validated by their care providers, and control over the events and activities surrounding their labours and births as contributing to their feelings of fear, helplessness, disappointment, defeat, discouragement, loneliness and lack of positive anticipation for their births.

5.3 Discussion

The study participants emphasized their sense of helplessness, disappointment, defeat, discouragement, loneliness, and fears for their babies. Many of these feelings are captured in the WDEQ and are also attributes of fear of childbirth including fear, loneliness, and lack of positive anticipation for their birth (Garthus-Niegel et al., 2011). The study participants described those attributes when they experienced barriers to being engaged in their labours and births.

The study participants indicated they were disconnected from their bodies, in part due to multiple distractions, restricted in their use of hospital space, exposed to impersonal care and excluded from decision-making. Those experiences contributed to mistrust toward caregivers and feelings of fear, anxiety, loneliness, and lack of positive anticipation for their births. A subset of these women's feelings are reflected in subscale factors in the revised version of the Wijma Delivery Expectancy/Experience Questionnaire (WDEQ-A) (Pallant et al., 2016). The WDEQ had been viewed as a unidimensional tool, which limited the usefulness of the tool in any exploration of different aspects of FOC (Pallant et al., 2016). Research conducted by Pallant and colleagues in 2016 suggested that this measure is best operationalized as a

multidimensional tool; the authors claimed that multidimensionality increases the psychometric soundness of the tool and improves inquiry into the effects of FOC. In the revised version (WDEQ-A) new subscale factors included, negative emotions, lack of positive emotions, social isolation, and moment of birth (Pallant, et al., 2016). My thesis work supported these authors' conclusions that exploring differential aspects of FOC is an important consideration when studying FOC because participants described experiences with negative emotions, lack of positive emotions, and feelings of social isolation (Pallant et al., 2016). Study participants also referred to their disconnection from the actual moment of their births, which contributed to their feelings of fear.

Study participants stated that under conditions in which they received impersonalized care they became disengaged with their labours. They described feeling outside of themselves, afraid, and uncertain of their surroundings. They felt a loss of self when they were viewed as another labour statistic rather than a unique woman with their own preferences and expectations about labour and birth. Receiving impersonal care contributed to their loss of control, uncertainty and mistrust towards their caregivers and fear. Current literature does not link women's receipt of impersonalized care to FOC; however, researchers have described women's needs for personalized, trust evoking, and collaborative care to feel safe and comfortable during their labours and births in hospital (Hall, Tomkinson, & Klein, 2012). My study findings appear to support previous work but also extend knowledge about the impacts of impersonal care on women's feelings of fear during labour and birth.

My study participants wanted team-based care that focused on their preferences, with them at the center of the team. Without that kind of care, they had difficulty

engaging with their labours and births and remaining connected to their bodies. The participants' expressed preferences fit with the concept of shared decision-making. Shared decision-making has been defined by the Institute of Medicine as being, "A partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care" (Elwyn, Edwards, & Thompson, 2016, p.4). My participants' preferences also fit with published recommendations for professional maternity caregivers to provide client-focused care (BC Perinatal Health Services, 2010) and compassionate care (Curtis, Horton, & Smith, 2012) as stated in guidelines by various local and international nursing and health-care professional governing bodies (Perinatal Services BC, 2010).

The study findings suggest that, under conditions in which limited shared decision-making occurs, women feel excluded, which can contribute to their negative feelings about labour and birth, namely lack of positive anticipation for their births, and fear. Patient engagement is not a concept that has received extensive attention in the literature relating to childbirth fear. My study participants' emphasis on lack of teamwork and shared decision-making extends our understanding about the contribution of a failure to work in teams to women's negative feelings and fear during labour and birth. The necessity for shared decision-making has been addressed in the context of particular elements of maternity care, such as position during second stage (Nieuwenhuijze, Jonge, Korstjens, & Lagro-Jansse, 2012), induction of labour (Moore, 2016), treatment for ruptured membranes (Beckmann, Cooper, & Pocock, 2015), and elective caesarean sections (Munro et al., 2016). The previous studies have explained

the importance of women receiving support to make well-informed decisions that are consonant with their values and ideals. However, the previous studies did not link women's fear of childbirth to instances when women perceive lack of shared decision-making in the interactions with care providers, and in the models of care that they are receiving. The women who participated in this study and experienced exclusion from decision-making felt uncertain, appraised their births negatively, and felt a loss of control, which enhanced their fear during childbirth.

The study findings indicate that women regarded professional caregivers as often lacking consistency in their care and expressed a need for client-focused care for all parts of labour and birth. The findings fit with research about key elements of midwifery care that contribute to women's perceptions of excellent care including: Promoting their individuality; supporting their embodiment; going with the flow, and receiving information and guidance, and personalized, shared decision-making during women centred-care (Borrelli, Spiby, & Walsh, 2016). My study extends our understanding of the importance of providing women with these elements during their maternity care because the findings illuminate effects of impersonal and unwelcoming care practices, women's exclusion from decision-making, and sharing limited information on women's FOC.

My study findings provide North American-based research that accesses women's perceptions about how hospital birth environments contribute to fear of childbirth. Only three international studies about hospital environments and childbirth fear were located. One Iranian study (Taghizadeh et al., 2015) described Iranian women's discomfort with aspects of birth environments in the context of psychological

birth trauma. Taghizadeh and colleagues (2015) found that women wanted to be in environments that were more relaxing for them, allowed them to have a birthing partner, and provided personalized care. An Iranian study investigated mothers' needs, values, and preferences during normal labour and birth in hospital; the findings highlighted mothers' fundamental need for feeling a sense of control and empowerment during childbirth (Iravani, Zarean, Janghorbani, & Bahrami, 2015). The participants in my study wanted trust and collaboration with their professional caregivers to permit engagement with their labours and births, which lessened their fears and put them at ease. This finding is similar to results from an Iranian study where women who had their informational needs met during their labours and births felt a sense of control and empowerment during their labours and births in hospital (Iravani et al., 2015).

My Canadian participants wanted personalized care, and relaxing hospital birth environments which they linked to reducing their anxiety and fear. A study that was conducted to explore first-time English mothers' expectations for a good midwife identified women's preferences for individualized care, with midwives providing information and guidance throughout their labours and births (Borrelli et al., 2016).

The women in my study described distractions from their labours and births when labouring and birthing in hospital environments. They regarded elements of the environment as not reflecting their needs during labour (e.g. calm, private, and intimate environments). Taghizadeh and colleagues' (2015) study described that the non-human environmental factors that Iranian women described as terrifying and interfering with their labours: Hospital rooms, equipment, and procedures. Study participants regarded

the lack of explanation about the presence of strangers, and clinical equipment and procedures contributed to them feeling uncertain, ill at ease, and their feelings of fear.

The study findings highlighted circumstances where the women thought that their worst fears about labour and birth were being realized during their intrapartum hospital stays. When study participants felt threatened by events, such as lack of shared decision-making, lack of privacy, and impersonalized interventions, they became very afraid and even described going into fight or flight mode. Other literature has described the vicious circle of fear that is initiated in hospital settings when women feel that their worst fears are becoming realized; the stress response prolongs labour, causes vasoconstriction in the mother's circulatory system, reduces placental perfusion, and has negative effects on labour progress and fetal wellbeing (Stenglin & Foureur, 2013; Zar, Wijma, & Wijma, 2001). Conversely, studies have suggested that some women find available medical technology a comfort because technology reduced women's anxiety during labour and birth (Goberna-Tricas, Banús-Giménez, & Palacio-Tauste, 2011). The women in the study describing medical technology as reassuring may not have experienced circumstances where there was lack of shared decision-making and privacy, and imposed impersonalized interventions.

Some of study participants indicated that they experienced negative effects when they arrived at the hospital and were discouraged from admission because they were in early labour. They regarded the hospital admission procedures as rigid and failing to take their personal experiences into account. My study participants also identified environmental factors, such as lack of communication when complications arose during their labours and births, and strangers present during the courses of their labours and

births as contributing to their unease and childbirth fear. These experiences mirrored other accounts of women's experiences of labouring in hospital environments which enhanced their childbirth fear (Bernhard et al., 2014; Nyman et al., 2011; Taghizadeh et al., 2015).

5.4 Implications for Clinical Practice

My study participants identified practices and interactions with their professional caregivers that inhibited their shared decision-making and engagement in their labours and births. In what follows, I outline the practice strategies that I have developed from these themes.

5.4.1 Women's Engagement with Their Labours and Births

The women's level of engagement in their labours and birth hinged on their level of inclusion which has implications for practice arising from care providers' collaboration with patients and families.

Professional caregivers can perform report for transfer of care in the presence of the patient, their support persons, and all pertinent caregivers. Giving women options to choose and to give input has been demonstrated to increase patient satisfaction and build relationships between caregivers (Anderson & Mangino, 2006). Because the women found care providers' conversations about them that excluded them anxiety and fear provoking providers can eradicate conversations occurring about women and their babies that only incorporate caregivers in the presence of labouring women.

When planning for women's courses of care behind the scenes and without a collaborative approach the women in my study described a loss of control for them and their families. Caregivers can take time to determine women's and families' levels of

knowledge about labour and birth and interventions and attend to women's needs for information before planning courses of care. Other researchers have supported that approach (Iravani et al., 2015).

5.4.2 Women's Connection to Their Bodies

The participants' connections to their bodies during labour and birth were promoted by time and space to be introspective about their bodies. Feeling disconnected from their bodies made the women afraid, and panicked. The women regarded forced schedules, and activities as diminishing calm environments for their introspection. Caregivers can critically reflect about their regular labour and birth-related time sequence plans so that they customize the care schedules and activities to women's preferences and unique needs. Critical reflection requires attention to women's feelings and methods they believe will promote their feelings of calm and control of their own bodies and mind. Caregivers can bridge the disjunction between home and hospital by asking women about what type of strategies were working well at home.

5.4.3 Women's Inclusion in Decision-Making

Participants indicated that inclusion in decision-making about their care increased their sense of control during their labours and births. When professional caregivers performed independent decision-making participants felt excluded and out of control leading to fear. Professional caregivers can minimize women's feelings of exclusion and fear by treating informed consent as a complex and ongoing component of patient care. They can use the guideline for maternity care pathway (Perinatal Services BC, 2010) to assess whether appropriate informed consent has occurred.

5.4.4 Women's Freedom to use the Hospital Space

Many participants described the importance of physical action to move through the rhythms of their labours. They needed the hospital space to move freely and freedom to access hospital equipment so they could feel in control and focus on coping with their labours. Otherwise, they became anxious and afraid of the unknown, whether their labours would progress, or whether they would need interventions from caregivers.

Professional caregivers can get involved in hospital designs that make waiting rooms, triage rooms and bathrooms more suitable for women in labouring positions. Other research has supported limits to labouring women's creative, active, and self-prescriptive use the space for their labours because there are inherent limitations in the design, furnishings, and semiotics of hospital environments (Mondy, Fenwick, Leap, & Foureur, 2016). Professional staff can assist labouring women to play an active role in their labours in hospital space. Providing women with opportunities to be active participants in their labours has been supported by other research (Ängeby, Wilde-Larsson, Hildingsson, & Sandin-Bojöö, 2015; Borrelli et al., 2016).

Study participants attributed the barriers they faced in feeling relaxed enough to be engaged, creative about their use of space, and feeling a sense of ownership of the hospital space to care providers' emphasis on risk management procedures. Other research has implicated procedures founded in risk management principles (i.e. rigid timelines for induction, and discouragement of flexible fetal heart monitoring) in limiting women's access to optimal birth spaces (Seibold, Licqurish, Rolls, & Hopkins, 2010), (i.e. Other strategies could be for caregivers to treat the use of equipment and interventions as a shared activity with women engaged in choices. Restructuring

admission practices to ensure a consistent welcoming and seamless arrival for women can communicate to women that they are welcomed guests in hospital spaces.

5.4.5 Women's Trust Toward Professional Caregivers

Participants describing lack of involvement in joint decision-making with their health care providers had limited feelings of trust toward their professional caregivers because personal preferences and opinions were not taken into consideration, and feelings were not validated. Lack of joint decision-making could lead to women losing confidence, feeling uncertain, and disengaging from their labours and births, culminating in fear, as the women in my study pointed out. Health care professionals' collaborative approach to the courses of care can enhance women's trust and validation.

5.4.6 Distractions from Women's Labours and Births

Participants linked unfamiliar equipment, structures, and strangers to feeling ill at ease, distracting from their inward focus during labour, and increasing feelings of insecurity, and fear. Care providers can take time to acquaint women and their families with unfamiliar elements in hospital environments. They can limit women's exposure to strangers by attending to their privacy and ensuring that any new arrivals (care providers) introduce themselves and spend time learning about the women they encounter. They can also inform women proactively about who they might be meeting while in labour in hospital and provide simple and clear explanations prior to any unfamiliar experiences or interactions.

Professional caregivers can guide women through all the events of an intrapartum hospital admission by explaining procedures and caregivers' regular activities. Those actions will reduce women's uncertainty. Study participants indicated

that they wanted some preparation prior to or during surprising and unfamiliar circumstances to make them feel included, less uncertain, and less fearful of the unknown. Nursing practice that reorients women to their internal focus, helps them feel validated in their abilities to cope and decreases the any loss of control and feelings of uncertainty. Helping women focus enhances their feelings of certainty about their labouring bodies. A Scandinavian study in home birth environments supported the link between treating women as the center of attention and their clear sense of self throughout labours and births, (Sjöblom, Idvall, & Lindgren, 2014).

5.4.7 Personalized Care

Study participants linked caregivers' use of assessments and tests, without orienting them to the test, asking permission, identifying themselves during the procedure, and updating them on the results or outcomes of the assessments and tests to impersonal care which increased their sense of disengagement and disconnection and reduced their trust in caregivers. Such experiences enhanced the women's fear. All care providers can attend carefully to women's expectations and experiences so that they can provide personalized care. The positive effects of women receiving personalized care is supported by current research on women's views of pillars of midwives' good care practices, which is attending to individuality (Borrelli et al., 2016).

Because study participants described their desire for shared decision-making and personalized and collaborative care practices health care providers in maternity care can incorporate principles of women-centered care by using guidelines. The Maternity Care Enhancement Project (Province of British Columbia, 2004) recommended care practices that are primarily women-centered, collaborative, and

team-based and that include all maternity care providers (Province of British Columbia, 2004). Women-centered practice initiatives have also been incorporated in the latest maternity care pathway from BC Perinatal Health Program (Perinatal Services BC, 2010).

5.5 Implications for Education

As new maternity professionals enter the field they are at risk of encountering practice realities that do not adhere to the ideals of client-centered care and compassionate caring (Curtis et al., 2012). The elements that seem to drive the values and in turn the actions of some care providers in maternity care are patient safety and efficiency of labour and birth rather than attending to women's personal experiences to prevent fear and promote a sense of security. My findings support the link between women's subjective experiences of their birth environments and their FOC. The findings of this study indicate that all practitioners need to attend to a culture of compassionate practice. Women in my study stated that they encountered medical care that kept them free of complications and life threatening outcomes but that did not instill a sense of teamwork and inclusion during their intrapartum experiences. Previous studies have suggested differences in nurses' and physicians' clinical judgements (Simpson, James, & Knox, 2006). The differences require attention in professional education so that team members can collaborate on safe and personalized care.

Education for specialty perinatal nurses entering the field should include the outcomes associated with women's FOC. There is a high prevalence of Canadian women experiencing FOC (about one quarter) (Hall et al., 2009) and the women in my study have stated that there are many factors contributing to their feelings of fear when

labouring in hospital birth environments. Specialty nurses need to attend to women's experiences and attitudes toward labour and birth in order to better understand what their patients would find reassuring during their births and enable women to stay engaged.

Another expectation of practice for registered nurses is compassionate practice (Curtis et al., 2012). This study highlights that the lack of personalized care which undermines compassionate practice. Nurses and other care providers who are not present with their patients and listening to women's preferences to enhance their comfort are failing to provide compassionate practice (Curtis et al., 2012).

Perinatal nursing educators need to impress upon those they teach that women's perceptions of hospital birth environments influence their FOC. This is because a culture of risk management and therefore, as Seibold et al. (2010) described, a maternity practice influenced by caregiver fear, is hindering optimal birth environments for women which influences their fear of childbirth. Furthermore, students can benefit from awareness of negative outcomes arising from women's childbirth fear and women's overall perceptions of their safety and their baby's safety in hospital (Melender, 2002).

CRNBC standards of practice indicate that nurses are to uphold client-focused provision of care, specifically nurses are to communicate, collaborate, and consult with clients and other members of the health care team about the client's care (College of Registered Nurses of British Columbia, 2005). The findings from this study indicate the negative implications of women being excluded in conversations about their care or having students 'do things to them' without adequate introductions. Nursing instructors

can work with students and regular nursing staff to ensure that students have proper introductions to patients and seek informed consent before engaging with them.

One outcome that requires incorporation in specialty courses in nursing maternity care is critical inquiry about how environments foster security for women. It is beneficial for students to identify challenges arising from labour and delivery contexts. Case study teaching about patient engagement should be included in curriculums with opportunities to critically inquire about the practices observed during clinical practicums in perinatal placements.

5.4 Implications for Research

The study findings demonstrate the need to study how women experience childbirth fear in different cultural settings. They raise questions about the applicability of the WDEQ-A survey in clinical settings for the purposes of evaluating the emotional health of women facing childbirth and identify those at risk of FOC (Pallant, et al. 2016). My study illuminates some factors at play with regards to developing fear during labour and birth for women. Because my findings suggested that shared decision-making, women's connections to their bodies, and limited distractions in the hospital spaces enhanced women's outcomes it is important to design studies that address barriers or challenges for professional caregivers attempting to institute strategies to enable women to engage in their labours and births. Study designs could also examine institutional structures that undermine women's feelings of comfort and security in hospital settings.

Research studies can pose questions about how shared decision-making is being operationalized in maternity care environments. A research question attends to

professional caregivers' perceptions about women-centered care and mechanisms for its practice.

My study findings indicate that women prefer collaborative maternity care with attention to potential emergencies (e.g. risk management). Further research should focus on how caregivers might integrate rich relational practices with risk-management models. A research question could be: What are the experiences of maternity caregivers in enacting shared decision-making in the context of emergent and emergency intrapartum care?

5.5 Strengths of the Study

The women in this study had experienced a variety of birth experiences and were very motivated to tell their stories. The sample of women I interviewed delivered their infants in different hospital locations and received care from different types of care practitioners (general practitioners, obstetricians, and midwives). I followed principles of research rigor with regards to reflexivity and data confirmability through the digitally recorded interviews and verbatim transcription. I obtained rich descriptions from a variety of cases which successfully identified women's perceptions of hospital birthing environments and the influence of the environments on women's feelings of fear. My supervisor engaged with my interview data and assisted with data analysis which reduced researcher bias and enhanced transferability.

5.6 Limitations of Study

There are some limitations to my study. The participants that I interviewed all came from a fairly homogenous status, for example they had higher levels of education and household incomes. The findings lack perspectives from women who are exposed

to higher vulnerability through socio-demographic factors and other determinants of health. The interviews and a considerable portion of the data analysis rested on one interpretation. Although the women experienced a variety of primary care providers they were exposed to very similar hospital practices in a large urban Canadian setting. The findings are not generalizable but may be transferable to women in similar settings.

5.7 Conclusion

FOC is an important phenomenon in our society, and women's experiences with childbirth and their attitudes toward modes of birth influence the presence or absence of this type of fear in both men and women. Limited empirical information about how hospital birth environments contribute to women's perceptions of their FOC restricts evidence available to professional caregivers so that they can reflect on their practices and environments. The central theme from the findings indicated that women wanted to be included, engaged and connected to their bodies while experiencing labour and birth. As well, despite the shortcomings they described, many women wanted to experience birth and labour in hospitals. Even in highly resourced environments Canadian women described experiences which created anxiety, loneliness, uncertainty, and fear. These women's experiences of labouring and giving birth in many instances do not reflect compassionate and patient-centred care. Implications from the findings for professional caregivers arising call attention to participants' perceptions of the influence of hospital birth environments on FOC. Attention to factors at the individual and system level is necessary to diminish women's FOC.

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Appendix A: Recruitment Letter



a place of mind
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Recruitment Letter

The Influence of Environments on Fear of Childbirth During Women's Intrapartum Hospital Stays

My name is Jenny Auxier and I am a registered nurse and currently enrolled as a graduate student in the master of nursing program at UBC. I have worked in hospital as a labour and delivery nurse for 4 years. I am studying how women perceive their hospital birth environments by undertaking a research study about those environments and their potential effects on women's feelings of reassurance or fear. To help this, I would like to recruit women who have delivered a child in the hospital at least two months ago. This study will be conducted through one-on-one interviews in a location chosen by you. The interviews will last between 40-90 minutes.

Criteria for participation:

- Has given birth to their first child in hospital a minimum of two months ago, either vaginally or by cesarean section
- Has delivered in a hospital located in Vancouver or Richmond city area (does not have to reside in these cities to participate in this study)

If you would be interested in participating in my study on women's perceptions of their hospital birth environments, please contact me by email or phone. If you would like to contact the Principal Investigator for any reason Dr. Wendy Hall can be contacted by email.

Appendix B: Consent Letter



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

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Consent Letter

The Influence of Environments on Fear of Childbirth During Women's Intrapartum Hospital Stays

Principal Investigator: Dr. Wendy Hall, UBC School of Nursing

Co-Investigator(s): Jennifer Auxier, UBC School of Nursing, Master's in Nursing Student (being performed for my graduate degree)

Purpose:

I am a graduate student at the University of British Columbia School of Nursing who is interested in examining women's fear about childbirth. Because we want intrapartum hospital settings to facilitate comfort and safety for all women in labour it is important to identify the environmental factors that can contribute to or reduce women's childbirth fear during their hospital stays. If we have more information about women's experiences changes to intrapartum environments that can increase labouring women's feelings of security or decrease their fear responses in hospital birthing settings will be more possible. Therefore, my research question is: What are women's perceptions of the influence of environments on FOC during intrapartum hospital stays? I am inviting you to take part in my research study because you have recently given birth to your first child in a local hospital environment.

Study Procedures:

Your participation in the study will involve 1.5 hours of your time. I will come to your home or other setting you might choose to be interviewed. These interviews will be digitally recorded and subsequently transcribed for analysis. The transcribed data and recorded information will be kept in files on an encrypted hard drive and stored in a locked cupboard in the principal investigator's (PI) office and the PI will be the only individual with a key to this cupboard. Any technological devices that are used to perform data analysis will be encrypted and pass code protected. All identifying

elements within the data set will be removed and pseudonyms will be applied to preserve confidentiality for participants.

You may be asked to provide feedback on my analysis and summary of the themes identified. You will be requested to answer some general questions after the interview has been conducted to identify some brief demographic information.

Your newborn may be present for interviews and you can expect the interviews to last between 40-90 minutes.

Potential Risks:

If you feel uncomfortable at any time during the interviews, I will stop the recording and enable some time to talk it through. Information about counselling and support services will be provided for you to access independently if you are experiencing overwhelming negative responses to study questions.

Potential Benefits:

As a participant in this study you will have the opportunity to share your birth experience. You might benefit from sharing detailed information about your birth environment, given the unique experience of birth and the power of sharing your story with a research professional. It is expected that the knowledge gained from this research study will illuminate both supportive elements and possible barriers to providing patient-centered care in maternity hospital settings. I will send you a summary of my findings. I also plan to disseminate my study findings to parent groups, healthcare professionals, and through peer reviewed publication.

Confidentiality:

Your identity will be kept strictly confidential and this will be achieved by the removal of all individual identification information from transcribed notes and all other research files. Although your, anonymity will be ensured, the data from your interview will be incorporated in the study findings which will be published in a peer-reviewed journal.

Contact for information about the study:

If, at any time, you have questions about procedures, or the topic of study please feel free to contact the researcher Jenny Auxier or the supervising faculty Dr. Wendy Hall by email.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your healthcare.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Signature

Date

Printed Name of the Subject signing above

Appendix C: Demographic Questionnaire

Demographic Questionnaire

What is your age?

What was your mode of birth?

If you experienced labour did it begin spontaneously?

What is the gender of your child?

What is your child's health status?

What is the highest level of education you have completed?

What is the yearly average income of your household?

20,000-34,999

35,000-49,999

50,000-74,999

75,000-89,999

≥ 90,000

Do you live with a partner?

Are you employed outside the home?

Appendix D: Interview Guide

Birth Environment Questions

1. Remember back to the day you gave birth, what were your memories or your first impression when you were in the hospital environment.

2. What were your experiences as you spent time during your labour and birth in hospital?

How would you describe the effects of the spaces on your labour and birth experience?

How would you describe the effects of the people you encountered on your labour and birth experience?

3. Please give your account of your most memorable interactions that affected your labour and birth experience in hospital. What made these interactions memorable for you?

4. What would you say were some of the important events during your hospital stay?

5. In each event:

How did those events affect your feelings about your labour/birth including any feelings of reassurance and comfort or fear?

Can you recall any memorable sounds, sights, touches, or smells during your labour and birth experience in hospital? How did those elements affect your labour/birth experiences including any enhanced sense of fear or comfort?

Overall how did the hospital birth environment affect your feelings of comfort/safety during your birth and labour?

Overall how did the hospital birth environment affect your feelings of fear/stress during your birth and labour?

Appendix E: Modified Interview Guide

Birth Environment Questions

Remember back to the day you gave birth, what were your memories or your first impression when you were in the hospital environment. (you can begin from when you were having labour at home and what made you decide you were going to come into hospital).

- Did you enter the hospital prior to arriving during your intrapartum stay, did you attend a hospital tour?

What were your experiences as you spent time during your labour and birth in hospital?

- What were your perceptions of the events that led to the progression of pain management plans, or of labour progression plans?
- If an emergency moment occurred, what was decided and how was it decided upon, what were the effects of the decisions and how this planning occurred?
- How did the decision-making processes influence women's feelings of safety, comfort, or fear?

How would you describe the effects of the spaces on your labour and birth experience?

How would you describe the effects of the people you encountered on your labour and birth experience?

Please give your account of your most memorable interactions that affected your labour and birth experience in hospital. What made these interactions memorable for you?

What would you say were some of the important events during your hospital stay?

In each event:

How did those events affect your feelings about your labour/birth including any feelings of reassurance and comfort or fear?

Can you recall any memorable sounds, sights, touches, or smells during your labour and birth experience in hospital? How did those elements affect your labour/birth experiences including any enhanced sense of fear or comfort?

Overall how did the hospital birth environment affect your feelings of comfort/safety during your birth and labour?

Overall how did the hospital birth environment affect your feelings of fear/stress during your birth and labour?

Appendix F: Second Memo Part 1

Introduction:

Women in our study describe that hospital birth environments contribute to their feelings in an impactful way during their labours and births. The different components of women's experiences of hospital labours and births that are contributing factors of their feelings are interactions with others, foreign and unfamiliar clinical procedures and processes, hospital rooms and equipment, women's expectations influencing their feelings of affinity with their birth environments, emergency procedures influencing feelings of fear, feelings of helplessness resulting from times of uncertainty and loss of control, and times of uncertainty influencing feelings of fear.

Some women have expressed that they wanted to birth in hospitals so that they could be sure they would be medically supported, this notion gave them reassurance for their own safety and for the safety of their babies (IN4 I1859-864; IN13 I1332-334; IN12 I1653-657). Some women have expressed that although they felt medically supported in their births and labours while in hospital birth environments they felt that in the hospital birth environments they were faced with many hindrances in their abilities to create the birth that they wanted for themselves, and this left some of the women feeling helpless, and in some cases fearful (IN11 I1766-769).

Some women have explained how hospital environments produce, for them, circumstances and events that contribute to ambivalent feelings. These feelings represent women having a sense of security and a fear of the unknown at the same time while experiencing labour and birth in hospital environments (IN10 I1665-668, I1851-855). Some women explain this as them having positive feelings of security knowing

that medical back up is present in the hospital birth environments but at the same time that they are presented with many environmental factors that contribute to their fears of the unknown, and fears that are brought on by their sense of loss of control and helplessness in the intuitional, medicalized environments of hospital birthing spaces (IN7 11733-756; IN15 176-181, 730-736; IN10 508-519).

Although some women in the study experienced these conflicting feelings there were examples of women feeling that they had empowering births in hospital (IN14 11585-592). Some women stated that these experiences took place because they received effective and comfortable labour support from hospital staff and the caregiver teams (inclusive of doctors, specialists, midwives, and/or nurses). Some women stated that that influenced their sense of control over their own abilities to create the birth that they wanted for themselves, which gave them feelings of empowerment and comfort. These women stated that in the event that they felt an affinity between themselves and the care givers that they were reassured and also experienced agency in their births and labours. Some women stated that they were able to experience agency of their births and labours in part due to positive interactions between themselves and the members of their caregiver teams. Specifically, some women were reassured in their ability to have agency in their births when members of the caregiver team initiated informative, measured conversations with them about any uncertain circumstances that arose (i.e. Lack of progress in labour, or abnormal fetal heart rate findings).

Some women in our study have described how the hospital environment influences their ambivalent feelings and their feelings of fear in the following ways:

Interactions with Others

The women in our study have mentioned how interactions with hospital staff, their support persons, and others have greatly influenced their feelings. Women in our study have described that some interactions that they had with others while entering and being in hospital environments during their births and labours were impactful of their feelings of comfort or of fear. Women encountered many others while in hospital and this really is a striking component of all hospital births and labour experiences, as hospitals are public spaces. As such women in our study described that they came into contact with many members of the public in hospital spaces and this is all while they were undergoing one of the most life changing (IN1 I1506-513) and, ideally, intimate experiences of their lives. While the women in our study give accounts of when they came into contact with members of the public they of course are were interacting with hospital staff in a variety of ways also. The nature of interactions with hospital staff is very stimulating and sometimes fear provoking for women because they often were meeting these staff for the first time and often were speaking to these strangers while experiencing great distress and low energy as a result of labour.

The women in our study described hospitals as public spaces. Women in our study mentioned that they experienced interactions with strangers in hospital and sometimes this was very distracting and at times fear provoking. Some women stated that they witnessed women labouring and birthing in stalls next to them (IN11 I149-58; IN14 I182-93, I1101-104; IN7 I138-40) during their initial triage experiences. Others stated that they were made to wait in hallways with other patients and families (IN13 I175-77), and in one case a women waited within ear shot of health care professionals speaking

about other patients in detail (IN5 II67-71). Women described having to travel in elevators and through hallways which left them at times feeling very exposed to strangers and also on occasion hearing others (like patient visitors or hospital porters) talk about them during these travels but not be able or willing to respond giving them distracting thoughts and feelings making it hard for them to completely relax into their labours or emergent circumstances (e.g. Transferring for an Emergency c-section) (IN8 II225-228; IN2 II202-207). Other women mention that they had become distracted by other women vocalizing in labour (IN8 II653-675) and in one case a women witnessed the delivery of a baby from behind the next curtain (IN11 II49-58), this distracted her, and made her anxious but also filled her will a sense of amazement, ultimately resulting in her first impressions of the hospital spacing promoting ambivalent feelings, feelings of curiosity, amazement and those of discomfort, and anxiety.

Women in our study gave account of important interactions with staff that influenced their feelings of fear and loss of control, and in some cases anger. (IN11 II322-332; IN15 II108-121; IN14 II152-157; IN7 II491-506). Some examples of these experiences are that staff would disregard a women's opinion, tell them that a procedure did not hurt when in fact it did, or prescribe activities to the women in very forceful ways (IN1 II128-139; IN15 II114-115). Some women have given accounts of periods where members of their care provider team asked them questions in very leading ways and didn't seem to be truly inquiring for the actual experience of the women but the experience that the health care provider had already assumed as being true, for example when some women stated that their epidurals were not working or that they began feeling contractions again some members of the team repeatedly asked

them to re take the test without trouble shooting or re-assessing the epidural itself (IN11 II409-431). Some of the women in our study told us that they felt pressured to answer in certain ways even if they really didn't think that was true or if they remained unsure about where they felt the cold or if they were experiencing effective treatment with the epidurals (IN10 II846-858).

Foreign and the Unfamiliar Clinical Procedures and Processes

Women in our study have expressed that they encountered unfamiliar procedures being performed around them during their labours and births in hospital. Some women mentioned that there were elements of this care model that were seen as impersonal and inefficient to them (IN13 II18-20). This foreign and unfamiliar environment struck many women as being uncomfortable and in some cases fear provoking (IN5 II94-112; IN6 II136-144). Some women found that many elements of the medical model of care for birth and labour. Some examples women gave of these types of procedures were, the registration and waiting processes, invasive procedures, members of the care team wearing face masks, having students providing care without full informed consent given by women, allocation of room assignments for patients, and the restriction of movement in cases of emergency C-sections, instrumental deliveries, or because of the use of an epidural (IN1 II276-280; IN2 II555-560; IN8 II163-169; IN7 II384-389; IN12 II187-202; IN11 II375-391, 397-406; IN10 II536-549; 640-646) Overall the women in our study explained that some of the processes and procedures of the medical model of care for labour and birth were something that confused them at times and hindered them in their abilities to create a relaxed and calm atmosphere for their labours and births.

The various examples of procedures and processes that the women in our study described gave many of them feelings of being put off, and unsettled in the hospital birth environments. One woman explained that she got an unsettling feeling at one point and that shortly after this her labour, which had been intensifying while at home now stopped (IN11 II204-210). This woman stated that this happened after she spent sometime in the triage area witnessing a birth, being made to wait to be assigned to her room and her nurse which was a confusing and chaotic process and being in a room, in the tub with no real feeling of being this being an intimate process with everyone standing around staring at her, having a sense that people would just come and go as the bathroom had only a curtain to enclose her (IN11 II133-178, 181-195).

Women in our study have a variety of different approaches to participating in their care during labour and birth in hospital. Many of the components to labour and birth are foreign to new mothers and the hospital procedures can be hard for women to understand. Women vary in their desire to understand the details of the medical model of care for labour and birth. At some point all of the women in our study contemplated a limit to what was under their own understanding and abilities when it came to their labours and births. For example, some women felt that the induction of their births and decisions how to manage lack of progress of labour was something they could be given information about and make informed decisions about while other women felt that these matters were best understood and prescribed by their health care team. One woman explained that she found the many options and suggestions from staff and their explicit attitude of team work with her throughout her labour in hospital gave her confidence and

security during her labour and birth in hospital even though she was immersed in an unfamiliar environment the team of care providers at the hospital communicated with her in a very measured and accommodating way which put her at ease throughout many strange and unfamiliar experiences like in the case when the OB had to manually rotate the baby's head without her having an epidural. Because the team gave her options she felt secure enough to take the option that involved less interventions (IN12 11250-269).

Whether women felt they had a good understanding of the medical procedures and processes for the management of labour these were sometimes unsettling experiences that became distractions for these women. What appears to develop in each woman's story is that in all these cases the distractions prevented the women in focusing inwardly feeling that they cannot effectively do the "job" they have to do and this can lead to panic, or fear of failure, of the unknown, and of possible further scary interventions.

Appendix G: Second Memo Part 2

Hospital Rooms and Equipment

Some women stated that the hospital environment and birthing rooms did not seem set up for the special event of labour and birth. This fact left them feeling not at ease, because they got a sense that their birth was nothing special in this context of care. For example, one woman states that the hospital is a place where the space, does not belong to her, that many women have come before to birth in this room and others will quickly trickle in after her (IN11 II689-695) that this is just the everyday occurrence here in the hospital. Another woman states that the space surprised her, how clinical it looked, not like a bedroom, not special and comforting like she had imagined birth spaces should be like (IN2 II159-169). This institutional feel that some women speak about has put some women off their game so to speak, and puts doubts into their minds about how they might be considered just another tick box (as one woman mentioned) (IN13 II92-93) on the hospital staff's list of people to care for, rather than an important and unique mother giving birth to a special child. This is an example of how women's feelings of positive anticipation, an important component in women feeling comfort during labour and birth, is influenced by hospital birth environments. Some women in our study describe how they become un-inspired during their births due to some underwhelming relatives of the physical space and attitudes of the staff they meet and this makes them question whether their experience can and will be a truly special and positive one.

While the women in our study felt that the hospital space was not always set up in a way that gave them a sense of positive anticipation they also mentioned many

examples of how they either felt freedom to utilize the space or not. And this feeling of freedom within the space seemed to be, for many of the women in our study, an influencing factor in their ability to feel secure in their ability to do their job in labour. So what mattered to the women was that the work of labour and birth was accomplished, some women really wanted this work to be in their hands, others preferred to leave most of the work up to the staff in hospital. Some women mentioned that they value that the hospital was set up to do a job and it did its job for them (IN14 I1630-634; IN12 I1443-453; IN13 I1525-535; IN5 I1554-557). The ways that some women felt secure was that the hospital was equipped with the supplies and instruments required for birth and labour (laughing gas, extra towels, basins, clinical monitoring tools etc.). Other women mention that they actually were able to use the beds and birthing balls and laughing gas in a way that completely supported them in doing the work of their labours. One woman stated that she was so tired from standing up with every contraction while labouring at home that to be able to lay down on the hospital bed and use the laughing gas for the rest of her labour was a really helpful way for her to focus inwardly and feel powerful enough to get through the contractions (IN6 I180-89). Although this woman did find it very fear provoking when the laughing gas tanks became empty and when the care provider team took the gas away when it was time for her to push (IN6 I1316-326).

Women's Expectations Influencing Their Feelings of Affinity Towards Hospital Birth Environments

Some women who have experienced events not as their expectations had prepared them for and this produces a variety of emotions depending on the specific expectations and standards each woman had for their labours and births.

Women in our study have reflected on their experiences of the local hospital birthing environments as clinical, and producing of a feeling that when you enter them that you are somehow sick or in need of some kind of fixing from medical professionals (IN15 11360-365). Some women, from our study, have explained that they have their very own personalized standards for birth and labour that sometimes include being surrounded by the clinical expertise of the staff, although many of these very same women stated that they preferred not to view birth as a state of being ill or needing to be fixed (IN4 11569-572). The women in our study explained that they value having the back up of hospital staff and technologies in cases of extreme risky and/or life or death situations (IN4 11859-864, IN9 11929-933).

All of the women in our study noted that they were grateful for the lifesaving and/or important work that hospital staff did for them while they were birthing and labouring in hospital. Some women mentioned that they do however, hold some ambivalence toward wanting to have their births in hospital for reasons of feeling secure medically and yet finding that they were made to feel helpless in some cases due to the risk-oriented and medical management of labour that comes from having medical professionals and clinical procedures lead the courses of their care (IN10 11851-855). After interviewing a variety of women it is important to note that some women in our study experienced very clinical procedures that influenced their feelings of helplessness even if they were under the care of a midwife in hospital.

Women in our study have presented a variety of ideals about the medicalization of birth and the institutional style of care of hospital birth environments. Some women

state that they preferred to labour as naturally as possible with minimal interventions. Others stated that they wanted to make use of all the drugs for a labour that would be as pain free as possible. And others put the most emphasis on having their care be provided in a way that was personalized to their unique situations and that their support system and care givers would work with them and offer them suggestions on how to move along with uncertain circumstances that might come up during labour and birth.

What we found is that all of the women hoped to have an affinity with their care giver and wanted to receive a care model that suited their birth attitudes. What has evolved from the narratives is that every woman in our study had a reaction, either positive or negative depending on whether they felt this affinity to the care givers and well aligned care models to their own attitudes of birth. For example, some women in the study expressed that they had an expectation for feeling safe in the case of an emergency during their births in hospital, and when emergency did strike in some cases these women were reassured by the efficiency and speed of the care providers to deliver their babies safely with no ill effects or poor outcomes (IN2 II259-262; IN15 II574-587). As well, some women expressed that they had expected to feel listened to and be made a part of their labour and births were left feeling helpless, out of control, and left out when they were not spoken to directly about plans of care and uncertain circumstances of their labours and births (IN15 II140-143). For example, some women noticed a limited amount of disclosure from medical staff about possible risks or dangerous circumstance and this gave the women feelings of fear of the unknown and lack of control over their own bodies and the safety of their unborn babies (IN10 II387-393).

Women in our study received information about birth and labour from others and/or labour and birth informational resources. This information prepared them with a variety of interesting expectations about their own birth and labours. One common topic that came up for some of our participants was the hope and possibility of a virtually pain free labour and birth. Some women had been told exuberantly by others to “Get the epidural, whatever you do, get the epidural” (IN9 I1240) other women had heard that using the laughing gas could be something that takes enough of the edge off that you could use it for the entire labour (IN6 I1506-511) and not need anything else the entire time. Others still, looked to the possibility of being able to move through each contraction as if it was a wave or lap and just work through the ebbs and flows with breathing and water therapies and not becoming distracted from their inward focusing (IN4 I1565-586).

In each unique case the women all expressed that they were influenced emotionally whether their expectations for their labour were met or not. Women who were able to stay in their zone or inward focus felt reassurance because they were able to progress in labour while doing what they had hoped to do. And when these women were given words of positive affirmation and updates about their labour progress this increased the feelings of reassurance. Women who got the opportunity to receive an epidural at their request when they felt it was the right time to implement this intervention were comforted and reassured with their ability to rest for a time while still having contractions (IN2, IN3, IN10 IN13, IN15)

One woman who had hoped for a break in contractions and wanted to build some seclusion around herself was repeatedly told by the majority of her mixed group of

caregivers (inclusive of midwives, nurses, and doctors) that she was suffering and that she needed an epidural, this provoked feelings of frustration and fear for this woman during her labour and birth (IN1). As well, some women experienced having surprising procedures or events occur without their consent and in some cases without debriefing after the fact and this left women feeling out of control, helpless, and fearful (IN9, IN11). In either case whether women's labour and birth expectations were met or not left them with either feelings of affinity with the care context and providers or feelings of inequality with care providers and themselves. When women felt a sense of affinity with care providers this gave them a sense of security and comfort. When they did not have these feelings of affinity with the care context and providers they felt unsettled and distracted from their focus, and in many cases very fearful.

Emergency Procedures Influencing Feelings of Fear

Some women experienced certain obstetric emergencies while in hospital. Some women in our study who mentioned that they experienced an emergency during their care in hospital felt more secure in these moments when one person who was an expert completely explained everything to them as it was happening (IN1, IN10). In some of the cases for the women in our study who experienced emergencies this did not happen. In the cases where women in our study did not know what was going on entirely but did know that something dangerous was happening they became very afraid, and in many cases felt really lonely and abandoned by caregivers (IN11, IN7, IN15, IN9, IN10, IN8).

Some women said that they have ambivalent feelings about the emergency circumstances, these women said they were grateful for the life-saving skills and

resources that the hospital offered but that they find it impactful that they were left feeling lonely and frightened during these times. Some women did not receive debriefing about the details of the emergency situation, even to the point where they are not entirely sure that the primary care provider was truly dealing with an emergency or if they were acting to avoid liabilities (IN7, IN15).

Helplessness Feelings Resulting from Times of Uncertainty and Loss of Control

When any feelings of helplessness and loss of control occur when they get a sense that all the actions and work of their own labour or birth become work that they cannot or don't feel they have been invited to take part in but that is being done to them with implied consent.

Women in labour are inherently going to feel helpless at various times during their labours. What some women in our study have highlighted through the telling of certain events is that the hospital birth environment contributes to another layer of helplessness that is externally produced. Some women have discussed how some conditions of their births in hospital contributed to them feeling powerful and in control during their labours and births. For example, having a button to control the strength of the sensation they felt from contractions (IN10 II240-246). Some women in our study have suggested that the hospital environment, inclusive of interactions, physical space, and clinical procedures and processes has the influence to either promote empowerment during their births or contribute feelings of helplessness during their birth and labours which in some women's cases made them very afraid.

Times of Uncertainty Influencing Feelings of Fear

Uncertain circumstances are inherent in all labour experiences. Women in our study who birthed and labored in hospital have given accounts of how uncertainty was enhanced by the actions of their care provider teams. Some women felt that while in labor they lost their resolve and motivation to speak for themselves in many cases, and what seemed to happen in such times is that staff acted in a way that was as if the women were not in the room when they spoke, (IN7; IN12; IN11; IN15; IN9). Other times women stated that staff would come to look at the machines in their birthing rooms and not first speak to them (IN11, IN9). One woman accounted for an incident when she brought attention to one staff member that they had not introduced themselves to them first before acting on the women (IN15). At times when women had consented to a major procedure, like an epidural insertion or an emergent c-section the staff would begin to do many things to prep the women without actually explaining what they were doing, so women describe being prodded and pulled at in various ways which gave them such a strange feeling of being acted upon without them knowing what was happening exactly (IN10, IN7).

Conclusion

Through an early analysis of the data we are able to see that many of the women had ambivalent feelings towards the circumstances surrounding their hospital birth environments due to certain common components of the environments. These components were, interactions with others, foreign and unfamiliar clinical procedures and processes, hospital rooms and equipment, women's expectations influencing their feelings of affinity with their birth environments, emergency procedures influencing

feelings of fear, feelings of helplessness resulting from times of uncertainty and loss of control, and times of uncertainty influencing feelings of fear. The fact that the women in our study often had these feelings of ambivalence towards the hospital birth environments shapes our understanding of how hospital birth environments locally are a major contributing factor to women's lasting and in the moment feelings about their births and labours in hospital and how this can influence their perceptions of their fear of childbirth.

Appendix H: Reflective Note

July 25th, 2016

Transcribing Notes. P 5

At time signature of 10 minutes and 50 seconds

I am reflecting on the significance of the kindness of the anesthesiologist in her account of what it was like to ask for two support people to be present for her c-section.

What I am thinking is regardless of why he agreed to her request, the result was that all the fear she felt went away.

I need to make sure I am not assuming things I cannot determine. I have a great many assumptions about the dynamics between the nurse who first implied that the woman would not be able to have this done the way she wanted, and the anesthesiologist.

These assumptions are based on my own experience and what I perceive as a culture of conflict that occurs between nurses and consultants in some cases.

This story is important but not for the system implications that I first think about, it is important because the woman is discussing how important the personalized care, and being listened to were for the decreasing of her fear in that moment, she discusses that she felt she was in a fight or flight mode after the nurse's interaction with her and very calm and more excited about the birth after the anesthesiologist agreed to her request.

Appendix I: Thank You Letter

Dear Participant,

I want to express sincere gratitude for your participation in the research study investigating influences of hospital birth environments on labouring women's perceptions of fear of childbirth. Your contribution to this study will impact further understanding on this phenomenon and this important information could not have been accessed by any other means.

Attached to this letter is a summary of findings from the study. I ask that you review the summary of findings and inform me if you have concerns or questions about the material presented. It is important that these findings represent the combined work and ideas of all the participants and myself, the researcher, so any feedback from you is gladly welcomed.

Please feel free to contact me if you have any further questions about this study and findings now that your participation is complete. Or you may also contact the Principal Investigator, Dr. Wendy Hall by email.

Best regards,

Jenny Auxier