Women and Birth

The social conception of space of birth narrated by women with negative and traumatic birth experiences

--Manuscript Draft--

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Abstract:	Background Many women experience giving birth as a negative or even as a traumatic event. Birth space and its occupants are fundamentally interconnected with negative and traumatic experiences, highlighting the importance of the social space of birth. Aim To explore experiences of women who have had a negative or traumatic birth to identify the value, sense and meaning they assign to the social space of birth. Methods A feminist standpoint theory guided the research. Secondary discourse analysis of 51 qualitative data sets/transcripts from Dutch and Czech Republic postpartum women and 551 free-text responses of the Babies Born Better survey from women in the United Kingdom, Netherlands, Belgium, Germany, Austria, Spain, and the Czech Republic. Findings Three themes and associated sub-themes emerged: 1. The institutional dimension of social space related to staff-imposed boundaries, rules and regulations surrounding childbirth, and a clinical atmosphere. 2. The relational dimension of social space related to negative women-healthcare provider interactions and relationships, including notions of dominance, power, authority, and control. 3. The personal dimension of social space related to how women internalised and were affected by the negative social dimensions including feelings of faith misplaced, feelingdisconnected and disembodied, and scenes of horror. Discussion/Conclusion The findings suggest that improving the quality of the social space of birth may promote better birth experiences for women. The institutional, relational, and personal dimensions of the social space of birth are key in the planning, organisation, and provision of maternity care.

Response to Reviewers:	Dear Editor and Reviewers, Thank you for your time and efforts to review our paper. We are pleased with your positive comments and have addressed your suggestions. Thanks again for your feedback, which will contribute to the quality of the paper. Reviewer #1: Thank you for the opportunity to review this interesting and well-crafted paper on a very important topic. This paper makes a significant contribution to conversations about the interaction between the physical birth space and the interactions between women and healthcare staff within it. Feminist Standpoint theory and Secondary Discourse Analysis are highly appropriate for analysing the large amount of data collected and the complexity of managing different languages to synthesise the emergent themes. The three themes were considered and well evidenced. I have the following recommendations for minor changes that will strengthen the paper and make it more replicable in other settings and by other researchers. Thank you very much for kind words and the acknowledgment of the significance of the paper and for confirming the methodological choice. We have revised the paper and incorporated your recommendations. 1. There was no mention of the ethical approval for the interview component of the study - please add this We indeed only mentioned that ethic approval was obtained in the text and in the ethical statement, without mentioning the protocol reference numbers. We have added the all necessary ethical information (standards, procedures, protocol reference numbers) to the ethical statement. 2. There is no description of the recruitment method or interview questions for the interview participants - please add this For the recruitment and interviews of the Dutch participants we refer to the original paper. Information regarding the Czech interviews has been added. 3. There is no way to identify in the results section which data are from the interviews and which from the BBB survey - please add this or provide a rationale for not presenting the data in this way. The labels arising from the discourse fragments from the interview transcripts aligned with the labels from the B3 responses and were merged into one matrix. This information has been added to the discourse analysis paragraph. 4. The methods section describes that data were collected from birthing women in 2 countries, The Netherlands and the Czech Republic, and then described the BBB survey with respondents from 7 countries. The table of included participants/data makes it clearer but there also needs to be some reorienting of the participants/source of data with perhaps begin with describing data were collected from women in 7 European countries, in two ways: xx individual in-depth interviews with women from xx and xx and, an open-ended question in the BBB survey with xx respondents from xx, xx, xx, xx, xx, xx, xx - or provide a link/reference to the published paper that describes this in detail Thanks for pointing out this could be clearer described. We have added this to the paragraph: Selection qualitative data and B3 responses. I look forward to seeing the paper published with those minor changes. Thank you again for your comments which we hope to have addressed this satisfactory. Reviewer #2: Brilliant if heartbreaking piece of work - beautifully written brought me to tears - we have to change this for women and your paper provides the detail needed to do so. Thank you. Thank you for this response. We felt overwhelmed by the results, realising a change is most definitely in order.

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14 April 2022

Dear Dr. Editor-in-Chief,

Please find enclosed the revised manuscript entitled "The social conception of space of birth narrated by women with negative and traumatic birth experiences" which we would like to submit for publication as an original research article in Woman and Birth.

We can confirm that this manuscript is our original work and has not been published and is not currently under consideration by another journal. The manuscript entails our original work to promote research, affective disorders among women in order to contribute to women's mental health and healthcare. All authors have approved the manuscript for submission.

There are no conflicts of interest.

Thank you for receiving our manuscript and considering it again for review. We appreciate your time and look forward to your response.

Sincerely,
Prof. dr. Yvonne J Kuipers

The social conception of space of birth narrated by women with negative and traumatic birth experiences

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Part of the data derives from the Babies Born Better project that was developed as part of the EU-funded COST Action IS0907 and continued in EU COST Action IS1405: BIRTH: "Building Intrapartum Research Through Health - an interdisciplinary whole system approach to understanding and contextualising physiological labour and birth", supported by the COST (European Cooperation in Science and Technology) Programme as part of EU Horizon 2020.

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	1
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4,5
Purpose or research question - Purpose of the study and specific objectives or questions	6
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	6
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	10
Context - Setting/site and salient contextual factors; rationale**	7,8
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	7,8
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	7
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	6,7

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6,7
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	8, Figure 1
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	9,10
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	9,10
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	9,10

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	10-16
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	N/A

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	16-18
Limitations - Trustworthiness and limitations of findings	18,19

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	20
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	20

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

12 April 2020

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The social conception of space of birth narrated by women with negative and traumatic birth experiences

ABSTRACT

Background

Many women experience giving birth as a negative or even as a traumatic event. Birth space and its occupants are fundamentally interconnected with negative and traumatic experiences, highlighting the importance of the social space of birth.

Aim

To explore experiences of women who have had a negative or traumatic birth to identify the value, sense and meaning they assign to the social space of birth.

Methods

A feminist standpoint theory guided the research. Secondary discourse analysis of 51 qualitative data sets/transcripts from Dutch and Czech Republic postpartum women and 551 free-text responses of the Babies Born Better survey from women in the United Kingdom, Netherlands, Belgium, Germany, Austria, Spain, and the Czech Republic.

Findings

Three themes and associated sub-themes emerged: 1. The *institutional* dimension of social space related to staff-imposed boundaries, rules and regulations surrounding childbirth, and a clinical atmosphere. 2. The *relational* dimension of social space related to negative women-healthcare provider interactions and relationships, including notions of dominance, power,

authority, and control. 3. The *personal* dimension of social space related to how women internalised and were affected by the negative social dimensions including feelings of faith misplaced, feeling disconnected and disembodied, and scenes of horror.

Discussion/Conclusion

The findings suggest that improving the quality of the social space of birth may promote better birth experiences for women. The institutional, relational, and personal dimensions of the social space of birth are key in the planning, organisation, and provision of maternity care.

Key words social space; space perception; social environment; place of birth; psychological trauma; traumatic birth experience; discourse analysis.

STATEMENT OF SIGNIFICANCE

Problem/issue

For many women giving birth can be experienced as a negative or traumatic event. The birth environment can influence women's birth experiences. Institutional and medicalised birth environments affect women and midwives in their actions and interactions. If the woman perceives the birth environment, its occupants, and atmosphere as distressing or unsafe, release of oxytocin may alter or be affected.

What is already known

The birth environment is regarded as a social space, being an interactive process of humans and their actions and activities in the space – use of the space, deployment of materials, human responses to the space.

What this paper adds

The study provides narratives from women in seven European countries, emphasizing that women in these Western emancipated countries, up to this day and age, are still not treated or regarded as essential stakeholders, as equals and as owners of their birth process by healthcare professionals.

INTRODUCTION

Women can experience childbirth as transformational that involves feelings from great happiness [1], strengthening and healing [2] to suffering and trauma [3]. A negative transformation is associated with psychological injury, while a positive transformation is described by amplifying psychosocial wellbeing [4]. While negative or traumatic birth has been associated with obstetric interventions, spontaneous or non-invasive birth does not, however, necessarily guarantee a positive birth experience [5,6].

Evidence highlights that many women experience giving birth as a traumatic event, with a worldwide prevalence of 9-50% of all childbearing women [7-12]. Where women give birth can influence their experiences [13-15]. Women describe sensory sensations related to the birth environment, and for those who have had a negative or traumatic birth, these sensations form part of their traumatic memory and birth recollections [16]. Institutional factors that influence midwives' practice can also impact on women's experiences. For example, the degree of the midwife's professional autonomy affects the quality of the interactions with the women in their care [17-21]. Medicalised environments and cultures such as hospitals, that super-value risk rather than normality, can reduce midwives' morale and promote more controlling behaviours towards women; whereby women's choices, perceptions of control and informed consent are diminished [22]. Birth environments therefore affect both women and midwives in their actions and interactions [13,23,24].

It has been suggested that the birth environment should be understood as consisting of the physical space, the human interactions within it, and the institutional context [25]. Research suggests that due to birth related neuro-hormonal mechanisms birthing women are experiencing a heightened sensitivity towards their environment [26]. The mechanism of the association between the birth environment and women's negative or traumatic experiences is likely to be explained by oxytocin, an essential hormone for physiological birth [26].

Oxytocin release is boosted by a safe, secure, and confidence-inducing environment [27]. Plasma concentrations of oxytocin in women can be altered by anxiety and stress during labour [28]. The birth environment may alter or affect the release of oxytocin during labour if the birth environment, its occupants, and the meaning of the place is perceived as highly distressing or unsafe [29,30]. How the use, sense, and experience of the birth environment influence women's wellbeing can be explained using the theory of *social space*.

Social space

Social space is the interactive process of human activity in a space [31,32]. Individual's perceptions of a space result from being in a space and its atmosphere and from human action, that is, using the space, deployment of materials, human responses to the space [31-34]. Through use, sensing and ownership, a space is assigned with meaning, value, and social power. Social space is also related to the purpose of the space, which can be political, health related, social etc [31]. The word *space* conveys social and cultural meaning, regarded with specific value and meaning at an individual level. The conception of space is highly personal and is constructed by thoughts, feelings and responses resulting from interactions within it [31]. In this study the *social space* refers to a social environment where labour and birth take place, where there is a network among the individuals (inhabitants) in the environment, forming different types of relationships. In this study *social space* refers to the positioning of individuals in the space, their habits, acting in and interacting with the space and with the individuals in it [35]. *Social conception of space* in this study refers to the personal value, sense and meaning the woman assigns to the space, the atmosphere and to the relationship dynamics of the people in the space [31].

Women with traumatic birth experiences have voiced that their sense of the birth space and its occupants, interconnects with their negative and traumatic experiences and

affects their thoughts and emotions and recollections and memories of the birth [16,36,37]. However, the underlying psychological, social, cognitive mechanisms that interconnect the women's conception of the birth space and their birth experience has not been explored. Understanding the role of social space of birth in women's negative or traumatic birth experiences is important because it can inform preventive measures and create opportunities for the emergence of new ways of thought. We therefore aimed to gain a (deeper) understanding of how women's conception of social space intertwines with their experiences of a negative or traumatic birth.

METHODS

Theoretical approach

A feminist standpoint guided how we addressed our research aim. A feminist standpoint is recognised as important in reproduction where power differentials within a patriarchal society are explored. As most women do not give birth in their own environment but in a clinical or medical environment run by others, the influence of power relations in these birth settings seems evident [25]. Women's voices of negative or traumatic birth experiences and perspectives of social space of birth are of central feminist concern and regarding the broader position and status of women in society [38]. Feminist standpoint theory posits that knowledge needs to be grounded in the lived experiences of women [39].

Design

This work was undertaken as part of the EU COST Action "Perinatal mental health and birth-related trauma: Maximizing best practice and optimal outcomes" (www.cost.eu/actions/CA18211), consisting of researchers and clinicians from across Europe and beyond. A group of academics were formed to focus on this topic area and available data in the languages spoken by the authors were considered for eligibility. The available data

consisted of narrative interview and semi-structured interview transcripts and free-text responses from the Babies Born Better (B3) multi-language survey (https://www.babiesbornbetter.org/about/).

Transcripts interviews

The qualitative data set consisted of 61 original interview transcripts (36 – Netherlands; 25 - Czech Republic). The 36 Dutch participants had been purposively selected for the original study (2016-2018), after self-identification of labour and birth as a psychological distressing experience with an enduring emotional effect. Recruitment and interview questions are described elsewhere [40]. We selected 33 of these transcripts for the secondary analysis, as three transcripts did not include any references to social space. The primary study in the Czech Republic consisted of 25 interviews (2012-2015) that did not have *a priori* selection of women with a traumatic birth experience, rather the focus was on birth experiences in general that had taken place no longer than two years before the interview. Non-probability and snowball sampling techniques were used to recruit participants. Interviews started with the question: "Please tell me about your birth". The interviewer acted as an active listener, interrupting, and asking additional questions as little as possible. To select relevant transcripts, the interviews were read to only include those where the woman considered the birth to have been a negative or traumatic experience and where social features of birth had been discussed. We selected 18 Czech transcripts. Dutch and Czech national ethical standards and procedures were adhered to.

Babies Born Better (B3) survey

The Babies Born Better (B3) study is a trans-European, anonymous, mixed methods online survey run over three waves (version 1: 2014-2016, version 2: March-August 2018; version 3: June 2020 – current). The aim of the B3 is to capture women's views of their maternity care

and childbirth (http://www.cost.eu/COST_Actions/isch/IS1405). Women reported on births that had taken place between 2013 and 2018. Regarding the B3 data set, one of the questions asked participants to rate their birth experience on a scale of 1 (mostly very good) – 5 (mostly very bad). We selected survey respondents who had scored either a 4 (mostly bad) or 5 (mostly very bad) and then extracted their answers to one open-ended questions (see Table 1). There was no word limit for the free text responses. We also extracted the demographic and birth details of the included participants. The B3 survey received ethical approval.

PLEASE INSERT TABLE 1. "OPEN-ENDED B3 SURVEY" AROUND HERE

Selection qualitative data and B3 survey responses

Overall, we included 51 transcripts of Dutch and Czech women. At the time of these studies, the participants were between six weeks and three years postpartum. Of the 13,110 potential B3 respondents from the countries of interest, we included 1,660 women with mostly bad/very bad birth experiences. After removing participants who did not refer to social space or who did not provide answers to the open-ended questions, 551 participants remained. In total 602 participants were included. Women reported on their last birth, no longer than three years ago. The selection of the participants is shown in Fig 1. Data were collected from women in seven European countries, in two ways: 51 individual in-depth interviews with women from the Netherlands and the Czech Republic and, an open-ended question in the B3 survey with 551 respondents from Austria, Belgium, Czech Republic, Germany, Netherlands, Spain, United Kingdom.

PLEASE INSERT FIG.1 "FLOWCHART PARTICIPANTS" AROUND HERE

Discourse Analysis

Actions of individuals and processes are influenced by use, sense, and ownership of space – making it a lived experience of individuals in that space at that time – a so called *discourse on space* [41,42]. Discourse on space directed the choice of our analysis towards discourse analysis. Discourse analysis is used to understand the complexity of the phenomenon in a certain context, to reveal power relationships, and how certain groups can be marginalised [41,42]. We considered this to be applicable to the women in our study and aligned with the theoretical approach of the study. Discourse analysis is an inductive exploration of social reality that is constructed in actions and interactions, resulting in theory developed from knowledge based on the discourse of experience [43]. Analysis closely examines the subtleness of language in various elements of the data – such as words, sentences, paragraphs, and overall structure – and relates them to attributes, themes, and patterns [44-46]. In our study this concerned how the use and ownership of the birth space are interwoven with women's negative/traumatic birth experiences.

To generalise and condense meaning, we applied a stepwise procedure of qualitative text reduction: (i) the native speaking working group members read the original data in their own language for familiarisation and to understand the structural features of the text, recognising where to look for fragments related to the topic of study [46]. Based on the literature we identified several *a priori* cues to be relevant to select discourse fragments related to the birth space [13,15,33,47,48]. The cues are presented in Table 2. (ii) Per country, the native speaking working group members selected the discourse fragments from the data. This involved paraphrasing passages by using a text fragment that represented the meaning of the discourse, followed by summary sentences, that is, summarising the core content of the discourse fragment [22]. Per country, the working group members used a matrix to organise the data (X, X, X, X, X, X, X, X). The summary sentences were translated into English

and then used to construct a new matrix. The B3 responses were regarded as paraphrases, from which summary sentences were formulated to be added to a separate matrix. (iii) All the phrasing, paraphrasing, summary sentences and English translations were validated by a second reviewer (X, X, X, X). This involved discussing the contents, asking questions to resolve what was unclear or not understood, resulting in transparent, understandable, and meaningful summary sentences. (iv) Per country, a further process of open coding (labelling) and abstraction was applied - known as content analysis [46,49,50]. (v) Two authors (X, X) read all the summary sentences to identify labels. (vi) The labels arising from the discourse fragments from the interview transcripts aligned with the labels from the B3 responses and were therefore merged into one matrix. The labels were then clustered into an initial set of themes and sub-themes. (vii) Following an iterative process between the labels and (sub)themes and the discourse fragments from transcripts, involving all group members, the themes and sub-themes were reviewed and discussed until consensus was reached.

Acknowledging that culture affects social conception of space [31], an overview of the context of birth spaces in the various countries is given in Appendix 1.

RESULTS

Participants

The 18 interviewed women from the Czech Republic had mostly given birth in a hospital setting. The sample consisted predominantly of multiparous women, six were primiparous. Their age ranged from 26 to 42 years. All women were in a relationship, mostly married. The 33 Dutch women were predominantly primiparous women of which one woman had a homebirth. The 1,663 B3 respondents were between 21 and 48 years of age. Most women were in a relationship, 53 women were single, 12 had a living-apart-together relationship, and three women were divorced at the time of study. Most of the B3 participants had given birth

in hospital, five in a birth centre and 59 women had a home birth. Mode of birth was not collected as part of the B3 survey.

Themes

Forty-nine labels emerged from the data, which were synthesised into eight subthemes and three main themes (see Table 3). Below we provide a summary narrative of all the key points conveyed within each theme, together with exemplar quotes. This approach is frequently used in qualitative systematic reviews when representing a wide and varied data set [51].

Theme 1. The *institutional* dimension of social space

We observed that most of the women in our sample had a hospital birth. Women described the institutional conception of birth space through '*staff-imposed boundaries'* on how their birth was managed. This involved women's perceptions of staff dictating care based on their own convenience, knowledge, expertise, schedule, (lack of) clock-time and the power of staff to determine the use equipment and resources. For example, women from the Netherlands, Germany, Belgium, and Spain referred to how they had to birth lying down to suit preferences of healthcare professionals: "*She did not like vertical births and therefore did not do them" (Spain).* Women from all the included countries referred to how their requests for childbirth and intrapartum care were often denied, such as being told that they were unable to move off the bed, or to have a bath to ease labour pains. A woman in the Netherlands spoke to how she was unable to have the birth she wanted due to the midwife's lack of expertise: *"The midwife had never conducted a waterbirth, so I had to give birth lying on the bed*". Staff not having enough time to attend to the women during labour and birth were also highlighted. For example, women reported feeling "*persuaded"* to undergo procedures as, a woman from the UK said: *"she* [midwife] *did not want to hang around".* Other temporal issues reported in the Netherlands, Belgium, UK, and Czech Republic related to delays in the administration of

pain relief or pushing due to the timescales of staff. A woman from the Netherlands stated: *"The nurse said: "well, I go on my lunch break, it's going to take a while before I will come back and then I'll sort your pain relief".* A Belgian woman described: *"I was not allowed to push because I had to wait for the doctor…the nurse left, and I was told not to push."*

Contextual-related issues were also described. These related to formal '*rules and regulations'* regarding the use of equipment, (staff)resources, ward and visiting policies and protocols, and unwritten rules, including institutional (social) norms. For instance, a woman from the UK complained of how she was told she was unable to go home due to having strong contractions, while at the same time she was insufficiently dilated to have her own room. There were recurrent issues around a lack of space on the unit, often coupled with insufficient time and which could lead to women's care being "*rushed"*. A UK woman reported: "*My induction was rushed as there was no room on the suite. Therefore, things were done too early e.g., breaking of waters".* Women from all included countries described situations of care being dictated by imposed rules and standards such as refusing to provide pain relief irrespective of a woman's subjective perceptions of her pain. A woman from Spain described: "*They repeatedly refused to give me any pain relief as it was 'too early'… in who's rule book? so I was left convulsing in pain. I must have asked at least five times".* Women from Austria, Belgium, Spain and the UK also referred to how rules were imposed to deny significant others entrance to the birth environment as illustrated by a woman from the UK: "*My own midwife was refused entrance by the hospital staff. The only person I had was my husband and they made him go home most of the time".*

Women from all countries described a '*clinical atmosphere'* to the birthing space. This related to environmental features associated with a clinical setting - *"All the time, big bright lights, another white coat entered the room" (Belgium);* the use of medical, complex language - "*They kept talking about medication and interventions, using words about things and stuff to do, it was a medical circus"* (*Czech Republic);* and women feeling institutionalised due to

being "*made"* to wear hospital clothing - *"When I arrived, I was told to put the hospital gown on. By doing that I was forced to change in someone else who was not me" (UK).*

Theme 2. The *relational* dimension of social space

Women perceived the relational dimension through experiencing '*dominance, power, authority, and control'* enacted by obstetricians, midwives, anaesthetists, and nurses. Women frequently felt cognitively, and emotionally overpowered, and sometimes described the use of physical force. For example, women in Spain, Germany, Austria, the Netherlands, UK, and the Czech Republic repeatedly referred to being physically forced into positions or into certain spaces; *"They physically forced me on my back while I wanted to be upright" (Germany)*; *"They wheeled me to theatre while I was not ready to go" (Austria).* There were also recurrent issues regarding use or misuse of (medical) information, sometimes perceived as threating. A woman from the UK described that she was advised to have a caesarean section and when questioning the doctor, she was told: *"you could bleed out... the baby is too big, and your cervix is swollen".* Similarly, there were examples of the 'baby card' with women feeling coerced into accepting interventions: "*they bullied me into having the induction medication by saying things like your baby is at risk"* (*UK)* or "*because I was scared into it" (Spain)*. Some of the women were also told they had to cooperate or otherwise they would be drugged or referred to statutory authorities for potential child harm. A woman from the Netherlands was threatened by the anaesthetist prior to her caesarean section: *"he said: when you don't stop being so hysterical, I give you full anaesthetics and you will not know that your baby is being born".* A woman from Belgium said: *"During birth the doctor came and said that when we would not cooperate in taking the baby's blood, he would report us to child protection".*

In addition to threatening information, women also reported occasions of information being withheld and consent assumed. For example, a Spanish woman reported: *"The obstetrician determined that it was necessary to perform an emergency caesarean section, he*

gave no reason or explanation why". Women perceived that healthcare professionals centred their care around the needs of their baby rather than their own. *"Baby rules, it is all about the baby, nothing about me. I was side-lined" (Austria).* There were also occasions of the learning needs of the students being prioritised, and without considering women's wishes: *"The student needed to learn although I had explicitly and repeatedly said I did not to want a student looking after me, they did not listen" (Netherlands).* Women from all countries repeatedly reported health professionals displaying a lack of respect and interest in their wishes: *"I spent three hours arguing with midwives who wanted to break my waters to help things along who wouldn't listen to me when I told them there was no evidence to support this" (UK).*

Further issues reported across the data set related to '*health professionals know best'*. These experiences often related to women's experiential knowledge – so called inner knowledge - being undermined and dismissed. This often happened in what was described as a condescending way, negating women's know-how for what is happening with their bodies and excluding women from their own birthing process or decision-making. A woman from the Netherlands recounted what she was told after she had asked a question about her care: *"We don't discuss this with you, that is something to be discussed by doctors only".* Women from all the included countries reported being told by doctors, midwives, and/or nurses that they were "*not in labour"* even though they were: *"Each time I phoned, they 'could tell' from the sound of my voice that I wasn't in labour" (UK).* They also described healthcare professionals calling them "*fussy*", "*hysterical*" or "*exaggerating"* and without apologising to the woman when being mistaken. A woman from Austria wrote: "*I was portrayed as a hysterical woman to the staff".*

Theme 3. The *personal* dimension of space

Personal conception of space concerns what women experienced at an individual level; their experiences of interacting and attuning within a physical space with others. Women described '*faith misplaced*' as the birth space and how their carers responded were at odds with what they had envisaged. Women associated the birth space (i.e., hospitals, birth units and healthcare professionals) with safety and standards of optimal quality care. A place where it is supposed to be safe to birth, and to be cared for and supported by professionals. Instead, women described a false or a denied sense of safety and felt let down by those providing their care. A woman from Spain said: *"They sell something that is not true"*. Women from Austria, the Netherlands, UK, Czech Republic, and Spain described their birth space as "*dangerous"*, "*unsafe"*, and "*unhygienic"*. When visiting the birth space during pregnancy, some women were shown a bath where they could labour and birth in. However, when they were in labour, they were then told that these baths were not supposed to or could not be used. A Dutch woman who chose to give birth in midwife-led birth centre described it as a "*disguised hospital"*. Women felt deeply disappointed that the environment did not match their pre-birth ideals. They also felt let down by doctors and midwives because they did not do what they were expected to do - provide safe and person-centred care. A woman from Spain said: *"I felt let down in a place and people I put my trust in during this intimate time".*

Women experienced feelings of being '*disconnected and disembodied*' on an interpersonal level. Interactions with healthcare professionals were described using terms such as "*uncaring"*, "*impersonal"*, "*discriminative", "feeling like a number"*, "*feeling unwelcome"* or a "*nuisance"*. Women frequently reported being cared for by lots of different and unknown staff members, staff not introducing themselves, intrusions by staff at intimate moments (i.e., vaginal examination) or at times when women were trying to focus on labour and birth. Women from the UK, Austria, Netherlands, Belgium, Spain, and Czech Republic referred to invasive and distressing experiences such as doctors coming in, "*sticking their*

fingers in" and leaving, or a doctor "*having a look between my legs"* without introducing him or herself. A woman from the UK described: *"I never at any point felt like I was in a space where I could get on with the work of labouring… I never felt like I connected with anyone in the hospital as I was always in transition from one person to the other. I never saw the same midwife twice".*

Women from all countries provided descriptions of the birth space that depicted "*scenes of horror"*. The terms used to convey this *horror* included: "*dumpsite", "butchery", "mortuary", "Accident & Emergency Department", "a stage of rape and abuse", "asylum", "military base",* or *"prison"*. A woman from the Czech Republic said: *"For us women, labour ward equals evil"* and a woman from the Netherlands described: *"I looked around, the place was creepy and scary, it looked like a slaughterhouse".*

DISCUSSION

We aimed to gain an understanding of how women value, experience, sense and give meaning to the social space birth and how this intertwines with their negative or traumatic birth experiences. We used discourse analysis to understand the mechanisms underlying women's social conception of space and to reveal potential power relationships, and marginalisation of labouring women [41,42]. In the first theme – the institutional dimension of social space – we found that women are not an important and essential stakeholder in their own care. Similar to other research, women's accounts highlighted how their authoritative experiential knowledge were dismissed and ignored, while the midwife's professional knowledge and expertise and institutional rules were super-valued [25,53,54]. Acknowledging and respecting the woman's experiential knowledge is known to reduce inequalities in healthcare, and to improve positive health outcomes [52] – this was not evident in our study. Women's

narratives suggest that in many cases there was little consideration for the preferences and wishes/needs of the birthing woman in what is supposed to be her individual birthing space and thus her own personal birthing experience [31,33].

In general, the women in our study describe a medical model that emphasizes risk management that controls professional behaviour [58]. This resonates with wider literature of midwives' accounts of specific organisational hospital goals and/or institutional barriers preventing them from providing women-centred care in hospitals where midwifery is dominated by a medicalised approach to care [56,57]. Indeed, it is also worth considering that midwives are usually women and part of patriarchal and hierarchical medical hegemonic and medical dominant maternity system, where midwives are often caught in dilemmas in remaining true to the woman, themselves, their profession, or the system [22,59-61].

Theme two – the relational space of birth – illuminates how women perceive it is the staff, rather than themselves that have ownership and control over the birthing space [13,15,25,62,63]. As individuals tend to hold healthcare professionals in high esteem this can create power differentials [64] which in turn can create difficulties in individuals making complaints about their care [65]. Furthermore, poor care can instil mistrust and avoidance of future health care, with obvious negative implications [66]. For instance, one consequence is that women may choose to give birth without the assistance of a midwife or doctor outside the maternity care system (i.e., 'free birthing') in a future conception [67]. Although positive to note that in more recent years women's movements have started to respond to women's negative experiences and inadequate care, and to challenge biomedical expert tendencies of blaming women for their negative childbirth experience [68].

In Theme three women reported feeling deceived within the birth space. This is similar to findings by Thomson and Downe [5] who found that women's faith in maternity care providers was felt to be 'faith misplaced' following their traumatic birth. Women expect the place where they are giving birth to be a safe, secure, and confidence-inducing environment

[27]. It is self-evident that these traumatic and negative experiences will cause feelings of anxiety and stress [29,69]. However, the extent to which women were marginalised and disembodied during intrapartum care is indicative of 'othering'. This term is often used to explain the discrimination levied towards more vulnerable or disadvantaged populations. Othering is a process that reinforces and reproduces positions of domination and subordination [70]. In our study, othering was evident in women and their bodies being objectified and nullified, and often via scenes of horror. These discriminatory practices in part appeared to be related to staffing issues, with women being attended by multiple caregivers. However, there was also evidence of insensitive and abusive practices such as professionals performing clinical and invasive procedures on women's bodies, with a complete lack of consideration of the woman and/or her needs. The violation, helplessness, and powerlessness described by the women in our study is also, as argued by others reflective of wider traumatic experiences, such as those who have experienced child abuse [71]. It represents obstetric violence, a defilement of human rights, that should not be tolerated.

Strengths & limitations

Although our data set was large and rich, a limitation is that we have only given voice to women with negative and traumatic birth experiences. Fig 2 shows that we excluded many women with more positive experiences, acknowledging that not all women have bad experiences. Nevertheless, as historical studies [68,72,73] since the 1940s have recorded negative and traumatic institutionalised births across various cultural contexts, our results demonstrate how these continue to be a dominant feature of modern society [38]. Despite reported similarities between the women in the respective countries, we must consider that there are cultural differences that might have influenced our results and may be more relevant for one country than the other. Our findings are only transferable to women with similar experiences in similar cultures and places. We analysed data that was not originally collected

to answer our research question. However, by purposively selecting and extracting data, we might have avoided selection bias of attracting women with very particular experiences. The data we report were collected as part of either a more complete picture of the negative or traumatic experience, or women reporting on their most overt recollection of the experience. It could be that by not including studies that specifically focused on the social space of birth, there are other issues not reported in our findings. Due to the differences in the number of women and available data, we might have possibly overrepresented certain countries such as the UK, Spain, and the Netherlands, and underrepresented other countries such as Belgium and Germany. Further research should be undertaken to elicit whether these accounts resonate with women's experiences from countries not included, and particularly from low-middle income countries, where care is generally poorer [74].

CONCLUSION

Our study clearly conveys that women with a negative or traumatic birth assign negative meanings to the social space of birth. Women's experiences are influenced by institutional, relational, and personal aspects of the social space of birth and frequently experienced their social birth environment as coercive and disrespectful. The birth space was overwhelmingly perceived as being more professional- and/or organisation-orientated rather than woman-centred. This study advances the debate about humanizing birth and demonstrates the mutually constitutive nature of individual subjective accounts and the social context of birth. From a human and feministic perspective, we need to keep addressing and emphasizing that maternity care organisations and professionals need to change for the better – particularly as the social space of birth being described in women's narratives reflects the broader position and status of women in society. Further work is needed to advocate for women to give birth in home-like, low-risk settings (where possible), for suitable staffing, and to re-consider local

policies in terms of how they can prevent against poor, inconsistent, and abusive care. Maternity care professionals need to sensitise their interactions for creating a safe birth environment and for continuity of care for women to help facilitate safe and personalised maternity care that promotes positive birth experiences. Women's narratives could be used within healthcare maternity care professional training to create awreness .as an impetus for positive change.

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Figure 1. Flowchart participants

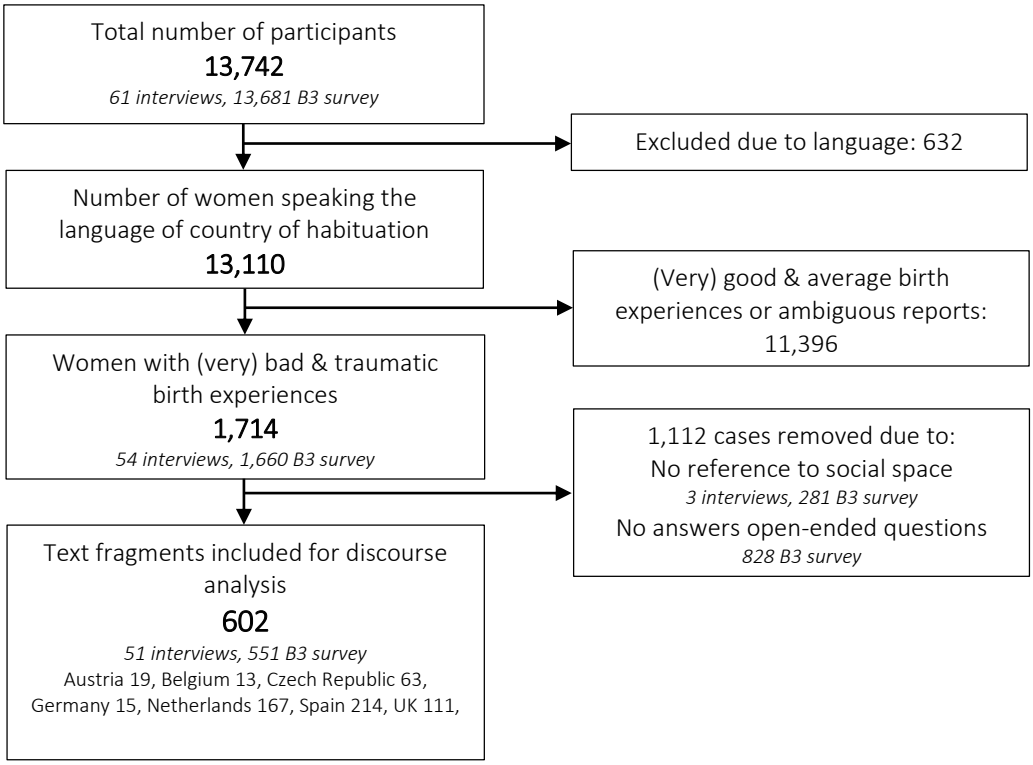

Table1. Open-ended questions B3 survey

What do you think could have made your experience better? (You do not need to fill in all boxes. If you have no suggestions, please write 'none' in the first box)
▪ First….. ▪ Second….. ▪ Third…..

Table 2. Guide/cues to select discourse fragments

Sense of autonomy, choice, and self-determination in accessing and using facilities and equipment
Sense of privacy (e.g., lacking, interrupted, non-confidential)
Presence of others (e.g., overwhelming, oppressive, authoritative, dominant, disrespectful, intimidating, disconnecting)
Meaning and sense of (use of) time and (sacred) moments
Assigned meaning to the space (e.g., institutionalised, protocolised, clinical, emergency, authoritative, scientific, theatre, detention, sanatory, inappropriate)
Communication with/ by others (e.g., disrespectful, patronising, sarcastic, angry, aggressive, assumptive, lack of consent, analytic, un-consenting)
Woman-professional relationship (e.g., emotionally distant, hostile, unfriendly, unequal, bored, unengaged, impersonal, overlooked)
Sense of ownership of the birth environment (e.g., feeling/being part of own birth experience/process, feeling/being involved in own birth experience/process, having/taking authority of using the birth place; feeling/being encouraged to use the birth environment as wanted, being able to take responsibility for achieving what is wanted, having the feeling to do what is wanted or planned to do, taking initiative and not waiting for someone else to act; feeling/being encouraged to achieve needs, taking own decisions, being acknowledged during the birth process by others, able to explain oneself, having leadership in own birth process, demanding health professionals' best effort, being critical of what is happening, rewarding the advocacy of the health professional)
Perception of atmosphere (e.g., negative, hostile, cold, tense, hopeless, scary, harsh, aggressive, frustrating, dissonance, unsafe, threatening, lonely, loveless)

Perception role and/or attitude healthcare professional (e.g., overbearing, direct, insensitive, disrespectful, intimidating, not listening, neglect, blaming, trivialising, emotionless, detached, uninterested, directive, forcing, threatening, secretive, abandoning, discriminative, non-dignified, inhumane, submissive)
Sense of power and control

Table 3. Coding tree

Main themes	**Subthemes** (n)
The *institutional* dimension of social space	Staff imposed boundaries (1)
	Rules & regulations (2)
	Clinical sphere (3)
The *relational* dimension of social space	Dominance, power, authority & control (1)
	Health professionals know best (2)
The *personal* dimension of social space	Faith misplaced (1)
	Feeling disconnected & disembodied (2)
	Scenes of horror (3)

CONFLICT OF INTEREST

None declared.

ETHICAL STATEMENT

The study included a secondary analysis of primary studies that all independently were performed in adherence to local ethical standards. The primary Dutch study received ethical clearance from the Scientific Research Ethics Committee Rotterdam (TWOR ref. no. T2016-72, 15 March 2016). The primary Czech study was conducted in line with ethical principles codified by the Czech Association for Social Anthropology (CASA), of which the interviewer/author (EH) is a member (http://www.casaonline.cz/?page_id=7). Formal ethical approval was not required, as neither the university where the research was carried out, nor the Czech Science Foundation funding the study had a governing body to approve and monitor ethical conduct of social science researchers. The B3 study received ethical clearance from the University of Central Lancashire, Ethics Committee BuSH 222 and the e-Ethics Committee for Science, Technology, Engineering, Medicine and Health (STEMH) (1 April 2016). Approval from the primary authors and B3 country coordinators in Austria, Belgium, Czech Republic, Germany, Netherlands, Spain, and the United Kingdom to to analyse data from the first two waves was requested and received.

Author Agreement

We the undersigned declare that this manuscript is original, has not been published before and is not currently being considered for publication elsewhere.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We understand that the Corresponding Author is the sole contact for the Editorial process. He/she is responsible for communicating with the other authors about progress, submissions of revisions and final approval of proofs

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