Parents' Experiences of Limiting Family Size After Birth Trauma: a Hermeneutic Phenomenological Study

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This thesis is submitted to the University of Dublin, Trinity College, in fulfilment of the requirements for the Doctorate of Philosophy in Health Sciences

Declaration

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Sofia O'Byrne

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Abstract

Background: Pregnancy and childbirth is a profound and life-changing time for women and their families. Although it can be a positive and empowering experience, for some it can be a traumatic event. Birth trauma can have severe impacts on a woman's mental health, on the family unit, and on future reproductive decisions. After a traumatic birth experience, some women alter their future birth plans, for example by opting for an elective caesarean section or planning a homebirth. However, there are those who are so traumatised that they choose to forgo future pregnancy and birth altogether, even if they badly desire another child.

Aims and Objectives: The aim of this study is to develop an in-depth understanding of the lived experience of limiting family size to less than desired as a result of birth-related trauma. In order to provide meaning to this aim, specific objectives were identified; to gather rich descriptions of the lived experience of parents' who have chosen not to have more children as a result of birth-related trauma, and to uncover meaning in these experiences through hermeneutic analysis.

Methodology : This study utilised a hermeneutic phenomenological approach underpinned by the philosophy of Heidegger and Gadamer.

Data Collection: In-depth interviews were used to collect data. They were conducted both in-person and online.

Recruitment: Participants were recruited from a separate longitudinal study. Purposeful sampling was used to recruitment women who had limited their family size as a result of a traumatic birth experience. Women's partners were also invited to participate.

Sample: The sample included 15 women who had experienced a birth or birth-related event they identified as traumatic, along with 4 men who were their partners.

Data Analysis: Hermeneutic analysis was conducted using the Dibley *et al*.'s (2020) guidance for iterative interpretive analysis.

Findings: The findings are presented through three passages, eight emerging themes, and one constitutive pattern. Passage one, 'Confronting a Difficult Decision' consists of three emerging themes: 'Instinctive Knowing', 'Eliminating Risk', and 'Preventing Mental Anguish'. Passage two, 'Bearing the Burden in the Aftermath', consists of emerging themes 'Navigating Emotional Turmoil', and 'Enduring Unfulfilled Expectations'. Passage three, 'Moving Forward, But Not Moving On', consists of emerging themes 'Reaching Acceptance','

Lingering Trauma', and 'Making it Permanent'. The three passages and eight emerging themes are interconnected together through the constitutive pattern, 'Acting on Self-Preservation'.

Conclusions: This study offers the first qualitative exploration of the link between birth trauma and decisions to limit family size. Key findings highlight a crucial distinction between minimising and eliminating the risk of subsequent birth trauma, the development of mistrust in maternity services, and the role of modifiable versus non-modifiable contributors to trauma. These insights deepen our understanding of the lasting impact of traumatic births on reproductive decision-making.

Dedication

To all those who have been, or continue to be, affected by traumatic birth experiences.

Acknowledgments

First I would like to offer my heartfelt thanks and appreciation to the women and men who shared their stories with me. It is never easy to share a traumatic experience, especially with a stranger. I deeply admire their courage and trust. Without them, this research would not be possible. I sincerely hope I have honoured their stories, and that this piece of research resonates with them and their experiences.

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List of Abbreviations

APA	American Psychological Association
APH	Antepartum Haemorrhage
CB-PTSD	Childbirth-related Post Traumatic Stress Disorder
CS	Caesarean Section
CSO	Central Statistics Office
CTG	Cardiotocography
DOH	Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
ELCS	Elective Caesarean Section
EMCS	Emergency Caesarean Section
ER	Emergency Room
GDPR	General Data Protection Regulation
GP	General Practitioner
HBAC	Homebirth After Caesarean Section
HELLP	Haemolysis, Elevated Liver enzymes and Low Platelets
HIQA	Health Information and Quality Authority
HPO	Health Pricing Office
HSE	Health Service Executive
ICU	Intensive Care Unit
IOL	Induction of Labour
IVD	Instrumental Vaginal Delivery
MAMMI	Maternal health And Maternal Morbidity in Ireland
MMAT	Mixed Methods Appraisal Tool
NCPHSBBR	National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research
NWIHP	National Women and Infants Health Programme
NICU	Neonatal Intensive Care Unit
NMBI	Nursing and Midwifery Board of Ireland
PPH	Postpartum Haemorrhage
PPROM	Preterm Premature Rupture of Membranes
PTB	Preterm Birth

PTSD	Post Traumatic Stress Disorder
PTSS	Post Traumatic Stress Syndrome
RM	Registered Midwife
SVD	Spontaneous Vaginal Delivery
TCD	Trinity College Dublin
UBW	Unregulated Birth Worker
UK	United Kingdom
USA	United States of America
VBAC	Vaginal Birth After Caesarean Section
WHO	World Health Organisation

Chapter 1: Introduction

1.1 Rationale For This Research

Childbirth is a profound experience that has physical, psychological, and social impacts in the short and long-term (Held, 1989). As birth is a subjective experience, many women recall it as a positive, life-changing moment in their lives. However, women can also be left with negative feelings towards their birth experience and some may end up feeling traumatised (Ayers *et al.,* 2015). In a recent Irish study, 18% (n=209) of women in one maternity hospital ward reported that they experienced their birth as traumatic (Nagle *et al.,* 2022). Trauma may arise from the birth itself, or the events around the birth during pregnancy or the postnatal period (Svanberg, 2019). Research suggests that women change their future reproductive decisions in response to traumatic childbirth. Some may choose to have an ELCS or plan a homebirth (Hull *et al.*, 2011; Mancuso *et al.*, 2006; Sassine *et al.,* 2021; Tschudin *et al*., 2009; Turnbull *et al.*, 1999). However, there are those who are so traumatised that they choose to forgo future pregnancy and birth altogether, even if they badly desire another child (Allen, 1998; Porter *et al.*, 2006; Taghizadeh *et al.,* 2013). There is currently a notable gap in the literature regarding the decision to limit family size to less than desired as result of traumatic birth experiences. While this phenomenon has been mentioned in several research studies, there have yet to be any in-depth qualitative investigations specifically focused on exploring it. Research investigating the long-term effects of birth trauma is essential for expanding our understanding of this challenging experience. By concentrating on this area, we can amplify the voices of those impacted, thereby enhancing the overall knowledge base surrounding traumatic birth experiences.

1.2 Research Questions, Aims and Objectives

The aim of this study is to develop an in-depth understanding of the lived experience of limiting family size to less than desired as a result of birth-related trauma. In order to provide meaning to this aim, specific objectives were identified:

→ To gather rich descriptions of the lived experience of parents' who have chosen not to have more children as a result of birth-related trauma.

→ To uncover meaning in these experiences through hermeneutic analysis.

1.3 Research Design

Hermeneutic phenomenology was chosen as the research methodology for this study as it aims to develop an in-depth understanding of a lived experience. Purposeful sampling was utilised to recruit women who had limited their family size as a result of traumatic birth experience. Their partners were also invited to participate. Fifteen women and four men participated. Data was collected through in-depth interviews. Data analysis was conducted using Dibley *et al*.'s (2020) guidance for iterative interpretive analysis. Reflexivity was a key component to data collection and analysis to reduce researcher bias. Prior to data collection, my own prejudices and preunderstandings were examined. I also kept a reflexive diary throughout the research process.

1.4 Structure of Thesis

Chapter 1 introduces the study and outlines the structure of the thesis.

Chapter 2 provides a background to birth trauma, laying the foundations of the topic and providing context to the study.

Chapter 3 presents the literature review, of which the primary objective is to explore the existing body of research on birth trauma and future reproductive decisions. The chapter is divided into two sections; section one focuses on what future reproductive decisions after birth-related trauma, and section two contextualises the relationship between future reproductive decisions and birth-related trauma.

Chapter 4 explores the philosophical grounding and methodological framework for hermeneutic phenomenological research. The chapter begins with a discussion on ontology, epistemology, and paradigm. It is then divided into two sections: the first outlines the philosophical foundations of hermeneutic phenomenology, while the second examines its application as a research method.

Chapter 5 outlines the methods used to conduct the research. This chapter serves as both a guide to the research procedures employed in this study and a narrative that connects

the conceptual and philosophical frameworks to their practical application throughout the research process.

Chapter 6 introduces the participants and provides short summaries of their subjective lived experiences.

Chapter 7 presents the findings that emerged from the iterative hermeneutic analysis of the transcripts. The findings have been presented with the aim of conveying the participants' lived experiences in a way that resonates with the reader.

Chapter 8 presents a discussion of the findings, highlighting the key findings, while comparing and contrasting them to previous literature. The sample demographics, study strengths and limitations are also discussed.

Chapter 9 concludes the thesis, providing an overview of the contribution to knowledge, recommendations arising from the findings, a dissemination plan, and final reflections.

Chapter 2: Background

2.1 Introduction

This background chapter provides a comprehensive overview of birth trauma, laying the foundations for understanding this phenomenon. Given the extensive body of literature on birth trauma, this chapter serves as a broad overview rather than an exhaustive account of the topic. This chapter begins by discussing definitions of traumatic birth, followed by an overview of childbirth-related post-traumatic stress disorder (CB-PTSD) as a distinct and diagnosable consequence of traumatic birth experiences. The prevalence of birth trauma and CB-PTSD is then addressed. The many influences and contributors to birth trauma and CB-PTSD are discussed, followed by the long-term effects that birth trauma can have on women and their families. The chapter also includes a discussion of how birth trauma affects men who witness a complicated or traumatic birth.

To present an alternative perspective on birth experiences, a section on positive birth experiences and strategies for optimising the birth experience is included. To conclude, birth trauma within in the context of this research study is discussed, specifically how definitions of birth trauma guided sampling and acknowledged the participants' individual experiences.

2.2 Maternity Care in the Republic of Ireland

In the Republic of Ireland, the majority of maternity care is provided under the Maternity and Infant Care Scheme. Originally introduced in 1954, the scheme consists of combined-care between a woman's General Practitioner (GP) and an obstetric-led hospital service (Kennedy, 2010). It entitles women to free care during pregnancy, labour and birth and up to six weeks postpartum (Kennedy, 2010). The stipulations of this scheme has aided in cementing the central role that doctors and hospital have in birth in Ireland (Kennedy, 2002). Hence the majority of births occur in a hospital setting with less than 1% of births occurring at home (Healthcare Pricing Office (HPO), 2018).

There are nineteen maternity units across Ireland, all funded by the Health Service Executive (HSE) (Health Information and Quality Authority (HIQA), 2020). Four of these units are stand-alone maternity hospitals, meaning they are not located on the same site

as an acute general hospital (HIQA, 2020). The remaining 15 maternity units are co-located and have on-site access to surgical and medical specialties, as well as an intensive care unit (HIQA, 2020).

Women with private health insurance, or those who can afford the out of pocket expense, can opt for private obstetric care (Huschke, 2022; Leahy-Warren *et al.*, 2021). However as there are no private maternity hospitals in Ireland, these women attend a public hospital for their labour and birth (Leahy-Warren *et al.*, 2021). When admitted as an in-patient, women under private obstetric care are cared for by staff midwives and other allied healthcare professionals employed by the hospital. The private obstetric consultant will oversee the woman's care and be involved in decision-making. Furthermore they will attend bedside consultations with the woman and facilitate the birth after the woman has laboured. The availability of public and private care within the same units has created a two-tier system (Huschke, 2021). Private obstetric care has been shown to significantly increase the likelihood of obstetric intervention irrespective of risk factors (Lutomski *et al.,* 2014), however it remains one of the only options for women to guarantee continuity of carer (Leahy-Warren *et al.*, 2021).

Six maternity units provide Domiciliary In and Out care, otherwise known as DOMINO care, and is available to women living in certain catchment areas (HIQA, 2020). This model of care is available for obstetrically low risk women and is provided by a team of community-based midwives. Antenatal care is shared with the GP and midwifery-led clinics in the hospital or community (HIQA, 2020). Women attend the hospital for birth but can avail of an early discharge home and postnatal care visits in their home (HIQA, 2020).

Two maternity units have a midwifery-led unit co-located with a consultant-led unit (Department of Health (DOH), 2016). This service is delivered by midwives and covers the antenatal, intrapartum and postnatal periods (DOH, 2016). Midwifery-led units are founded on the principle that childbirth is a normal physiological event and are a safe alternative to consultant-led care for obstetrically low-risk women (Begley et al., 2011). Women cannot access this model of care if they have previously had a caesarean section, PPH, 3rd degree perineal tear, are over 40 years of age, under 16 years of age, have had more than 5 babies, or have a body mass index of less than 18 or greater than 30 (Health Service Executive (HSE),

n.d.). Women who do not live within a specific catchment area or do not meet the eligibility criteria cannot avail of this service. The birth notification system does not differentiate births in midwifery-led units from other hospital births so it is difficult to find the latest figures of women availing of this service (HPO, 2024).

Homebirth is a restricted service in Ireland, it only caters to women with a very specific low obstetric risk pregnancy, it is also not available nationwide (Gregory *et al.*, 2023). For women who wish to have a homebirth, there are currently three options; the HSE's National Home Birth Service, the National Maternity Hospital's homebirth scheme, and a private company called *The Private Midwives* (Farsaci, 2022). Between 2018 and 2020, only 489 women had a planned homebirth, this results in an average of 0.275% of total homebirths in Ireland per year for these years (San Lázaro Campillo *et al.*, 2022). Experts have argued that Ireland uses overly strict criteria for assessing obstetric risk for publicly funded homebirth in comparison to other countries (Gregory *et al.*, 2023; OBoyle, 2014).

The majority of women in Ireland are restricted to hospital-based obstetric-led care due to a lack of access to alternative choices. Figures reported by the maternity services show that intervention during labour and birth has become standard practice. In 2022, the spontaneous vaginal delivery rate was 47.9% (n=26,162), the CS rate was 38.9% (21,220), and the instrumental vaginal delivery rate was 13.4% (n=7,291) (HPO, 2024). In the same year the induction of labour rate was 37.5% (n=20,081), with a notable disparity between primiparous women (47.1%, n=9,994) and multiparous women (31.1%, n=10,087) (National Women and Infants Health Programme (NWIHP), 2024). Other notable figures include 41.6% (n=22,244) of women using epidural analgesia in labour, and 26.8% (n=8,820) of women who had a vaginal birth had an episiotomy (NWIHP, 2024).

Based on a survey of 3,824 individuals who gave birth in Ireland between 2019-2024, researchers found that the majority of participants experienced medicalised birth (Huschke *et al.*, 2025). The study identified numerous medical interventions that characterised these births including; restrictions on movement during labour, limitations on food and fluid intake, continuous electronic fetal monitoring, multiple vaginal examinations, induction of labour, amniotomy, epidural analgesia, coached pushing, episiotomy, instrumental vaginal delivery, and CS (Huschke *et al.*, 2025). The authors concluded that intervention during

labour and birth has become the standard, with physiological intervention-free birth being an exception (Huschke *et al.*, 2025).

In 2016, Ireland's first *National Maternity Strategy- Developing a Better Future Together 2016-2026* was published (DOH, 2016). The strategy's purpose is to provide framework for a better and safer maternity service that caters to women's individual needs, their vision is a service where;

> *Women and babies have access to safe, high quality care in a setting that is most appropriate to their needs; women and families are placed at the centre of all services, and are treated with dignity, respect and compassion; parents are supported before, during and after pregnancy to allow them give their child the best possible start in life.* (DOH, 2016, p.4).

The strategy emphasises the need for greater choices in maternity care for women with low risk pregnancies (DOH, 2016). The strategy delineates three distinct care pathways: supported care is intended for women with normal-risk pregnancies (where normal risk denotes low obstetric risk), assisted care is intended for women with medium-risk pregnancies or those with normal-risk who opt for obstetric care, and specialised care is for women with high-risk pregnancies (DOH, 2016). Women in the supported care pathway should have the choice to give birth in an alongside birth centre or at home, whereas women in the other pathways will give birth in a specialised birth centre (an obstetric-led labour ward) (DOH, 2016). The strategy is still in its ten-year implementation phase.

2.3 Defining Traumatic Birth

Traumatic birth is a term that is widely and inconsistently used in the literature due to a lack of an agreed upon definition. Defining this concept is challenging due to its subjective nature, as the intensity of the traumatic experience is largely influenced by the perspective of the individual going through it. Childbirth situations can be objectively traumatic when the life of the mother and/or her baby is at risk, however, women may experience their labour or birth as traumatic even if, objectively, there was no threat to life (Horsch *et al*., 2024). Further complicating the discourse, is that birth trauma is used in obstetric and medical literature to describe physical injury that may occur to the mother or baby during

childbirth (Leinweber *et al.,* 2022). This overlap creates confusion between physical and psychological trauma, and to what extent each one contributes to the overall understanding of what constitutes birth trauma. A multitude of terms are also used throughout the literature to discuss psychological trauma resulting from birth. Greenfield *et al*. (2016) identified several terms in the literature that all refer to the concept of psychological traumatic birth; they were 'birth trauma', 'traumatic birth', 'difficult birth', 'traumatic experience of childbirth', 'negative birth experience', 'partial post-traumatic stress disorder resulting from childbirth', 'post-traumatic stress disorder resulting from childbirth', 'post-traumatic stress symptoms after childbirth' (p.255). The following section will discuss the definitions developed by researchers that reflect a more subjective experience of birth trauma (Beck, 2004a; Greenfield *et al*., 2016; Leinweber *et al*., 2022).

Beck (2004) suggested a definition for birth trauma that centres on the woman's psychological experience of birth;

> *Birth trauma is an event occurring during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror.* (p.28)

Beck (2004) also conducted a phenomenological study with 40 women who had experienced a traumatic birth with the aim of investigating the meaning of their experiences. The results of this research led to Beck suggesting that traumatic childbirth is "in the eye of the beholder" (p. 28), which emphasises the subjective nature of traumatic birth experiences.

Greenfield *et al.* (2016) conducted a literature review and concept analysis to produce a definition of traumatic birth. From their review of the literature, the authors identified traumatic birth being referred to as: a physical injury to the baby, the mother, or both, resulting in psychological distress; a fear of physical injury to the mother or baby and the associated psychological distress; or a psychological response to the experience of birth, including the care received, that causes enduring psychological distress (Greenfield *et al.*, 2016). As a result of their concept analysis, they suggested the following definition;

> *The emergence of a baby from the body of its mother, in a way which may or may not have caused physical injury. The mother finds the events, injury or the care she received deeply distressing or disturbing. The distress is of an enduring nature* (Greenfield *et al.*, 2016, p.257).

According to the authors, this definition challenges the medical model of traumatic birth, which is frequently associated with the mode of delivery, and also questions the interpretation that traumatic birth necessarily leads to a diagnosable mental health condition, such as PTSD (Greenfield *et al.*, 2016). Although this definition was developed for clinical and professional use (Greenfield *et al.*, 2016), Leinweber *et al.* (2022) speculate whether the definition is meaningful within the context of women's subjective experiences, and whether it would resonate with those who have experienced birth trauma.
Sun *et al.* (2023) also conducted a content analysis to provide a comprehensive insight into psychological birth trauma, and produce a definition for the same. The authors formulated the following definition;

> *Psychological birth trauma refers to the woman's subjective feeling caused by events directly or indirectly related to childbirth, which is manifested as intertwined painful emotional experiences that originate in the birth process and last until postpartum. It has a wide range of negative and, in some cases, positive effects on women*. (Sun *et al.*, 2023, p.11)

This definition acknowledges the subjective nature of traumatic birth experiences and recognises that these events may be directly or indirectly related to childbirth. However, it appears to imply that the intense emotional impact of birth trauma does not extend beyond the postpartum period, which the authors also do not clearly define.

Leinweber *et al.* (2022) formulated a definition of traumatic birth that seeks to be inclusive and acknowledges the subjective nature of such experiences. To achieve this, they co-created the definition with contributions from multi-disciplinary professionals (midwives, obstetricians, psychiatrists, and psychologists), academic experts working in the field of

childbirth and perinatal mental health, and women with personal accounts of a traumatic birth (Leinweber *et al.* 2022). They defined a traumatic childbirth experience as;

> *A traumatic childbirth experience refers to a woman's experience of interactions and/ or events directly related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/ or long-term negative impacts on a woman's health and wellbeing.* (Leinweber *et al.*, 2022, p.691)

This definition aims to acknowledge that a woman's experience is primary, interactions with care providers are critical to the experience, and that there are many possible events that may lead to a wide range of negative impacts on a woman's health and well-being (Leinweber *et al.*, 2022).

2.4 Childbirth-related Post-traumatic Stress Disorder

Childbirth-related post-traumatic stress disorder (CB-PTSD) has been recognised in recent decades as stressor-induced psychopathological response to the birth experience (Alcorn *et al.*, 2010; Dikmen-Yildiz *et al.*, 2018). A substantial amount of evidence shows that women can develop post-traumatic stress disorder (PTSD) in response to difficult or traumatic birth experiences (Ayers *et al.*, 2015). Meta-analyses suggest it affects 3.17% of women after birth at diagnostic levels and around 15% of women in high-risk groups, such as after a preterm birth or stillbirth (Grekin & O'Hara, 2014). The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders' (DSM-5) has a clearly established criteria for the diagnosis of PTSD (APA, 2013). According to the DSM-5 criterion A, childbirth is deemed traumatic if there is a perceived threat to the life of the mother, the infant, or if severe physical injury occurred (APA, 2013; Horsch *et al.*, 2024). Additionally, a person must exhibit at least one symptom from each of the following four categories (criteria B to E) for a period exceeding one month: re-experiencing, avoidance, negative thoughts or feelings, and arousal or reactivity (APA, 2013).

Several factors make PTSD following childbirth distinct from PTSD that results from traumatic experiences such as war, sexual assault, or bad accidents (Kranenburg *et al.*, 2023). Horesh *et al.* (2021) propose that childbirth-related PTSD (CB-PTSD) should be considered as a sub-type of PTSD due to its unique aetiological, clinical and sociological

characteristics. CB-PTSD results from a unique traumatic event as birth is socially considered to be a positive life event (Horesh *et al.* 2021). Furthermore, it results in unique clinical characteristics, has unique impacts for the familial unit, and only affects biologically female survivors (resulting in different physiological and sociological implications) (Horesh *et al.* 2021). Given these unique characteristics, the authors suggest that CB-PTSD should be re-evaluated and considered as a distinct subtype of PTSD (Horesh *et al.* 2021).

2.5 Prevalence of Birth Trauma and CB-PTSD

Studies show that between 9% to 45% of mothers report that their birthing experience was traumatic (O'Donovan *et al.*, 2014; Stramrood, Paarlberg, *et al.*, 2011). In a recent Irish study, 18% (n=209) of women in one maternity hospital ward reported that they experienced their birth as traumatic (Nagle *et al.* 2022).

Estimates of the prevalence of postpartum PTSD, or CB-PTSD, vary greatly due to differences in sampling, measurement and cultural context (Yildiz *et al.* 2017). Heyne *et al.* (2022) conducted a systematic review of 154 quantitative studies published in English, and identified a CB-PTSD prevalence rate of 4.7%, with 12.3% of women exhibiting post-traumatic stress symptoms (PTSS). Two other systematic reviews estimated postpartum PTSD rates to be 4% and 4.6%-6.3% in community samples, and 18.5% in high-risk samples (Dekel *et al.* 2017, Yildiz *et al.* 2017). Community samples consisted of women recruited from the general population (Dekel *et al.* 2017, Yildiz *et al.* 2017). High risk samples included women who experienced a difficult or traumatic birth, had an EMCS, severe tocophobia, a history of sexual or physical abuse, a history of childhood abuse, a very low birth weight baby, preterm birth, a diagnosed fetal anomaly, or severe complications in pregnancy such as pre-eclampsia or hyperemesis (Yildiz *et al.* 2017).

2.6 Influences and Contributors to Birth Trauma

Over the past twenty years, significant advancements have been made in birth trauma research, particularly in understanding who is more likely to experience birth trauma, and what factors contribute to these experiences (Svanberg, 2019). Ayers *et al.* (2016) suggest a diathesis-stress model of birth trauma, and identified factors that are strongly associated with the development of PTSD in the postnatal period. These factors can pre-exist pregnancy, or occur during the antenatal, intranatal, or postnatal period (Ayers *et al.*, 2016).

Numerous studies have explored these contributing factors, with findings from a selection of this research discussed below.

2.6.1 Influencing Factors That Pre-Exist Pregnancy

Experiences of trauma and sexual abuse prior to pregnancy can result in women being more prone to experiencing birth as traumatic (Beck *et al.*, 2013). Previous trauma and sexual abuse have been identified as risk factors for developing PTSD in the postpartum period (Andersen *et al.*, 2012; Ayers *et al.*, 2016). Soet *et al.* (2003) identified a history of sexual trauma as a significant predictor of traumatic birth. Phrases such as "open your legs", "this will hurt only a little", and "relax your bottom" can be interpretated negatively by survivors of childhood sexual abuse, and trigger negative thoughts and emotions (Simkin & Klaus, 2004, p. 74).

A history of mental health or psychiatric problems that predate pregnancy can also put women at a heightened risk of experiencing birth as traumatic (Andersen *et al.*, 2012; Beck *et al.*, 2013; Beck & Casavant, 2019; Nagle *et al.* 2022). This includes women who have severe tocophobia or previous traumatic birth experiences (Ayers *et al.*, 2016; Hofberg & Brockington, 2000).

2.6.2 Influencing Factors in Pregnancy

Antenatal health complications and poor prenatal mental health have been reported as predictors for traumatic birth experiences (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck *et al.*, 2013; Stramrood, Wessel, *et al.*, 2011; van Pampus *et al.*, 2004). Antenatal complications include severe pre-eclampsia, HELLP syndrome (haemolysis, elevated liver enzymes, and low platelets), and PPROM (preterm premature rupture of membranes) (Stramrood, Wessel, *et al.*, 2011; van Pampus *et al.*, 2004). Prenatal anxiety and depression have been repeatedly confirmed as significant contributors to birth trauma (Andersen *et al.*, 2012; Beck *et al.*, 2013).

2.6.3 Influencing Factors during Labour and Birth

Obstetric interventions, emergencies, intense pain, heightened negative emotions, and inadequate support from care providers during labour and birth have all been identified as factors contributing to women's perception of birth as traumatic.

Multiple studies have associated induction of labour, EMCS, and instrumental delivery with experiencing birth as traumatic (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck *et al.*, 2013; McGrath & Ray-Barruel, 2009; Nagle *et al.*, 2022). Severe pain, inadequate pain relief in labour or during an EMCS, and a long painful labour also contributed to birth trauma (Andersen *et al.*, 2012; Beck *et al.,* 2013; Nicholls & Ayers, 2007).

Experiencing persistent negative or distressing emotions throughout labour and birth can intensify women's perceptions of trauma. A loss of control and agency, such as being excluded from decision-making or lacking autonomy over one's own body, contributed to women's trauma (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck, 2004a; Dennis, 2015; Elmir *et al.*, 2010; Nicholls & Ayers, 2007)**.** Feeling helpless, violated, dehumanised, isolated, disconnected, invisible, abused, belittled, and degraded were reported by women who experienced a traumatic birth in multiple studies (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck, 2004a; Byrne *et al.*, 2017; Elmir *et al.*, 2010; Nicholls & Ayers, 2007; Thomson & Downe, 2008). Fear for oneself and one's baby, as well as perinatal dissociation, were also identified as contributing factors (Andersen *et al.*, 2012; Ayers *et al.*, 2016).

Arguably the most crucial factor during labour and birth that contributes to perceiving birth as traumatic is how women are treated and supported by caregivers (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck *et al.*, 2013; Svanberg, 2019). Care during labour and birth was described as mechanical, cold, and lacking in empathy; leading women to feeling isolated and unsafe (Beck, 2004; Thomson & Downe, 2010). Women felt dehumanised and devalued, likening themselves to a slab of meat on the delivery table (Elmir *et al.*, 2010; Thomson & Downe, 2008). Women who had a traumatic birth felt systematically stripped of the protective layers of caring (Beck, 2004a), and coerced into consenting for various procedures (Murphy & Strong, 2018; Peeler *et al.*, 2018). Women in several studies likened their birth experiences to rape, abuse, and torture (Beck, 2004a; Murphy & Strong, 2018; Nicholls & Ayers, 2007; Peeler *et al.*, 2018; Thomson & Downe, 2008).

2.6.4 Influencing Factors in the Postpartum Period

Postpartum depression, postpartum physical complications, and poor coping and stress after birth, were identified as contributors to birth trauma (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Horsch *et al.*, 2024). Postnatal complications included uterine infection and retained products of conception (Andersen *et al.,* 2012).

2.6.5 Influencing Factors Relating to the Newborn

Complications relating to the newborn can contribute to women's birth trauma. Preterm birth and having a baby admitted to the NICU can be a traumatic experience (Andersen *et al.*, 2012; Beck *et al.*, 2013; Chen *et al.*, 2022). Neonatal complications, such as asphyxia and very low birth weight, were strong predictors for the development of CB-PTSD (Andersen *et al.*, 2012; Fairbrother & Woody, 2007; Kersting *et al.*, 2004).

2.7 The Aftermath of Birth Trauma

In the aftermath of birth trauma, women may face challenges to their mental health, experience trauma-related symptoms, encounter difficulties with infant bonding and breastfeeding, experience strain in relationships, and changes in their future reproductive decisions. As previously discussed in section 2.4, women can develop CB-PTSD in response to traumatic experiences during the perinatal period (Dekel *et al.*, 2017; Heyne *et al.*, 2022; Yildiz *et al.*, 2017). Women have reported experiencing heightened levels of panic, grief, anger, anxiety, and depression (Bay & Sayiner, 2021; Beck, 2004b; Chen *et al.*, 2022; Elmir *et al.*, 2010; Fenech & Thomson, 2014; McKelvin *et al.*, 2021; Taghizadeh *et al.*, 2013; Türkmen *et al.*, 2021). Some women even suffer from suicidal thoughts or ideation of infanticide (Elmir *et al.*, 2010; Fenech & Thomson, 2014). Trauma symptoms such as flashbacks and reoccurring nightmares have been reported by women in a multitude of studies (Beck, 2004b; Elmir *et al.*, 2010; Fenech & Thomson, 2014; Shorey & Wong, 2022). Beck (2004b) describes how women had a non-stop video of their traumatic experience playing in their minds. Women also experience intrusive, painful memories and rumination regarding labour and delivery (Ayers, 2007). Fenech and Thomson (2014, p.187) reported that women were 'consumed by demons' as a result of traumatic childbirth.

The mother-infant dyad may become vulnerable as a result of traumatic childbirth, some women report feeling disconnected or detached from their infants following traumatic birth, as well as increased anger or anxiety when interacting with their baby (Beck, 2011; Beck & Watson, 2019; Molloy *et al.*, 2021; Watson *et al.*, 2021). Women may experience difficulties bonding with their baby (Bryanton *et al.*, 2008; Keedle *et al.*, 2022; Olde *et al.*, 2006). Women also report suboptimal breastfeeding experiences which includes insufficient milk supply, and terminating breastfeeding sooner than desired (Beck, 2011; Garthus-Niegel *et al.*, 2018). Evidence suggests associations exist between maternal PTSD and infant development such as poorer cognitive outcomes, eating and sleeping difficulties and increased cortisol levels following birth (Cook *et al.,* 2018).

Birth trauma and CB-PTSD can also negatively impact on women's relationships with their partners (Ayers *et al.*, 2006; Fenech & Thomson, 2014; Nicholls & Ayers, 2007). Women shared that birth trauma strained their relationship with their partner, negative effects on their relationship include sexual dysfunction, increased conflict, and blame for the events of birth (Ayers *et al.*, 2006). Women may avoid intimacy as it triggers flashbacks of the traumatic birth, as a way of protecting their 'battered and bashed body', or from fear of becoming pregnant again (Nicholls & Ayers, 2007, p. 499).

Birth trauma can also impact on future reproductive decisions, leading to changes in their birth plans, such as opting for an ELCS or homebirth, or limiting family size (Allen, 1998; Gottvall & Waldenström, 2002; Greenfield *et al.*, 2019; Porter *et al.*, 2006; Sassine *et al.*, 2021; Shorey *et al.*, 2018). As this is central to the current research, it is examined in greater depth in Chapter 3.

In terms of more positive outcomes, research shows that women can display resilience (Brown *et al.*, 2022), and post-traumatic growth (Beck & Watson, 2016; Ketley *et al.*, 2022) following birth trauma. Brown *et al.* (2022) explored how women rely on external and internal resources after traumatic birth experiences in a move towards resilience. Post-traumatic growth following psychological birth trauma can increase self-confidence and price and, improve relationships with partners, friends, and children (Beck and Watson, 2016; Ketley *et al.*, 2022).

2.8 Men and Birth Trauma

Witnessing a complicated or an unexpected adverse birth experience can be distressing for men, with some reporting symptoms of birth trauma (Elmir & Schmied, 2016). Bradley and Slade (2011) found that the prevalence of depression in fathers shortly after childbirth was around 1–8%. Bradley *et al.* (2008) reported that 6.6% of fathers experienced significant anxiety, and 3% of fathers reported a significant number of symptoms of PTSD. A meta-analysis of 154 studies found that following a traumatic childbirth, 1.2% of fathers develop PTSD and 1.3% develop PTSS (Heyne *et al.*, 2022).

Bearing witness to birth complications, emergencies, and interventions contributed to men's negative or traumatic perceptions of their partner's birth. Men recounted the sudden onset of birth complications, expressing feelings of panic and shock, and in some cases, fearing for the lives of their partner or baby (Elmir & Schmied, 2016). Furthermore, their partner's pain and suffering had a direct impact on how they perceived the birth (Elmir & Schmied, 2016; Inglis *et al.,* 2016). Distressing or traumatic events included EMCS (Inglis *et al.*, 2016; Johansson *et al.*, 2015; Nicholls & Ayers, 2007; White, 2007, 2007; Yokote, 2007), instrumental deliveries (Inglis *et al.*, 2016), major PPH (Snowdon *et al.*, 2012), and neonatal resuscitation (Harvey & Pattison, 2012).

Across several studies men reported feeling unprepared for what happened during the birth as they had not expected, or been prepared, to witness a complicated birth or an obstetric emergency (Daniels *et al.*, 2020; Elmir & Schmied, 2022; Etheridge & Slade, 2017; Inglis *et al.*, 2016). Being unprepared for an emergency event at the birth led to feelings of emasculation, helplessness, and powerlessness, as they were unable to support their partners (Elmir & Schmied, 2022; Nicholls & Ayers, 2007). Daniel *et al.* (2020) reported that fathers did not feel they had been prepared for the likelihood of a complicated birth from antenatal classes or from staff during the birth. Feeling dismissed and poor communication with staff was a common theme contributing to fathers' negative experiences. Fathers felt that they were either not informed properly of what was going on or felt dismissed by healthcare professionals (Daniels *et al.*, 2020; Elmir & Schmied, 2022; Etheridge & Slade, 2017; Inglis *et al.*, 2016; Nicholls & Ayers, 2007). The participants expressed a strong desire to be involved in every aspect of their partner's labour and birth, even during complicated situations (Elmir & Schmied, 2022). They felt distressed when they were excluded from the

birthing process, particularly when they were not informed about how their partner's birth complications were being managed (Elmir & Schmied, 2022). All seventeen men interviewed by Elmir & Schmied (2022) described feeling worried and anxious during adverse birth events as they feared for their partner and baby's wellbeing. Their anxiety and concern increased when large numbers of health professionals were gathered in the birth room unexpectantly, leaving them to guess who they were and their purpose for being there (Elmir & Schmied, 2022). On the occasion that their partners were taken to theatre for an emergency procedure, some men described feelings of abandonment or isolation (Inglis *et al.* 2016, Etheridge & Slade 2017). A lack of control during complicated experiences, such as EMCS, contributed to trauma (Daniels *et al.,* 2020; Nicholls & Ayers, 2007). Being excluded from part or all of the birth heightened feelings of worry and vulnerability, as men were often left unaware of what was happening to their partners (Elmir & Schmied, 2022). According to Wells (2016) fathers who reported being treated respectfully by healthcare professionals were four times more likely to describe the birth positively, as they felt they had greater control, lower anxiety and believed their partner was safe.

For some men, witnessing their partner's traumatic birth had significant effects on their mental health, leading to issues such as depression, anxiety, postnatal stress, obsessive-compulsive disorder, and symptoms of PTSD (Elmir & Schmied, 2016; Etheridge & Slade, 2017; Daniels *et al.*, 2020). All eleven men interviewed by Etheridge and Slade (2017) met the DSM-5 criterion A for PTSD, indicating they were exposed to a situation in which they believed there was a threat of death or serious injury to their partner or baby at some point during the birth. In one study, the male participants reported feeling less in control of their emotions as they struggled with unpredictable feelings, comparing their experience to an emotional roller-coaster (Etheridge & Slade, 2017). Daniels *et al.* (2020) reported that a portion of the men they surveyed continued to deal with mental health issues that had originated from witnessing their partner's traumatic birth some months or years ago. Perceptions of masculinity limited fathers from talking about their experiences which lead to suppressing their emotions and not seeking help (Charman *et al.*, 2024; Daniels *et al.*, 2020; Etheridge & Slade, 2017; White, 2007). Charman *et al.* (2024) described how men coped by 'boxing away" their emotions as communicating their distress led to feelings of vulnerability and shame (p.1). They tended to dismiss their own feelings of trauma as

nothing physical had happened to them and they believed their partner's suffering was worse (Daniels *et al.* 2020; Etheridge & Slade, 2017). One participant disclosed that when he shared his experience with colleagues he was met with ridicule, they questioned how birth could be traumatic for anyone other than the mother, while others responded with laughter (Charman *et al.* 2024).

There were mixed reports on the effects the birth had on relationships between the fathers and their partners. For some men their relationship experienced a positive impact, it grew stronger in the aftermath of the traumatic birth as the couple felt they had survived the experience together (Daniels *et al.,* 2020; Inglis *et al.,* 2016). In another study, the intensity of the birth resulted in some men experiencing a deepening of feeling for their partner, reporting that their relationship had taken on a new dimension (Etheridge & Slade, 2017). However, for others, the birth experience had a negative impact on their relationships. Inglis *et al.* (2016) reported that some men described how the trauma had a detrimental impact on their relationship as they were unable to communicate properly afterwards. In other studies men reported coping by disconnecting which acted as a barrier in their relationship and led to avoidance of physical and emotional intimacy (Etheridge & Slade, 2017; Daniels *et al.,* 2020; Nicholls & Ayers, 2007; White, 2007).

For some men, the birth experience impacted on bonding with their child and how they perceived themselves as fathers. When they did not experience an instant bond with their child, they felt intense guilt and shame around fatherhood (Daniels *et al.,* 2020). However, some fathers believed they had a closer bond with their child as they were the primary caregiver to their baby after birth when their partners were unwell (Charman *et al.*, 2024; Etheridge & Slade, 2017). As a result of the adverse birth experience, some participants reported increased anxiety, leading to behaviours that differed from their anticipated parenting style, such as being overly protective or having more intense reactions to their child (Charman *et al.*, 2024).

2.9 Positive Birth Experiences

This chapter has focused on describing traumatic birth experiences, examining both the contributing factors and their long-term impacts. However many women recall birth as a positive experience; this raises the question, what factors contribute to making birth a

positive experience for women? A positive birth experience encompasses more than just the physical well-being of the mother and baby. Researchers have found that women want a positive birth experience that either meets or exceeds their personal or socio-cultural beliefs and expectations of childbirth. This includes giving birth to a healthy baby in an environment that is both clinically and psychologically safe, with practical and emotional support from birth companions, as well as care from competent, compassionate clinical staff (Downe *et al.*, 2018). Birth experience can be optimised by holistic, woman-centre, and human right-based intrapartum care (WHO, 2018).

Karlström *et al.* (2015) found that women attributed their positive birth experiences to both internal factors, including their personal abilities and strength, and external factors, such as a trusting and supportive relationship with their midwife and the father of their child. Research indicates that inadequate support from birth professionals can evoke feelings of abandonment, contributing to a negative experience (Nilsson *et al.*, 2013). Instead, a sense of security fostered by a supportive environment enables women to gain control during childbirth, allowing them to focus on techniques that aid in managing labour (Hosseini Tabaghdehi *et al.*, 2020; Karlström *et al.*, 2015). Individualised emotional support has been shown to empower first-time mothers, increasing their chances of a positive birth experience even in cases of prolonged labour or birth complications (Nilsson *et al.*, 2013). Beneficial support included effective communication, awareness of women's individual needs, contentious updates on progress in labour, and adequate physical care (Hosseini Tabaghdehi *et al.*, 2020). Support from trusted birth partners and healthcare professionals also enhances women's feelings of empowerment during childbirth (Nilsson *et al.*, 2013). When women feel empowered, it further increases their sense of control, birth satisfaction, and ability to manage pain (Nilsson *et al.*, 2013).

Positive birth experiences can also be influenced by women's perceptions of pain and the use of birth interventions. Karlsdottir *et al.* (2018) found that women who had a positive experience of pain during childbirth, were more likely to have had support from a midwife during labour and birth, used epidural analgesia, and had low intensity pain during labour and birth. In their meta-analysis of effective interventions for fostering a positive birth experience, Taheri *et al.* (2018) identified that intrapartum care with minimal intervention, along with birth preparedness and supportive care, proved to be the most successful.

Positive intrapartum interventions relaxation through massage and music, and early labour assessment to minimise obstetric interventions (Taheri *et al.*, 2018).

The World Health Organisation published a report in 2018 that outlines 56 recommendations for good-quality and evidence-based intrapartum care, it promotes interventions that not only ensure a safe birth, but also a positive experience for women and their families (WHO, 2018). They recommend against the use of routine episiotomy, enemas, pubic shaving, vaginal cleansing, and pelvimetry (WHO, 2018). The routine use of CTG to assess fetal wellbeing on labour admission, or during labour, in healthy pregnant women is not recommended (WHO, 2018). Both pharmacological and non-pharmacological pain management techniques should be available for women who request them (WHO, 2018). Crucial to a positive birth experience and good quality intrapartum care is respectful maternity care, effective communication between care providers and service users, companionship during labour and childbirth, midwife-led continuity of care (WHO, 2018). Continuity of midwifery care enhances the birth experience through multiple factors, including improved maternal self-management of pain, increased ability to cope with the challenges of labour, greater sense of control over the birthing process, support from trusted professionals, and a reduction in stressful examinations and interventions (Taheri *et al.*, 2018). Respectful maternity care preserves a woman's dignity, privacy, and confidentiality, protects against harm and mistreatment, and provides continuous support while ensuring autonomy and informed decision-making during labour and birth (WHO, 2018).

2.10 Birth Trauma and this Research

This study recognises that birth trauma is a subjective and deeply personal experience, embracing Beck's (2004) view that traumatic birth is "in the eye of the beholder" (p. 28). Therefore, this study is adopting Leinweber *et al.*'s (2022) inclusive woman-centre definition of traumatic childbirth to guide recruitment and sampling. Firstly, this means that anyone who perceived any part of their pregnancy, birth, or postpartum experience as traumatic can participate. For the participant, their traumatic experience is self-defined. Second, a diagnosis of CB-PTSD is not required for participation, as not all women who experience birth-related trauma will develop full PTSD (Svanberg, 2019). Some may have been severely negatively impacted by their experience, but do not have clinical symptoms

of trauma, while others might exhibit PTSD symptoms without meeting the full diagnostic criteria (Ayers *et al.*, 2015; Svanberg, 2019). By recognising the subjective nature of birth trauma, the study underscores that trauma cannot always be fully understood or measured from an external perspective, allowing participants to bring their own definitions and experiences to the forefront.

2.11 The Relevance of Birth Trauma Research

Research into the various aspects of birth trauma is relevant to multiple stakeholders such as policymakers, healthcare services, healthcare providers, service-users, and those impacted by birth trauma. The significant prevalence of traumatic birth experiences, coupled with associations between CB-PTSD and poor developmental outcomes in infants, emphasises the need to recognise traumatic birth as a public health priority (Thomson *et al*., 2021).

For policymakers, understanding the prevalence and impact of birth trauma informs resource allocation and evidence-based policy reform, with the goal of improving maternal outcomes and potentially reducing healthcare costs. Ayers *et al.* (2024) recommend that healthcare policies for maternity and mental health services should include specific recommendations for prevention, detection, and treatment of traumatic birth and CB-PTSD. These recommendations should be based on the best available research and evidence. From an Irish perspective, the National Maternity Strategy ensures that the National Women and Infants Health Programme will oversee improved access to psychiatry and psychology services within the maternity services, and that additional support will be available for women who have experienced a traumatic birth or a baby loss (DOH, 2016). These services and supports should be based on research to ensure they effectively meet the needs of the individuals utilising them.

From an economic perspective, it is in the interest of policymakers to quantify the healthcare costs associated with traumatic births, for example longer hospital stays, increased readmissions, increased use of mental health or specialised services, and the cost differentiation between prevention and treatment. This may also extend to the economic impact of sick-leave and women's participation in the workplace. Ayers *et al.* (2024) make

a recommendation for research on the economic costs of traumatic birth and CB-PTSD to highlight and quantify the adverse implications for the family and society as a whole.

Furthermore, the global total fertility rate is decreasing, which will eventually result in a declining global population (Fauser et al., 2024). In Ireland, the number of births registered fell from 68,930 in 2013 to 54,678 in 2023 (Central Statistics Office (CSO), 2024). Over the last decade the Irish birth rate has dropped from 14.9 per 1,000 in 2013, to 10.4 per 1,000 in 2023 (CSO, 2024). An aging population requires increased pension and healthcare costs, but at the same time there are fewer workers producing the wealth to support them through economic growth and taxation (Fauser *et al.*, 2024). Economic development, urbanisation, improved education, secularisation, gender equity, and family-planning policies have all contributed to slowing world population growth (Fauser *et al.*, 2024). Rising rates of birth trauma may also potentially be influencing this trend. It is within the interest of policymakers and governments to address this increase as a possible influence to why families are getting smaller.

For healthcare services and healthcare providers, the urgency to understand traumatic birth and how to tackle it is imperative. Studies on the causes of birth trauma have already demonstrated that adverse encounters with healthcare providers can significantly contribute to traumatic experiences (Andersen *et al.*, 2012; Ayers *et al.*, 2016; Beck, 2004a; Beck *et al.*, 2013; Elmir *et al.*, 2010; Nicholls & Ayers, 2007; Svanberg, 2019; Thomson & Downe, 2008). Research of this nature is essential for educating healthcare providers on potentially harmful practices and guiding them toward implementing meaningful adjustments in their daily clinical practice. Furthermore, healthcare services are generally ill-equipped to deal with birth trauma. A comprehensive assessment of policies, services, and training related to traumatic birth across 18 European countries revealed a lack of national policy on the prevention, care, and treatment of birth trauma, as well as inadequate services and professional training (Thomson *et al.*, 2020).

Between 2020-2022 in the UK and Ireland maternal suicide was one of the leading causes of direct maternal death, the other causes were sepsis and obstetric haemorrhage, all three occurring at equal rates (Felker *et al.*, 2024). The majority of these maternal suicide deaths occurred between six weeks and one year after birth (Felker *et al.*, 2024). As outlined

earlier, traumatic birth experiences can lead to women developing CB-PTSD, depression, anxiety, and suicidal ideation (Bay & Sayiner, 2021; Beck, 2004b; Chen *et al.*, 2022; Dekel *et al.*, 2017; Elmir *et al.*, 2010; Fenech & Thomson, 2014; McKelvin *et al.*, 2021; Taghizadeh *et al.*, 2013; Türkmen *et al.*, 2021). In light of the established connection between birth trauma and adverse mental health outcomes, as well as the worrying statistics on maternal suicide, research into the prevention and treatment of birth trauma is critical to guide healthcare providers and broader healthcare services. Evidence-based, standardised guidelines that are accessible and provide actionable recommendations for implementing trauma-informed care practices are urgently needed (Donegan *et al*., 2025).

Furthermore, research shows witnessing a traumatic birth event can have a profound emotional and physical impact on midwives and other maternity care professionals (Aydın & Aktaş, 2021; Uddin *et al.*, 2022). This goes largely unacknowledged within the maternity workforce, leading to a lack of support for those affected (Uddin *et al.*, 2022). Documenting these experiences through research is critical to raising awareness and demonstrating the need for support and services.

Although the interests of the stakeholders listed are important to demonstrating the relevance of birth trauma research, the most compelling argument for conducting such research is to amplify the voices of those directly affected and learn from their experiences. The voices of individuals who have had a traumatic birth experience are vital to implementing meaningful change within the maternity services. Gaining insight into these experiences is essential for developing effective prevention strategies and treatment approaches for birth trauma. Although research participants themselves may not receive immediate personal benefits from these studies, their testimonies have the potential to interrupt the vicious cycle of birth trauma for future service-users.

2.12 Conclusion

In conclusion, this chapter has provided an overview of the current understanding of birth trauma. The chapter started with an outline of the existing definitions for birth trauma, followed by an explanation of CB-PTSD and its latest diagnostic criteria. Prevalence rates for birth trauma and CB-PTSD were then addressed. An extensive overview of the many contributing factors to traumatic birth experiences and CB-PTSD were presented, followed

by an exploration of the aftermath of birth trauma and the long-term impacts it can have on women and their families. The impact traumatic birth experiences have on men were then discussed. The chapter also included a section on positive birth experiences, along with strategies and recommendations for optimising birth experiences. The final section discussed how birth trauma is defined in this research study. The succeeding chapter presents a literature review, the aim of which is to explore and synthesise existing research on reproductive decisions made by women who have experienced a birth-related trauma.

Chapter 3: Literature Review

3.1 Introduction

A literature review serves several important purposes that are critical to conducting high quality research. One of the primary objectives of a literature review is to explore existing research relating to the topic of interest, and to provide a concise, up-to-date account of this research. Reviews also allow for researchers to identify gaps in the evidence and formulate research questions, essentially providing a foundation on which to build and justify new research. Furthermore, a literature review provides background to the topic of interest and situates a piece of research in the wider academic context.

The focus of this literature review is to explore and synthesise existing research on reproductive decisions made by women who have experienced a birth-related trauma. The literature review aimed to answer the following questions;

→ What future reproductive decisions do women make after experiencing birth-related trauma?
→ What or who influences women's future reproductive decisions after experiencing birth-related trauma?

Both questions have been addressed individually throughout this chapter. The findings from question one are categorised into reproductive decisions. Whereas findings from question two have been synthesised into themes and presented accordingly.

3.2 Literature Reviews in Hermeneutic Phenomenological Research

As outlined in the introduction of this thesis, this research adopts a hermeneutic phenomenological method. During a methodology course that I attended in preparation to conduct this study, the suitability of traditional literature reviews in hermeneutic phenomenological research was discussed between the facilitators and attendees. On one side, it was argued that a literature review does not align with the underpinning philosophy of this method as the purpose is to focus on individual experiences and meaning. Grounding the research in what is already known is not relevant to an individual's lived experience and the meaning of these experiences. It was even posited that a literature review could bias

the researcher. However, it was also acknowledged that a literature review is a key component of a PhD thesis, and it is not likely that a student could submit their final thesis without one. Those in favour of literature reviews in hermeneutic phenomenological research suggest they add to the richness and complexity of lived experience and recognised reviews as a means of broadening one's pre-understandings on their topic of interest. Although I saw merit on both sides of the discussion, I lean more towards the perspective that a literature review is a key component to any research project and serves to contextualise one's study and broaden one's understanding on their topic of interest regardless of the methodology. However, as with all stages in the research process, the conduct of the literature review should reflect the chosen methodology.

Dibley *et al.* (2020) argue that as with any other scientific endeavour, hermeneutic phenomenological researchers must demonstrate that their research is necessary. Smythe and Spence (2012) emphasise that in hermeneutic phenomenology the key purpose of a literature review is to provide context on the topic of interest and to provoke thinking. It adds to and informs the researcher's pre-understandings (Spence, 2017), and by engaging with the evidence base in an open, reflexive manner, researchers bring to the fore their own pre-suppositions and biases (Dibley *et al.*, 2020). The way to conduct a review in a hermeneutic manner is to move back and forth between existing understanding and the newly identified literature, which then informs the approach to and understanding of the topic of interest (Dibley *et al.* 2020). The nature of this type of research is that there are few rules to follow, instead there is a way to be attuned and, although there will be a centre influencing focus, insights may be found in unlikely places (Smythe & Spence, 2012). Acknowledging and exploring the existing evidence benefits the development of the research question, as well as enabling co-creation of understanding and meaning during data collection and analysis (Dibley *et al.,* 2020). van Manen (1997) discusses the importance of turning to the tradition of one's subject as "the work of others turns into a conversational partnership that reveals the limits and possibilities of one's own interpretive achievements" (van Manen, 1997, p.76). Considering these viewpoints, as well as the wider academic tradition of the literature review, it was deemed an important step in the process of this research study.

3.3 Search Strategy

A preliminary search of the literature confirmed an absence of studies solely investigating the relationship between birth-related trauma and limiting family size. The review questions were then adapted to include the relationship between birth-related trauma and any future reproductive decisions. In the pursuit of developing an effective and comprehensive search strategy, the advice of a specialist subject librarian was sought. The search strategy contained three main concepts; decision-making, birth-related trauma, and future reproductive decisions. A variety of terms and derivatives were developed for each concept. When appropriate, controlled vocabulary, MeSH terms, Emtree terms, Boolean operators, and truncation were used to enhance the search strategy. The detailed search strategy is located in the appendices (appendix 1). Systematic searches were then conducted in CINAHL, MEDLINE, Maternity and Infant Care, Embase, PsycInfo, Web of Science and ProQuest Theses and Dissertations. These databases were chosen as they were relevant to the subject matter and most likely to contain relevant literature. All the results were limited to English only. In ProQuest results were limited to PhD theses only. No date restrictions were applied to the searches. These searches yielded 8,319 results after duplicates were removed. The results were uploaded to Covidence for abstract and title screening. Additional literature was located from searching relevant studies' reference lists. Some studies that were already known and did not appear in the searches were added manually. The different phases of study selection are depicted in a PRSIMA diagram (appendix 2).

Developing the search strategy was some-what of a challenge as the concepts were difficult to define with appropriate search terms. This was particularly true for the concept of birth-related trauma as a psychological affliction. Although articles on birth-related psychological trauma were successfully located, the searches did yield copious amounts of literature that solely focused on physical trauma that results from childbirth, for example fourth degree perineal tears or neonatal birth injuries.

3.4 Adapting the Conduct of the Review

A systematic search allowed for a thorough and robust search of the databases; however, the analysis required a more flexible approach. Across the selected studies, the data varied considerably and many of the relevant findings emerged as side or incidental findings rather

than primary outcomes. While these findings were highly valuable for the review's aims, they were not suitable for a structured meta-analysis. Given the heterogeneity of the data and study types, a thematic analysis proved to be a more appropriate approach. This method allowed for extraction of key themes across the diverse sources and provided the flexibility that was needed to capture the nuances in the available evidence.

The following categories of data were extracted into an Excel sheet: study aim, design, population, sample details, inclusion and exclusion criteria, recruitment methods, interventions or measures, strengths, and limitations. Findings relating to reproductive decisions made as a result of birth trauma, negative birth experiences, or secondary tocophobia, were gathered from the articles. When available, the reasons behind these specific decisions were also recorded. Relevant quotes were also extracted from the articles. Themes were then developed to answer the two review questions.

3.5 Overview of the Literature

A total of forty-seven studies encompassing quantitative, qualitative, and mixed-methods designs were included in this review. This comprised of both published empirical studies and unpublished PhD theses. Two systematic reviews were identified as having some relevance to the review question (Bt Maznin & Creedy, 2012; Shorey *et al.*, 2018), and so the applicable studies were identified in each review and analysed individually.

Studies were included if any of the participants related their future reproductive decisions to a previous negative or traumatic birth experience, or secondary tocophobia. Birth-related trauma, negative birth experiences, or secondary tocophobia either appeared as findings or part of the inclusion criteria. Studies were also included if statistical analysis of quantitative data showed a relationship between future reproductive decisions or desires, and negative or traumatic birth experience, or secondary tocophobia. Secondary tocophobia is a fear of childbirth that develops after a traumatic event in a previous pregnancy or birth (Bhatia & Jhanjee, 2012). Studies were excluded if trauma was not directly related to childbirth or there was no link between childbirth experiences and future reproductive decision-making.

The studies in this review were dated from 1993-2024, spanning just over a thirty-year period. All participants were over the age of eighteen. They were conducted in a range of countries encompassing a multitude of cultural backgrounds; however, the majority were based in high income countries. Nine studies were conducted in Australia, 8 in the United Kingdom (UK), 6 in Sweden, 4 in the United States of America (USA), 2 in Brazil, 2 in Iran, 2 in The Netherlands, and 2 in Turkey. The other studies were conducted in Canada, Denmark, Finland, Greece, Hong Kong, Israel, Italy, Norway, Poland, Singapore, and Switzerland. There was one study conducted in both Ireland and the UK. There was also a cohort study that included samples from six nations; Belgium, Denmark, Estonia, Iceland, Norway, and Sweden, as well as an online survey with participants from the UK, the USA, Norway, Australia, India, New Zealand, Canada, South Africa, Belgium, France, Finland, Mexico, Romania, Laos, Iran, and Singapore.

Generally, the studies can be grouped into three categories. Some investigated future reproductive behaviour or decisions in a sample pre-identified as having experienced a traumatic or negative birth experience. Others explored or measured birth experiences and subsequent reproductive decisions. The largest category was comprised of studies that examined why women made a specified reproductive decision, and birth-related trauma appeared in the findings. Findings from qualitative, quantitative, and mixed-methods studies have been analysed and presented together

Table 1: Qualitative Studies included in Literature Review (n=24).					
Citation & Country	**Aims**	**Design**	**Sample**	**Relevant Results**	**Limitations**
Akgun & Boz (2019) Turkey	To interpret the decision-making processes and experiences of women who had a VBAC.	Phenomenological study using semi-structured interviews.	Twelve women who had a VBAC.	The most influential factor in choosing a VBAC was a previous negative or traumatic CS experience. A VBAC offered a way to avoid issues related to the previous CS such as depression, BF challenges, and poor bonding.	Women were recruited from a VBAC-focused social media group, potentially introducing bias. All participants were from a single city, their experiences may not be applicable to women in rural or regional areas.
Aksu & Serçekus (2023) Turkey	To explore women's traumatic childbirth experiences, their impact, and coping strategies.	Descriptive phenomenological. Semi-structured telephone interviews.	Sixteen women who had a traumatic birth in the last 6 months; 12 primiparous, 4 multiparous.	Participants developed tocophobia after their traumatic birth, as a result they postponed their plans for subsequent pregnancy or stated they did not want to become pregnant again.	There were limited explanations and quotes under some themes, particularly under the theme *'Fear of childbirth developing due to traumatic childbirth*', which is most relevant to this literature review.
Allen (1998) United Kingdom	To identify PTSD symptoms in women following childbirth and to provide data to guide psychological intervention.	Qualitative stage of a mixed-method study. Grounded theory using interviews.	Twenty women 10-months post-partum; 9 primiparous, 11 multiparous.	Eight women stated they would not have more children due to their birth experience, 6 of these had clinically significant PTSD. Of the 7 who would have more children, 2 would request ELCS.	Participants mainly resided in rural or small urban areas, and were from a higher socio-economic grouping. Limits generalisability of findings.
Baranowska *et al.* (2022) Poland	To explore the decision-making process of women who chose to freebirth.	Ethnography. Semi-structured, virtual fieldwork, and analysis of secondary data sources.	Twelve women who had a freebirth; all multiparous.	All the women were led to freebirth due to previously negative or traumatic birth experiences. Freebirth ensured a better birth environment, reduced intervention, and increased autonomy.	No primiparous women included in the study sample, and all participants had a previous negative birth experiences which may bias the results.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Bernhard *et al.* (2014) USA	To explore why women choose homebirth after a hospital birth, and their experience of homebirth.	Qualitative descriptive. Semi-structured focus group interviews.	Twenty women who had a hospital birth followed by a planned homebirth.	Previous birth trauma influenced the decision to homebirth. Homebirth helped heal the emotional trauma from hospital births, offering choice and empowerment after a loss of autonomy.	Focus groups may lead to group consensus or suppress individual views. All participants had their first baby in hospital which may have further contributed to negative perceptions of hospital birth. Limited generalisability as majority of participants were white, married, and could afford midwifery care out of pocket.
Bryanton *et al.* (2022) Canada	To explore women's lived experiences of tocophobia and planned CS.	Phenomenology. Open-ended interviews and journal entries.	Sixteen women with tocophobia who had an ELCS; 7 primiparous, 9 multiparous.	Tocophobia arose from a previous traumatic birth experience. Women feared another traumatic birth, as well as EMCS, episiotomy, perineal tears, de-humanising care, and medicalised birth.	Interviews were conducted in person, via Skype, and by phone. Differences in data collection may impact upon quality of data.
Canbay & Çitil (2023) Turkey	To explore women's decision-making for mode of birth in subsequent pregnancies following a CS.	Phenomenology, antenatal and postnatal interviews.	Seventeen women who had a previous CS, parity not stated.	Fourteen women planned for a VBAC. Previous negative CS experiences and fear of surgery influenced decision-making.	Participants were recruited from one hospital site, previous experiences of CS may reflect practices at study site.
Chen *et al.* (2022) USA	To explore factors influencing contraceptive choices in women who's babies were admitted to NICU.	Qualitative descriptive utilising semi-structured interviews.	Twenty-six women who had a preterm baby admitted to the NICU; 14 primiparous, 12 multiparous	Preterm birth was emotionally and physically traumatic. It influenced future reproductive decisions such as delaying or avoiding subsequent pregnancies.	Generalisability is limited as participants were recruited from one site. Interviews were conducted by doctors who work at the study site, this may have influenced participant's answers. Interviews at 2–8 weeks postpartum may have been too early for participants to be certain about their future reproductive decisions.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Feely & Thomson (2016) United Kingdom	To explore and identify what influenced women's decision to freebirth.	Interpretive phenomenological analysis. Written narratives and semi-structured interviews.	Ten women who had a freebirth; 1 primiparous, 9 multiparous.	Six women reported previous birth trauma during a hospital birth. Freebirth offered autonomy, control, and a sense of safety.	Homogenous sample does not represent all who choose free-birth. Online recruitment strategy excludes those who are not active online. Previous birth trauma may be emphasised in findings as sample is mainly multiparous.
Floriano *et al.* (2023) Brazil	To understand the motivations of women choosing planned homebirth.	Qualitative descriptive utilising semi-structured interviews.	Fourteen women who planned a homebirth; 2 primiparous, 12 multiparous.	Several participants experienced their previous hospital birth as traumatic. In response, they planned a homebirth to feel safe and ensure autonomy.	Limited generalisability as participants were recruited from one site. Majority multiparous sample may influence findings on women's motivations.
Greenfield et al. (2019) United Kingdom	To explore what choices were made by women with previous traumatic births and why.	Grounded theory utilising semi-structured interviews.	Nine pregnant women with a previous traumatic birth experience.	Women made birth-plans to protect their choices and sense of control after a previous traumatic birth. Their plans included ELCS, homebirth, and freebirth.	The homogenous and small sample may limit generalisability. Some participants reproductive decisions were impacted upon their socioeconomic background and financial barriers to care.
Hauck et al. (2007) Australia	To explore how expectations impact on birth experience and plans for subsequent births.	Qualitative exploratory descriptive utilising in-depth interviews.	Twenty women; 11 primiparous, 9 multiparous.	Eleven women had negative experiences due to unmet birth expectations, leading to fear and anxiety about future birth. This prompted future birth plan changes like ELCS.	Of the sample, 65% had private health insurance. This was not representative of the population, and may account for 52% instrumental delivery rate.
Hofberg & Brockington (2000) United Kingdom	To classify tokophobia for the first time in the medical literature.	Longitudinal design, several interviews with each participant over a two-year period.	Twenty-six women with primary or secondary tocophobia.	Fourteen women developed secondary tocophobia after a traumatic delivery. Of these, 11 had a subsequent ELCS, one had a termination, and one had no other children. Overall, 10 opted for permanent contraception, it was unclear which of these had subsequent births.	The homogenous and small sample may limit generalisability. A standardised interview schedule was not used, and data collections/analysis were not clearly reported.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Hollander *et al.* (2017) Netherlands	To explore women's motivations for choosing homebirth or freebirth in high risk pregnancies.	Grounded theory, in-depth semi-structured interviews.	Twenty-eight women who had a homebirth or freebirth in a high risk pregnancy.	Previous birth trauma left some feeling unsupported and violated, influencing their decision to homebirth or freebirth. They desired autonomy, support, and to feel safe.	Findings may not be applicable outside of the Netherlands as their maternity care system offers greater choice. Online recruitment and snowball sampling may have led to overrepresentation of activist viewpoints. No participants regretted their decision, therefore findings may be positively skewed.
Jackson *et al.* (2020) Australia	To explore what motivates women to have a high-risk homebirth, or freebirth.	Grounded theory, in-depth interviews and written accounts.	Twenty-eight women who planned a homebirth or freebirth in a high risk pregnancy.	Birth-trauma was a leading influence. Women with harmful hospital experiences, the trauma was so severe they wished to avoid hospital birth. They found empowerment through freebirth and homebirth.	Homogenous sample of majority white and socially advantaged participants. Participants of indigenous background were not recruited, despite their known avoidance of mainstream services. Findings may be skewed more positively as those who had a poor outcome were not included.
Johansson et al. (2023) Sweden	To explore women's experiences of freebirth.	Qualitative descriptive, semi-structured interviews.	Nine women who had at least one freebirth. Parity varied from two to eight.	Previous traumatic hospital birth influenced the decision to freebirth. Women wished to avoid disrespectful care and unnecessary intervention. Many would have preferred midwife-assisted homebirth but faced resource issues.	The authors note that time perspective may have influenced experiences, as some women gave birth long ago while others did so recently. Findings may be skewed more positively as participants had good birth outcomes. The small sample size limits generalisability.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Keedle *et al.* (2015) Australia	To explore reasons for and experiences of choosing a HBAC.	Qualitative interpretive, combination of in-person and online in-depth interviews.	Twelve women who had a HBAC. Ten had a midwife, one had an UBW, and one had a freebirth.	Women sought to avoid another traumatic birth. For some, a HBAC healed their birth trauma, fostering empowerment, pride, joy, and improved bonding with their babies.	Limited generalisability due to a small sample and exclusively metropolitan participants. Findings may be positively skewed as all had positive HBAC experiences, and the sample was predominantly pro-VBAC/HBAC due to recruitment methods.
Lightfoot (2017) United Kingdom	To explore women's experiences of undiagnosed breech birth.	Experiential qualitative using secondary data from online discussion forums.	Women on Mumsnet who had an undiagnosed breech birth.	An undiagnosed breech birth was so traumatic for some that they decided to forgo future pregnancies. Others either had or planned to have a ELCS in subsequent pregnancies.	Context of women's experiences can be lost when using online secondary data. Demographics of sample are largely unknown. Potential for researcher bias when selecting comments for analysis, as well as the influence of the author's own experience of an undiagnosed traumatic breech birth.
Lou *et al.* (2022) Denmark	To explore women's motivations and preparations for freebirth.	Qualitative design informed by anthropological theory and using semi-structured interviews.	Ten women who either had or planned for a freebirth, all multiparous.	Negative hospital and home birth experiences influenced the decision to freebirth. They sought out a holistic approach that was compatible with their birth philosophy as the mainstream system was too medicalised.	Small sample size may limit findings and generalisability. Poor freebirth outcomes were not represented.
Muhandule *et al.* (2024) Brazil	To understand why women request a caesarean delivery.	Descriptive phenomenology using semi-structured interviews.	Eighteen pregnant women who requested a CS; 6 primigravid, 12 multigravida.	Some multiparous participants were influenced by previous traumatic birth experiences. They requested a CS to avoid slow progression in labour, pain and IOLs. A CS allowed them to feel greater control.	Participants were recruited from a tertiary referral service, therefore the sample consisted of mainly high risk pregnancies and a CS may be clinically indicated. Furthermore, it is not representative of the overall population.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Rhodes (2013) United Kingdom	To explore women's experiences of ELCS following a traumatic birth.	Interpretive phenomenological analysis using written narratives and semi-structured interviews.	Thirteen women who had an ELCS in the last 5 years. Eight women provided written accounts and 5 completed semi-structured interviews.	Women feared birth after their traumatic experience. ELCS permitted thoughts of future childbirth, enabling them to increase their sense of control.	Participants were recruited at different time points following their CS (up to 5 years), retrospective reflection may alter appraisals of experience. The combination of written accounts and interview data may have resulted in variations in depth and quality of data.
Rigg *et al.* (2017) Australia	To explore why women choose to give birth at home with an unregulated birth worker (UBW).	Thematic analysis of in-depth interviews.	Five women who gave birth with UBWs, and four UBWs (who also gave birth with an UBW).	Previous hospital and homebirth (with a midwife) were traumatising and disempowering. Women chose birth with an UBW as they provided a sense of safety and increased autonomy.	The small sample size may not be reflective of all those who have accessed UBW care. Women may be reluctant to participate due to possible scrutiny or fear of legal ramifications. Findings may be skewed more positively as all participants had good birth outcomes. Furthermore, UBWs will likely have overwhelmingly positive views of birth with UBWs.
Ryding (1993) Sweden	To obtain an understanding of women who wanted a CS when it was not medically necessary.	Qualitative design using interviews and a psychotherapeutic intervention. Women requesting CS were offered sessions with a psychotherapeutically trained obstetrician during pregnancy. Women were interviewed during pregnancy and in the postnatal period.	Thirty-three pregnant women who requested a CS without medical indication, 28 were multiparous.	Among the multiparous women, reasons for requesting an ELCS included fear of pain, death, concerns for the baby's health, fear of a repeat traumatic EMCS, and fear of postnatal depression. After receiving counselling 14 women had an uncomplicated SVD, only one of which regretted this decision.	This study interviewed women on their experience of a unique intervention, therefore it may not be easy to replicate and the findings may not be generalisable. Details of the psychotherapeutic training received by the obstetricians were not provided.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Taghizadeh *et al.* (2013) Iran	To explore women's responses to psychological birth trauma.	Qualitative design using interviews.	Twenty-three women with psychological birth trauma.	Birth trauma impacted on future reproductive decision-making. To avoid another trauma, women avoided future pregnancy and had less children than desired. Some had a CS in future births due to fear of vaginal birth and the delivery ward.	The authors did not report on participant demographics. Cultural expectations of Iranian women may influence family making decisions, may limit transferability of findings.

Table 2: Quantitative Studies included in Literature Review (n=20).					
Citation & Country	**Aims**	**Design**	**Sample**	**Relevant Results**	**Limitations**
Bracken *et al.* (2008) USA	To explore preferences for mode of delivery	Cross-sectional survey study. Surveys distributed to pregnant women at two major hospitals over a 6 month period.	Pregnant women (n=550); 43% nulli-parous (n=236), 57% multiparous, (n=314).	A previous negative birth experience did not significantly influence the preference for either a CS or vaginal birth.	Excluding non-English speaking women resulted in the exclusion of a large Hispanic population at one study site. Non-random sampling may result in a bias, however a power calculation was used. Large portion of missing responses however they were recorded as same and not calculated in final result.
Chong & Mongelli (2003) Singapore	To assess women's attitudes, knowledge and expectations towards CS and vaginal birth.	Cross-sectional survey study. Women were recruited at random from antenatal clinics in one hospital.	Pregnant women (n=160); 42.7% nulliparous (n=68), 57.3% multiparous (n=92).	Only 3.7% (n=6) preferred an ELCS, as 95% (n=152) preferred a vaginal birth. Three women requested an ELCS due to previous stressful vaginal births.	Women were not asked about previous birth experiences. Women were only recruited from one study site, opinions may reflect practices at study site.
Gamble & Creedy (2001) Australia	To determine the incidence of women's preferred type of birth, and factors associated with their preference.	Cross-sectional survey study. Women recruited from one hospital and six private obstetric clinics.	Pregnant women (n=310); 44.2% nulliparous (n= 137), 55.8% multiparous (n= 173).	The majority preferred a SVD (93.5%, n=290). Only 6.4% (n=20) preferred a CS, and were more likely to be multiparous, describe their previous birth negatively, and experience anxiety or fear about labour.	Women were recruited at 36-40 weeks of pregnancy, excluding women who delivered earlier.
Ghanbari-Homayi *et al.* (2021) Iran	To assess the prevalence of negative birth experiences and their impact on attitudes toward future pregnancies and births.	Cross-sectional survey study. Postpartum women were randomly invited to participate from 64 urban and rural health centres.	Primiparous (n=800) women 1-4 months postpartum.	A total of 37% (n=296) had a neg-ative childbirth experience. This experience was linked to reluc-tance about future pregnancies or an unwillingness to have a sub-sequent vaginal birth. Negative childbirth experience decreased desire for another child by 58%.	Women were recruited at 1-4 months postpartum, may be too soon for certainty about future reproductive decisions. Cultural expectations in Iran may influence reproductive decisions, may limit transferability of findings.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Gottvall & Waldenström (2002) Sweden	To investigate whether women's experiences of their first birth affects future reproduction.	Prospective cohort study using survey data from a previous trial and birth registry data. Participants from original trial were followed up on the birth register 10 years later.	Women (n=617) who gave birth to their first child between a set time period and participated in the Stockholm Birth Centre Trial.	Overall, 32% scored their first birth experience low signifying a negative experience. Negative birth experience, being over 35 years old, or being single was associated with not having a subsequent child or delaying subsequent births.	The sample may have had higher expectations for birth as they had chosen a birth centre, therefore they may be more likely to rate their experience negatively. As this study used quantitative longitudinal data, other unknown variables may have influenced the participant's reproductive decision-making.
Hildingsson *et al.* (2013) Sweden	To compare birth outcome and parents' feelings in parents with instrumental vaginal birth (IVD) or a spontaneous vaginal birth.	Prospective longitudinal cohort study utilising a survey. Couples were recruited during routine ultrasound appointments at three hospitals sites.	Women (n=936); 45% primiparous (n=420), 55% multiparous (n=512). Men (n=827); 47% one child (n=390), 53% two or more children (n=427).	Overall, IVD had a negative impact on birth experience. In the IVD group, 25% of women feared the baby would be damaged during birth, 6% decided against future children due to their birth experience, both findings were statistically significant. Only 1.8% of the SVD group chose not to have more children due to their birth experience.	Non-Swedish speakers were excluded, limiting the generalisability of findings. The findings are further limited by the observational design, wide confidence intervals, and missing values/drop-outs in follow-up stages of study which can lower the power and lead to bias.
Holopainen *et al.* (2020) Netherlands	To explore the relationship between previous birth, trauma factors, and subsequent birth experience, and to test the association between toco-phobia and coping in subsequent births.	Correlational survey design. Recruitment through advertisements on social media forums related to traumatic childbirth experiences.	Women (n=474) with a previous traumatic birth experience, and at least one subsequent birth.	Average time between traumatic and subsequent birth was 2.8 years, 83.8% of which were planned. Longer birth intervals resulted in a more positive subsequent birth experience. Birth plans, home birth in a high-risk pregnancy against medical advice. and ELCS were linked to subsequent positive birth experiences.	No control group included, may reduce reliability of findings. Participants recalled their experiences retrospectively, their memories may have altered with time. Findings may not be applicable outside of the Netherlands as their maternity care system offers greater choice.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Hull *et al.* (2011) Worldwide, majority UK and USA	To explore pregnant women's motivation for preferring an elective caesarean section birth.	Cross-sectional online survey study. Recruitments through advertisements on a ELCS website and at a conference.	Pregnant women (n=356) who preferred an ELCS; 55% primigravida (n=196), 45% multigravida (n=163).	Dread of birth and/or a previous negative or traumatic birth experience were identified as motivators for preferring an ELCS. Previous traumatic experiences were often due to EMCS and/or a lack of supportive care.	Sample may be biased as participants were recruited from a pro-ELCS website. Findings cannot be generalised due to homogenous sample.
Joensuu *et al.* (2023) Finland	To study the impact first childbirth experience has on likelihood of, or interval to, subsequent births.	Retrospective cohort study using medical birth register data. Childbirth experience measured by a Visual Analogue Scale. Follow-up period of 7 years.	Primiparous women (n=45,947) who had a live term birth at one of five study sites over a five year period.	Negative childbirth experience (9.5%, n=4,360) decreased the likelihood of subsequent birth by 20%. The average interval between the 1st and 2nd child was 1.4 years longer for those with a negative first childbirth experience.	The Visual Analogue Scale may oversimplify birth experiences. It was completed within 72 hours post-birth and not repeated, possibly capturing experiences too soon for accuracy.
Jolly *et al.* (1999) United Kingdom	To relate subsequent obstetric performance with primary mode of delivery.	Cross-sectional study utilising surveys and hospital record data. Participants were recruited from the birth registry in one hospital, over a set period of time	Women (n=476) who delivered their first child 5 years ago.	Women who had an IVD or CS were more likely to report a negative birth experience and greater secondary tocophobia compared to those who had a SVD. Among the 170 who had no more children, 21 cited tocophobia or sterilisation, however it was only statistically significant in the CS group.	Women were not asked whether they perceived labour as traumatic or whether they were suffering from symptoms of PTSD. "Other reasons" was reported as an influence over future reproductive decisions, however participants were not given an opportunity to provide further details and it was not explored further.
Klint Carlander et al. (2014) Sweden	To investigate which factors related to the first birth influence subsequent reproduction within 5 years after the birth.	Quantitative prospective cohort study utilising sequential questionnaires and medical records. Recruited from one study site.	Women (n=451) who delivered their first child 5 years ago.	No significant associations between having a subsequent child and tocophobia, concerns related to childbirth, postnatal depression or negative birth experience.	Homogenous sample and recruitment from one study site limits generalisability. Limited amount of influencing variables measured. Study site has a birth debriefing service and a tocophobia clinic, may skew findings.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Moysaidou (2023) Greece	To determine women's reasons for choosing VBAC, their feelings during pregnancy, their VBAC experience and satisfaction.	Cross-sectional study, online questionnaire. Recruitment through social media groups targeting women who wanted a VBAC.	Women (n=454) who had a previous CS followed by a VBAC.	Twenty-eight (6%) women chose to have a VBAC due to a previous traumatic CS. The majority chose VBAC because they desired a normal birth or wanted to avoid extra surgery.	Online recruitment and data collection makes it difficult to confirm the validity of the data. Potentially biased sample as women recruited through social media groups that have pro-VBAC sentiments.
Pang *et al.* (2008) Hong Kong	To identify determinants for women who changed from preferring a planned vaginal birth to an ELCS after their first childbirth	Prospective longitudinal observational study utilising postal survey. Women from two hospitals were invited to participate 6-12 months after their birth.	Primiparous women (n=259) 6 months postpartum.	After their first birth, 23.8% changed their preference for vaginal birth to ELCS. Reasons included tocophobia (24.4%), perceived safety for baby (19.5%), less pain (10.5%).	Limited data on changing preference from CS to SVD for a meaningful analysis. The influence of their obstetrician, access to midwifery-care, socioeconomic background was not measured and therefore could not be analysed.
Preis *et al.* (2020) Israel	To investigate factors that contribute to changes in women's fertility intentions.	Prospective longitudinal study utilising sequential questionnaires (in pregnancy and at 2 months postpartum). Participants were recruited from 6 study sites.	Pregnant women (n=1,163), 40.7% primiparous (n=473), 59.3% multiparous (n=688).	Birth experience was unrelated to changes in desired number of children. Poor birth experience predicted an increase in desired inter-pregnancy interval.	Cultural expectations for Israeli women may influence future reproductive decisions, thus limiting the transferability of findings. The survey did not address additional variables which may influence fertility intention. Participants were followed-up at 2 months postpartum, possibly too soon after delivery to accurately capture their intentions.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Rigg *et al*. (2020) Australia	To explore the experiences of and reasons why women choose homebirth with an unregulated birth worker (UBW).	Cross-sectional online survey study. Recrui-tment through social media groups and sites relating to homebirth, birth rights, and birth workers. Also advertised on the research team's public social media accounts.	Women who had a planned homebirth with only an UBW present (n=82). All participants had a previous birth either in hospital, at a birth centre, or at home with a midwife.	A majority of participants found hospital care traumatising (70%, n=54), as well as disrespectful. (83%, n=64), abusive (70%, n=56), and unsupportive of normal birth (74%, n=57). Participants chose UBWs to avoid unnecessary intervention, inflexible hospital care, and to avoid being coerced/pressured by hospital staff or homebirth midwives. Others choose an UBW as they could not access midwifery care. Birth with an UBW increased women's sense of autonomy, they felt advocated for which led to feeling supported and emotionally safe. Some women regretted their decision as a result of poor birth outcomes.	Smaller sample size may reflect the controversial nature of the topic and the legality of UBWs in some areas of Australia. No data on ethnic background of participants. Participation was also limited to those with internet access.
Ryding *et al.* (2016) Belgium, Iceland, Denmark, Estonia, Norway, and Sweden	To explore differences between countries as to women's preferred mode of birth during pregnancy, and whether a preference for CS during pregnancy resulted in non-medically indicated CS.	Prospective cohort study utilising questionnaire data. Recruitment varied on country however all participants were recruited through hospital sites.	Pregnant women (n=6,549), 49.2% primiparous (n=3,223), 50.8% multiparous (n=3,326).	Across the 6 countries, 6.9–11.9% of multiparous women preferred a CS at 24 weeks gestation. A previous negative birth experience and tocophobia influenced the participant's preferences. Other influences included age, level of education, depressive symptoms, history of abuse, and a previous CS. Many participants developed a medical indication for CS, thus 9% had a non-medically indicated CS.	Results should be interpreted with caution due to the variation in health systems and cultural norms across the 6 countries. Surveys were only completed once at 24 weeks gestation, preferences may have changed as pregnancy progressed. Other influencing factors that were not included in the survey may have altered the findings.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Sassine *et al.* (2021) Australia	To explore the characteristics, needs and experiences of women choosing to have a homebirth (HB).	Cross-sectional online survey study. Survey advertised through social media and homebirth groups. Survey was open for 3 weeks.	Women who planned for, or experienced, a homebirth (n=1,681).	Motivations for choosing HB included avoiding medical intervention and hospital environment, previous birth trauma and/or PTSD associated with hospital birth. HB allowed for greater autonomy, a natural birth experience, and emotional safety.	Participation limited to those with internet access. Findings may be positively skewed as the sample were recruited from homebirth groups. The sample is not representative of the population as there are no Indigenous participants as well as few participants from a lower socio-economic background.
Sydsjö *et al.* (2013) Sweden	To investigate the time of subsequent delivery and delivery outcome in women with secondary fear of childbirth (FOC).	Retrospective case-control study using prospectively collected data. Recruited from two study sites.	Index group: 356 multiparous women with identified FOC. Control group: 634 multiparous women who gave birth on the same day as the index group and were not referred to specialist clinic for FOC.	Women with secondary FOC as a result of a traumatic birth experience had longer intervals between subsequent deliveries, and were more likely to have a CS in subsequent pregnancies.	Women in the control group may have experienced a traumatic delivery or have a FOC. Results may not be generalisable as women with secondary FOC in this study all received individual counselling and treatment. This intervention may have altered the findings.
Tschudin *et al.* (2009) Switzerland	To investigate pregnant women's intentions for opting for CS, their experiences regarding previous births and their expectations for subsequent delivery.	Cross-sectional survey. Participants recruited at two hospital sites and one private obstetric clinic.	201 pregnant women (n=201), 51.3% primiparous (n=102), 48.7% multiparous (n=97), (missing data n=2).	A previous negative birth experience and/or a previous CS experience was predictive of preferring an ELCS. Birth anxiety with regards to the forthcoming delivery was not predictive.	Sample not representative of the population due to above average levels of education. One third of women who preferred an ELCS did not state why. Due to anonymity, follow-up on whether women had a CS and their subsequent birth experience was not possible.

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Turnbull *et al.* (1999) Australia	To examine women's role in the decision to perform CS.	Cross-sectional survey. Over a six-month period, women who had a CS in the study site went sent a questionnaire.	278 women who had a CS at the study site and returned the survey.	One third of the sample had an ELCS. Previous negative experience of pregnancy/labour was reported by 26.5% (n=18) of women who had an ELCS, and by only 12% of those who had an EMCS. Other common reasons for ELCS and EMCS included advice from doctor, considerations for recovery, physical stress of labour, partner's attitude, ability to plan, and pain).	Conducted at one hospital site which has a higher than national rate of CS, findings may reflect local practices and policies and therefore findings may not be transferable.

Table 3: Mixed Methods Studies included in Literature Review (n=3).					
Citation & Country	**Aims**	**Design**	**Sample**	**Relevant Results**	**Limitations**
Dennis (2015) USA	To explore the experience and meaning of traumatic childbirth.	Mixed-methods. Semi-structured interviews followed by a survey measuring postnatal depression and traumatic stress symptoms. Recruitment through advertisements in hospital clinics and word of mouth.	Twenty women who reported a traumatic birth experience. Parity of participants not clearly reported.	Three women had no further children due to their traumatic birth experience. One woman had a termination due to severe tocophobia. Physical and emotional pain resulting from birth influenced the decision to limit family size. This decision reflected an attempt to gain back control and/or not risk further incidence of losing control.	The sample was 65% white and represented a rural population in the Southern USA, transferability of findings may be limited. For some participants it had been over 30 years since their traumatic birth, time may have altered their memory.
Porter *et al.* (2006) United Kingdom	To establish how mode of first birth affects women's decision-making about having another child.	Mixed-methods, using questionnaires and semi-structured interviews. Suitable participants were identified from hospital records and invited to participate.	Primiparous women with who did not have another child 5 years after the index birth, survey participants n=2,879, interview participants n=82.	Questionnaire data: 749 women had fewer children than planned. Most common reason was 'age, health, fertility', followed by experience of birth. Of those who had had a second birth, 696 (66%) had deliberately left a gap of 5 or more years. Interview data: The majority of women did not have the number of children they expected. The most influential factor was the experience of pregnancy and childbirth. Others factors were mental or physical health, lifestyle, partner, age, current child and fertility problems.	Interview data may be biased toward those with negative birth experiences seeking to share their stories. Survey data on age, health, and fertility were combined, as they are not entirely comparable this may have led to a loss of nuance in the data

Citation & Country	Aims	Design	Sample	Relevant Results	Limitations
Weaver *et al.* (2007) United Kingdom and Ireland	To examine whether, and in what context, maternal requests for CS are made.	Mixed methods design with four sub studies: Four sub-studies; 1. Diaries kept by pregnant women on birth planning. 2. Interviews with women who were considering a CS. 3. Interviews with obstetricians. 4. Postal questionnaires with obstetricians. Women recruited from clinics and wards at two study sites. Obstetricians for interviews recruited from 4 study sites, combination of convenience and purposeful sampling. Questionnaire sent to obstetricians in the UK and Ireland that were registered with the Royal College of Obstetrics and Gynaecology.	1. Pregnant women (n=64), 64.1% primiparous (n=41), 35.9% multiparous (n=23) 2. Women who were 6 weeks postpartum and had considered a CS in pregnancy (n=44) 3. Obstetricians (n=29) 4. Obstetricians (n=972). 23 35.9% multiparous, 41 64.1%primiparous). 2. Postnatal women who discussed CS in pregnancy n=44) 3. Obstetricians n=29 & 4. Obstetricians n=972	In the sample of multiparous women, 26% (n=6) wanted to have an ELCS. Their preference was influenced by a previous traumatic experience, an overriding concern for the safety of their baby, fear of vaginal birth, wishing to avoid an EMCS, and to control the timing of birth. The obstetricians reported that ELCS for maternal request in the absence of clinical or psychological issues was rare. They recalled cases due to poor body image, one woman's husband traumatised from previous partner's birth, and misinformation. They did identify fear of birth, that may have resulted from a previous traumatic experience, as an issue and considered it as an important factor.	Maternal request was not well defined. Perspectives on what obstetricians consider maternal request may differ, for instance, one may consider previous traumatic birth a legitimate clinical reason for CS. Women were recruited from only 2 study sites, findings may reflect local practices and not be easily transferable. Possibility of bias in multiparous women sample. The authors acknowledge that CS was likely only discussed with multiparous women based on their previous birth experience.

Section One: Future Reproductive Decisions after Birth-Related Trauma

The aim of section one of this review is to answer What future reproductive decisions do women make after experiencing birth-related trauma? The reproductive choices made by the participants in the included literature were organised into three main categories; 'Modifying Birth Plans', 'Delaying Subsequent Pregnancies and Births', and 'Limiting Family Size'. The first category, 'Modifying Birth Plans', is divided into five sub-categories; 'Elective Caesarean Section', 'Vaginal Birth After Caesarean Section', 'Homebirth with a Registered Midwife', 'Homebirth with an Unregulated Birth Worker', and 'Freebirth'. Further context to the participant's decision-making is outlined in section two.

3.6 Modifying Birth Plans

'Modifying Birth Plans' explores how participants in the included research adjusted their birth plans following a traumatic or negative birth experience. These modifications involved changes to their chosen mode of birth, the location or place of birth, or healthcare provider.

3.6.1 Elective Caesarean Section

In twenty-three studies, women reported to have had or were making plans for an elective caesarean section (ELCS) due to a previous traumatic or negative birth experience. Often participants did not report any medical indication for an ELCS, however there were instances where participants had an ELCS due to their previous experience along with a medical indication. This was the most reported future reproductive decision throughout the included literature. The high frequency of ELCS in the relevant literature may be attributed to a few reasons. First, there is a considerable volume of research dedicated to investigating what influences women to opt for ELCS. Second, ELCS may be more easily accessed by the participants, as other care options like homebirth are typically very limited or may not be available at all. In the following section, findings from quantitative studies are presented first, followed by findings from qualitative research.

Four survey-based studies were conducted to investigate influencing factors in the preference for ELCS, a total of 1,234 women were included in the samples (Hull *et al*., 2011; Mancuso *et al*., 2006; Tschudin *et al*., 2009; Turnbull *et al.*, 1999). Mancuso *et al.* (2006) surveyed 390 pregnant women in Italy, 141 of which were multigravidas. They found that

only 16.9% (n=66) of the total sample wanted an ELCS, 24 (17%) of which were multigravida women (Mancuso *et al.,* 2006). Motivations for primigravida and multigravida women were not reported separately. Overall, the most frequently reported motivation was a safer delivery for themselves or their baby (n=60, 90.9%), followed by a less traumatic childbirth experience (n=48, 72.7%) (Mancuso *et al.,* 2006). Only 13.6% (n=9) women were motivated by a previous negative experience (Mancuso *et al.,* 2006). It should be noted the questionnaire used by Mancuso *et al.* (2006) only allowed for participants to respond yes/no to a list of possible influences, there was no opportunity to leave a free-text answer or explain their responses. Turnbull *et al. (1*999) also conducted a survey to investigate women who chose to have a CS, the sample (n=278) had a CS seven weeks prior to completing the questionnaire. The authors did not differentiate between primiparous or multiparous women in their reporting of the findings. One third of the sample had an ELCS, the most reported motivating factors were information from their doctor (n=53, 75.7%), considerations for their recovery (n=42, 60%), and their partner's attitude (n=31, 44.3%) (Turnbull *et al., 1*999). Eighteen women (26.5%) were motivated by a previous 'awful' pregnancy or labour experience (Turnbull *et al.,* 1999). Tschudin *et al.* (2009) surveyed 201 pregnant women, 48.7% (n=97) of which were multiparous. Approximately 11% (n=23) of their overall sample were considering an ELCS (Tschudin *et al*., 2009). Statistical analysis identified previous CS and negative birth experiences as predictors for ELCS (Tschudin *et al*., 2009). The exact figures for the predictors were not provided by the authors.

Hull *et al.* (2011) conducted an online survey of 365 pregnant women, including 163 (45%) multigravida women, to explore their motivations for ELCS. The sample consisted of women from 16 different countries, however the majority (n=293, 81.6%) were in the UK or USA (Hull *et al*., 2011). Two themes emerged from thematic analysis of open-ended responses on rationale for choosing ELCS; 'Anti-vaginal birth' and 'Physical and psychological validation' (Hull *et al*., 2011). Women were concerned with the associated morbidity of a vaginal birth, as well as the potential harm to themselves and their babies (Hull *et al*., 2011). Some women were motivated to choose ELCS due to the psychological trauma they suffered after a previous birth experience; "I had to have an emergency caesarean on my previous pregnancy and I have suffered psychological trauma since then" (Hull *et al*., 2011, p.714).

Chong and Mongelli (2003), Gamble and Creedy (2001), Pang *et al.* (2008), and Ryding *et al*. (2016) all conducted surveys that investigated preferences or attitudes towards modes of birth. A vaginal delivery was preferred by the majority of participants within these studies, however a preference for ELCS was associated with feeling disappointed with the last birth, fear of vaginal birth, current obstetric complication, previously complicated delivery or CS, and a negative or traumatic previous birth experience (Chong & Mongelli, 2003; Gamble & Creedy, 2001; Pang *et al*., 2008; Ryding *et al*., 2016).

Two of these studies surveyed 470 pregnant women, 56% (n=265) of which were multigravida women (Chong & Mongelli, 2003; Gamble & Creedy, 2001). Chong and Mongelli (2003) found that only 3.6% (n=6) of women preferred an ELCS, with just over half citing a previous stressful or traumatic vaginal delivery as their motivation. Other motivating factors included the desire to avoid labour pain, prevent perineal trauma, reduce risks to baby, and to minimise the risk of an EMCS (Chong & Mongelli, 2003). Similarly, Gamble and Creedy (2001) reported that only 6.4% (n=20) of their sample preferred an ELCS. They found that the women who preferred an ELCS were more likely to be multiparous and to report their previous birth experience as 'awful' or 'unpleasant' (Gamble & Creedy, 2001). Both studies reported a low preference for ELCS among samples comprising of both primigravida and multigravida women (Chong & Mongelli, 2003; Gamble & Creedy, 2001). As these studies were conducted more than twenty years ago, the findings may not be relevant to today's population as maternity care trends and provisions change. Worldwide CS rates have increased significantly from 7% in 1990 to 21% today, with projections suggesting they will account for 29% of all births by 2030 . As one in five babies are born by CS, the procedure has become more normalised among the general population.

Pang *et al.* (2008) conducted an observational study of 259 primiparous women at 6-months postpartum to identify determinants for women who changed their preference in mode of delivery. Twenty-four percent of women changed from preferring vaginal birth to ELCS after their first childbirth (Pang *et al*., 2008). Fear of vaginal birth was the most common reported reason (n=14, 24.4%) for women changing their birth preference (Pang *et al*., 2008). Ryding *et al.* (2016) undertook a survey of 6,549 pregnant women across 6 European countries. Findings demonstrated that a preference for ELCS is associated with severe tocophobia and previous negative birth experiences (Ryding *et al*., 2016). Other

significant factors were higher age, lower educational levels, depressive symptoms, and a history of abuse (Ryding *et al*., 2016). Conflicting findings were reported by Bracken *et al.* (2008). In a survey of 550 pregnant women, 57% of which were multiparous, a previous negative birth experience was not a significant factor in preference for either ELCS or vaginal birth (Bracken *et al*., 2008). In this study, women preferring an ELCS believed it was less painful, less likely to affect sexual function, less likely to injure the infant, and less likely to result in vaginal injury or urinary incontinence (Bracken *et al.,* 2008).

Sydsjö *et al.* (2013) conducted a case-control study to investigate the time to subsequent delivery and delivery outcomes in women with secondary tocophobia following a traumatic birth experience. The index group consisted of 356 women, and the control group of 634 women (Sydsjö *et al*., 2013). They found that women in the index group were more often delivered by CS during the subsequent birth (Sydsjö *et al.,* 2013). Although this study is strengthened by its use of a control group, there is the possibility that participants in this group had a previous traumatic delivery or tocophobia (Sydsjö *et al.,* 2013). Furthermore, due to the study design, there was no opportunity for women to explain their motivations or give context to their decision-making (Sydsjö *et al.,* 2013). Holopainen *et al.* (2020) utilised an online survey to explore subsequent birth experiences in 474 women who had a previous traumatic delivery. Although only 7% (n=33) of the sample had an ELCS, it was significantly associated with having a more positive subsequent birth experience (Holopainen *et al*., 2020).

Hauck *et al.* (2007) and Taghizadeh *et al.* (2013) interviewed 43 women who had previously experienced a traumatic or negative birth. Although the specific number of women who altered their birth plans is not provided, some of them stated they would request an ELCS in future pregnancies as a result of their experiences (Hauck *et al*., 2007; Taghizadeh *et al*., 2013). Across five interview-based studies, a preference for an ELCS in any future or current pregnancies was disclosed by 32 participants who had birth-related trauma, secondary tocophobia, or a negative birth experience (Allen, 1998; Greenfield *et al*., 2019; Hofberg & Brockington, 2000; Rhodes, 2013; Ryding, 1993). Fifteen of these women reported that they would only have more children if ELCS was available to them (Allen, 1998; Greenfield *et al.,* 2019*;* Hofberg & Brockington, 2000). McGrath and Ray-Barruel (2009) interviewed 16 women who had a previous CS and opted for an ELCS. The participants' decisions were

motivated by both positive and negative influences (McGrath & Ray-Barruel, 2009). The authors reported that a desire to avoid a repeat traumatic EMCS influenced some of the participant's decision (McGrath & Ray-Barruel, 2009), an exact figure was not provided. Muhandule *et al.* (2024) interviewed 18 pregnant women who requested an ELCS. Twelve of the participants were multigravidas, previous traumatic birth experiences influenced some of their decisions to request an ELCS, an exact figure was not provided by the authors (Muhandule *et al*., 2024). Bryanton *et al.* (2022) interviewed 16 women who were planning an ELCS due to tocophobia. Nine of these women were multiparous, the majority of which reported their tocophobia arose from a previous physically or emotionally traumatic birth (Bryanton *et al*., 2022).

Finally, Lightfoot (2017) investigated women's experiences of undiagnosed breech birth in an experiential qualitative study that utilised secondary data from online forums. The experience of undiagnosed breech birth was commonly described as traumatic, the users frequently discussed their experience of having or planning for an ELCS in subsequent pregnancies (Lightfoot, 2017).

Although ELCS enabled women to consider and plan for future children, it was evident that the decision was not always embraced positively as they felt their experiences left them with no other choice (Greenfield *et al.,* 2019; Rhodes, 2013; Taghizadeh *et al*., 2013). One participant explains; "Electing for a caesarean is a very conscious choice, it's not really a choice when the choice is between having elective caesarean or risking permanent incontinence" (Greenfield *et al.,* 2019, p. 7). Hauck *et al.* (2007) reported that those who had a negative birth experience were left feeling fearful and anxious about subsequent births, and so changed their plans for future delivery to include ELCS or pain medication.

3.6.2 Vaginal Birth After Caesarean Section

Three studies reported on the relationship between choosing to have a vaginal birth after a caesarean section (VBAC) and a previous traumatic or negative birth experience (Akgün & Boz, 2019; Canbay & Çitil, 2023; Moysiadou, 2023). Akgün and Boz (2019) interviewed twelve women on their decision to have a VBAC in Turkey. A previous traumatic CS experience was the most influential factor in the decision to have a VBAC (Akgün and Boz,

2019). They chose to have a VBAC in attempt to avoid problems they associated with their previous CS such as depression, breastfeeding challenges, and poor maternal-baby bonding (Akgün and Boz, 2019). A fear of surgery and death also influenced their decision (Akgün and Boz, 2019). Canbay and Çitil (2023) also interviewed women in Turkey.

Canbay and Çitil (2023) interviewed 17 Turkish women with a history of CS on their decision-to have a VBAC or a repeat CS. In antenatal interviews, 14 out of 17 stated they would prefer to have a VBAC (Canbay & Çitil, 2023). Their motivations included a previous negative CS experience, fear of surgery, a desire for natural birth, and plans to have more children; one woman said "I think caesarean section is like death, imagine that the knife cuts through your stomach. I'm so scared..." (Canbay & Çitil, 2023, p.1507). The authors did not report whether the participants had a history of birth trauma. The women were followed up in the postnatal period and only five women had a VBAC (Canbay & Çitil, 2023). As women who had an EMCS were excluded, those who had a repeat CS did so due to obstetric advice and concerns for potential complications (Canbay & Çitil, 2023). Many of these women expressed feelings of anger and disappointment following their repeat caesarean (Canbay & Çitil, 2023).

Moysaidou (2023) conducted a cross-sectional survey of 454 women who had, or planned to have, a VBAC in Greece. Only 6% (n=28) choose to have a VBAC due to a previous traumatic CS experience. The most common reason for choosing a VBAC was a desire for a normal birth (n=104, 23%), believing vaginal birth is the normal way to give birth (n=101, 22%), or a desire to avoid additional surgery (n=64, 14%).

3.6.3 Homebirth with a Registered Midwife

A registered midwife (RM) is a healthcare professional who has completed the necessary education and training to obtain a license to care for women throughout pregnancy, labour, birth, and the postpartum period. They are registered with and governed by a regulatory body and are required to adhere to the relevant legislation and guidelines in the region where they are registered. Although it is dependent on the region, RMs can provide care in hospitals, birth centres, or at home. They may be independently or work for a public healthcare service. They work under a defined scope of practice, promoting normality, and

do not need to work under medical supervision. Eight of the studies found reported on women who had chosen a homebirth with a registered midwife after experiencing a traumatic birth (Bernhard *et al*., 2014; Floriano *et al*., 2023; Greenfield *et al*., 2019; Hollander *et al*., 2017; Holopainen *et al*., 2020; Jackson *et al.*, 2020; Keedle *et al*., 2015; Sassine *et al.*, 2021). Access to homebirth with a RM varies by country, and even where the option is available, access to the service is often limited by strict inclusion criteria or insufficient funding or both. Three of the included studies were conducted in Australia (Jackson *et al.,* 2020; Keedle *et al.,* 2015; Sassine *et al.,* 2021), two in the Netherlands (Hollander *et al.,* 2017; Holopainen *et al.*, 2020), and the remainder in Brazil (Floriano *et al.,* 2023), the UK (Greenfield *et al.,* 2019), and the USA (Bernhard *et al.,* 2014).

In Australia, publicly funded homebirth services are provided through public hospitals and operate under State or Territory guidelines (Jackson *et al.,* 2020). However, privately practicing midwives attend over half of homebirths and have greater flexibility in their care provision (Jackson *et al.,* 2020). Currently homebirth options in Australia are restricted due to financial constraints, as well as legislation, government, and hospital regulations (Sassine *et al.,* 2020). In 2022, 1,787 babies were born at home with a RM in attendance, this accounted for 0.6% of total Australian births that year (Australian Institute of Health and Welfare, 2024). The prevalence of homebirth in most European countries is relatively low, typically accounting for around 1% or less of all births (Galková *et al*., 2022). However, the Netherlands stands out as an exception, with a significantly higher rate of approximately 16.3% of all births (figure from 2019) (Galková *et al.,* 2022). Women in the Netherlands with a low risk medical and obstetric history can easily opt for a homebirth with a RM (Hollander *et al.,* 2017). In contrast, there are no publicly funded homebirth services in Brazil, and there is a general disproval for the practice by healthcare professionals and wider society (Floriano *et al.,* 2023).

Of the eight included studies, six used interview-based methodologies (Bernhard *et al.,* 2014; Floriano *et al.,* 2023; Greenfield *et al.,* 2019; Keedle *et al.,* 2015; Hollander *et al.,* 2017; Jackson *et al.,* 2020), and two utilised survey design (Holopainen *et al.*, 2020; Sassine *et al.,* 2021).

The qualitative studies primarily aimed to explore why women choose homebirth in a variety of circumstances (Bernhard *et al.*, 2014; Floriano *et al.,* 2023; Hollander *et al.,* 2017; Jackson *et al.*, 2020; Keedle *et al.,* 2015). Greenfield *et al.* (2019) specifically focused on decision-making among women who had previously experienced birth trauma. Homebirth with a RM was discussed as a future birth plan by 3 out of the 9 participants (Greenfield *et al.*, 2019). Bernhard *et al*. (2014) interviewed 20 women who had a hospital birth followed by a planned homebirth on what motivated their choice. Thematic analysis highlighted women's experiences of feeling dismissed and disrespected during their hospital birth, with some specifically describing the experience as traumatic (Bernhard *et al*., 2014). Not all the participants described their hospital experience negatively; however, even those who had a positive hospital experience disclosed at least one negative aspect usually relating to intervention (Bernhard *et al.,* 2014). Floriano *et al.* (2023) interviewed 14 Brazilian women who planned a homebirth. Twelve of the participants were multiparous, some of which were motivated to choose homebirth due to a previous traumatic hospital birth (Floriano *et al.,* 2023). One participant who had two hospital births followed by a planned homebirth said the following;

> *. . . my husband almost couldn't enter the room . . . they made me stay in the gynaecological position and it was totally uncomfortable for me . . . they called another doctor who got on top of me, it was very hard. He was born and they practically wouldn't let me see him. It was a very traumatic delivery . . . I was afraid of falling in a very bad place and that led us to look for other options so as not to have to experience all the traumas again.* (Floriano *et al.*, 2023, p.4)

Three studies interviewed samples of women (total n=51) who had a high-risk or complex pregnancy and chose to give birth at home with a RM (Hollander *et al*., 2017; Jackson *et al.,* 2020; Keedle *et al.,* 2015). Keedle *et al.* (2015) specifically interviewing women who chose to have a homebirth after a caesarean section (HBAC). Previous traumatic birth experiences associated with hospital care was identified as a motivator in all three studies by some of the participants (Hollander *et al*., 2017; Jackson *et al.,* 2020; Keedle *et al*., 2015). Many felt they had no other choice but to opt for a high-risk homebirth to prevent further trauma (Hollander *et al*., 2017; Keedle *et al*., 2015), one woman explains;

> *And he rammed that vacuum pump in, literally. Like that! He said: 'I am not here for my own amusement, I am here to help you.' And he rammed . . . that vacuum pump in without consultation (with me) . . . And then it was a C section. . . And I think it is mostly because I had that C section . . . and if there would not have been that last traumatic part that doctor X came in . . . then I don't think that I would have necessarily ended up here [giving birth at home].* (Hollander *et al.*, 2015, p.5)

In an Australian survey of 1,681 women who planned a homebirth, 63% (n=1,056) had previously given birth in a hospital or birth centre (Sassine *et al.,* 2021). One third of the sample (32%, n=533) described their hospital birth as a traumatic experience, and 6% (n=96) had been diagnosed with PTSD as a result (Sassine *et al.,* 2021). The participants mainly attributed their trauma to how they were treated by hospital staff, for example, being bullied or coerced, not listened to, and disrespected. Only 5% (n=81) of the sample reported their homebirth experience as traumatic, the majority of these were associated with how they were treated when transferred to hospital in labour. Holopainen *et al.* (2020) found that choosing a homebirth in a high-risk pregnancy against medical advice was associated with having a more positive subsequent birth experience following a traumatic birth experience.

3.6.4 Homebirth with an Unregulated Birth Worker

An unregulated birth worker (UBW) refers to a person who provides support services to women during pregnancy and childbirth without regulatory recognition, they have not had the sufficient, or any, training or maintained the sufficient standards that would enable them to register as a midwife or doctor (Rigg *et al*., 2017). UBWs include doulas, lay-midwives, childbirth educators and ex-registered midwives (midwives who either lost or chose not to remain on the register) (Rigg *et al*., 2015). Unlike registered midwives or doctors, UBWs are not required to adhere to any guidelines or codes of practice. The participants in this category intentionally planned a homebirth with an UBW. Four studies reported on this reproductive decision, interestingly they were all conducted in Australia (Keedle *et al*., 2015; Rigg *et al.*, 2017, Rigg *et al.,* 2020; Sassine *et al.*, 2021). According to Rigg *et al.* (2020) reports of homebirth with an UBW have increased in Australia, with some incidences resulting in coroner's cases and even legislative changes. The evidence base on

this topic is limited, which may be due to the controversial and sensitive nature of this topic, resulting in difficulties recruiting participants.

Two of the studies were exploring women's motivations for choosing homebirth, and a small number of participants revealed they had a homebirth with an UBW (Keedle *et al.*, 2015; Sassine *et al.,* 2021). Previous birth trauma was identified as a motivating factor in decision-making in both studies (Keedle *et al.*, 2015; Sassine *et al.,* 2021). Only one of the twelve women interviewed by Keedle *et al.* (2015) had a HBAC with an UBW (reason for choosing a UBW over a RM was not provided), and 5.5% (n=92) of participants in another study had planned to have a homebirth with an UBW (Sassine *et al.,* 2021). Some of these women altered their plans from homebirth with a RM to birthing with an UBW due to restrictive policies governing the RM's care (Sassine *et al*., 2021). Others would have preferred to have a homebirth with an RM but were unable to avail of this as homebirth services in Australia have been limited due to financial, legislative, and regulatory constraints (Sassine *et al*., 2021). When asked about their next pregnancy, 98 (5.8%) women were planning to have a homebirth with an UBW; however, this would decrease to 42 (2.5%) women if they have access to a publicly funded homebirth scheme, or private midwifery care (Sassine *et al.,* 2021).

The remaining two studies focused on why women specifically chose to give with an UBW (Rigg *et al.*, 2017; Rigg *et al.,* 2020). Rigg *et al.* (2017) conducted interviews with five women and four UBWs on what motivated women to choose to have a homebirth with an UBW. Analysis of interview data resulted in four themes; a traumatising system, an inflexible system, getting the best of both worlds, and treated with love and respect versus the mechanical arm on the car assembly line (Rigg *et al.*, 2017). The theme 'a traumatising system' related to how women experienced being cared for during birth in either a hospital or at home with a RM (Rigg *et al.*, 2017). Central to the traumatic experience was being treated poorly by staff and perceiving care as impersonal, this motivated women to seek care withy an UBW (Rigg *et al.*, 2017). Similar findings were reported in an online survey of 82 women who planned or had a homebirth with an UBW (Rigg *et al*., 2020). The majority of respondents found their previous hospital birth experience as traumatising (74%, n=57), disrespectful (83%, n=64), or abusive (73%, n=56) (Rigg *et al*., 2020). One respondent's comment highlighted the severe impact of her hospital birth experience;

> *I wouldn't call what happened to me in hospital a birth. Aside from the fact that babies were removed from my body, there was nothing about them that was birth like. Hospital birth left me traumatised and suicidal . . . Hospital birth is like a parade of indignity, it is inhumane, violent, and women who aren't compliant are punished. Hospital birth in Australia is a national disgrace.* (Rigg *et al*., 2020, p.88)

Some women stated that they preferred an UBW over a RM, as they perceived RMs as being constrained by institutional guidelines which ultimately restricts their care and support (Rigg *et al.*, 2017; Rigg *et al*., 2020). However, some participants attempted to access midwifery-led care but were unsuccessful due to high fees, risk factors excluding them from midwifery-led care, general unavailability of a midwife, or difficulty finding a RM who shared a similar birth philosophy (Rigg *et al.*, 2017; Rigg *et al*., 2020). One woman explains;

> *I did make contact with the midwives down at the birthing centre but the home birthing program still had not come through and it wasn't available... There were no other registered home birthing midwives available. It was at that period where there were no registered midwives...the publicly funded homebirth scheme was not up and running.* (Rigg *et al*., 2017, p.5)

3.6.5 Freebirth

Freebirth, or freebirthing, is characterised as the intentional decision to give birth without the attendance of a healthcare professional, such as a midwife or doctor, even where there is access to maternity care (Feeley, 2019). Freebirthing is also referred to as unassisted birth or birthing outside the system (Hollander *et al.*, 2017; Jackson *et al*., 2020). Nine studies reported on this reproductive decision (Baranowska *et al*., 2022; Feeley & Thomson, 2016; Greenfield *et al*., 2019; Hollander *et al.*, 2017; Jackson *et al*., 2020; Johansson *et al*., 2023; Keedle *et al*., 2015; Lou *et al*., 2022; Sassine *et al*., 2021)

Greenfield *et al.* (2019) interviewed nine pregnant women who had previously experienced birth trauma, one woman planned to freebirth due to her previous trauma. Seven qualitative studies interviewed women who either had, or were planning to have, a freebirth (Baranowska *et al.,* 2022; Feeley & Thomson, 2016; Hollander *et al.*, 2017; Jackson

et al., 2020; Johansson *et al.*, 2023; Keedle *et al*., 2015; Lou *et al.*, 2022;). Feeley and Thomson (2016) interviewed ten women who choose to freebirth in the UK, nine of participants were multiparous. Six of the participants reported previous birth trauma during a hospital birth which motivated them to freebirth, one participant explains;

> *I felt violated and humiliated. It ended up with the doctor telling me my baby was stuck and she would try to pull my baby out, in theatre, with an epidural, surrounded by strangers, in case it didn't work in which case they would perform an emergency c-section. It was the most awful experience of my life.* (Feeley & Thomson, 2016, p.5)

Baranowska *et al.* (2022) conducted an ethnographic study to examine Polish women's pathways to freebirth, and primarily used semi-structured interviews with 12 women, as well as observational fieldwork and secondary data sources. The common theme across the stories was that a previous negative birth experience, both in hospital and at home with a midwife, led women to freebirth (Baranowska *et al*., 2022). Women who gave birth in hospitals were much more likely to describe their experiences as traumatic or extremely challenging compared to those who had a homebirth (Baranowska *et al*., 2022). Similarly, Lou *et al.* (2022) interviewed ten women and found that previous negative experiences during hospital birth and homebirth fostered a critical awareness of the medical dominance in mainstream maternity care, ultimately leading the participants to freebirth. Finally, Johansson *et al.* (2023) interviewed nine women and found that previous negative or traumatic experiences of hospital-based maternity care motivated their decision to freebirth.

Hollander *et al. (*2017) and Jackson *et al*. (2020) both interviewed a combined total of 22 women with a high-risk pregnancy who chose to have a freebirth. One woman interviewed by Keedle *et al*. (2015) had a freebirth after a previous caesarean section. Findings from these studies were previously discussed earlier under section 3.6.3 'homebirth with a registered midwife' as the authors interviewed women who had either a homebirth or a freebirth (Hollander *et al*., 2017; Jackson *et al.,* 2020; Keedle *et al*., 2015). Traumatic birth experiences associated with hospital care or homebirth with a RM were identified as motivators for freebirth in all three studies (Hollander *et al*., 2017; Jackson *et al.,* 2020; Keedle *et al*., 2015).

Sassine *et al.* (2021) surveyed 1,681 women in Australia on their experiences of homebirth, 5.8% (n=97) of the sample disclosed that their most recent birth was a freebirth. As previously discussed, 63% (n=1,056) of the sample had previously given birth in a hospital or birth centre, and one third (32%, n=533) described their hospital birth as a traumatic experience (Sassine *et al.,* 2021). In the sample, 129 (7.7%) women were planning to have a freebirth in their next pregnancy, however this number decreases to 64 (3.8%) women if they have access to a publicly funded homebirth scheme, or private midwifery care (Sassine *et al.,* 2021). Women were predominantly excluded from public homebirth schemes due to geographical boundaries, or developing risk factors (Sassine *et al.,* 2021).

Similar findings were reported by Baranowska *et al.* (2022), Feeley and Thomson (2016), Jackson *et al.* (2020), and Johanssen *et al.* (2023). Freebirth was not always the participant's first choice. Many of the women interviewed by Baranowska *et al*. (2022) researched homebirth with a midwife but found that the service either did not meet their needs, wishes and preferences, or it was unavailable to them. Johanssen *et al.* (2023) reported that the women in their study would have preferred midwifery support, but due to the unavailability of homebirth midwives or the long travel distances to reach available midwives, combined with their reluctance to give birth in a hospital, they opted for a freebirth instead. Some of the women interviewed by Feeley and Thomson (2016) and Jackson *et al.* (2020) planned to have a homebirth with a RM but changed their plans due to feeling unheard and being bullied into compliance or having no access to midwifery care due to financial or geographical constraints (Feeley & Thomson, 2016; Jackson *et al*., 2020). Other factors that motivated women to freebirth were; a history of abuse or other negative life events, desire for greater autonomy, perceptions of safety, avoiding institutional guidelines and intervention, lack of support, and conflicting philosophies of birth (Feeley & Thomson, 2016; Lou *et al.*, 2022; Hollander *et al.*, 2017; Jackson *et al.,* 2020). One woman reported her Asperger's Syndrome contributed to her decision-making (Feeley & Thomson, 2016).

3.7 Delaying Subsequent Pregnancies and Births

The decision to have more children after a longer than originally intended time is categorised as delaying subsequent pregnancies and births. In the following section, findings from quantitative studies are presented first, followed by findings from qualitative

research. Four quantitative studies showed a relationship between negative or traumatic childbirth experiences and delaying subsequent pregnancies (Gottvall & Waldenström, 2002; Joensuu *et al.,* 2023; Preis *et al.,* 2020; Sydsjö *et al.,* 2013). Joensuu *et al.* (2023) performed a retrospective analysis of 45,947 primiparous women in Finland over a seven-year period. Statistical analysis showed that the interval between the first and second child was 1.4 years longer for women who had a negative childbirth experience (Joensuu *et al.*, 2023). Specifically, the median interval was 3.90 years for those with a positive experience and 5.29 years for those with a negative experience (Joensuu *et al.,* 2023). Similarly, in a prospective cohort study of 617 women, Gottvall and Waldenström (2002) found that negative birth experiences were associated with a longer interval to the second birth. In a case-control study that investigated the time to subsequent delivery and delivery outcomes in women with secondary tocophobia following a traumatic birth experience, Sydsjö *et al.* (2013) found that women in the index group (n=356) had a longer time interval to subsequent births. The strengths and limitations of this study have previously been discussed under section 3.6.1 'Elective Caesarean Section'. Finally, Preis *et al.* (2020) carried out a longitudinal study of 1,163 pregnant Israeli women, they found that poor birth experience was predictive of increasing desired time interval between pregnancies. Being multiparous was also associated with increasing time between pregnancies (Preis *et al*., 2020). The quantitative design of these studies provides valuable insights by identifying patterns and associations within the data, but they cannot provide the individual context behind women's decision-making processes. Influential aspects of women's experiences, such as their personal motivations, cultural background, or unique health considerations, may be overlooked or underrepresented in the analysis.

Findings from Porter *et al.* (2006) were inconclusive of the relationship between birth experience and delaying subsequent births (Porter *et al.,* 2006). Survey data (n=2,879) revealed that out of those who had a second birth (42%, n=1204), 66% (n=696) had deliberately left a gap of five years or more. The authors speculated whether women made a conscious decision to prevent birth, or they were simply indecisive (Porter *et al.,* 2006). They could not conclusively demonstrate whether birth experience or various other factors played a significant role in the decision to delay birth (Porter *et al.,* 2006).

In a survey of 474 Dutch women, the average time between a traumatic birth and subsequent births was 2.8 years (Holopainen *et al.,* 2020). Although the authors did not report on whether the desired interval between pregnancies had changed due to the previous birth experience; 83.8% (n=397) of the sample stated their subsequent pregnancies were planned (Holopainen *et al.,* 2020). The authors found that the longer time between births, the more positive the subsequent birth experience (Holopainen *et al.*, 2015).

Two qualitative interview-based studies also reported a relationship between traumatic birth experiences and delaying subsequent pregnancies *(*Aksu & Serçekuş, 2023; Chen *et al*., 2022). Aksu and Serçekuş (2023) interviewed 16 women who were less than 6 months postpartum and had experienced birth trauma. Several participants stated they had developed secondary tocophobia, as a result they planned to postpone subsequent pregnancies (Aksu & Serçekuş, 2023). Chen *et al.* (2022) interviewed women (n=26) who had a preterm birth (PTB) and were 2-8 weeks postpartum. The participants reported the experience of PTB as both physically and emotionally traumatic, which led to some to plan delaying future pregnancies (Chen *et al.,* 2022). The fear of experiencing another traumatic PTB, combined with uncertainty about their premature child's future medical needs, influenced participants' decisions future reproductive decisions (Chen *et al.,* 2022). Both samples of women were interviewed shortly after their traumatic birth experience (2 weeks to 6 months postpartum), this may impact on the findings as their reproductive plans may change considerably as more time passes.

3.8 Limiting Family Size

Limiting family size refers to the decision women make to not have further children after a birth-related trauma, especially if they originally had planned to have more children. Thirteen studies reported this finding (Aksu & Serçekuş, 2023; Allen, 1998; Chen *et al*., 2022, Dennis, 2015; Ghanbari-Homayi *et al.*, 2021; Gottvall & Waldenström, 2002; Hildingsson *et al.*, 2013; Hofberg & Brockington, 2000; Joensuu *et al.*, 2023; Jolly *et al.* 1999; Lightfoot, 2017; Porter *et al.*, 2006; Taghizadeh *et al.,* 2013), while two studies found no association between negative birth experiences and limiting family size (Klint Carlander *et al.*, 2014; Preis *et al*., 2020). In this section, findings from quantitative studies are presented first, followed by those from qualitative research.

Five quantitative studies reported some relationship between negative or traumatic birth experience and limiting future reproduction (Ghanbari-Homayi *et al.*, 2021; Gottvall & Waldenström, 2002; Hildingsson *et al.*, 2013; Joensuu *et al.*, 2023; Jolly *et al.* 1999). Whereas two quantitative studies did not find any association between birth experience and either fertility desires or realised future reproduction (Klint Carlander *et al*., 2014; Preis *et al.,* 2020). Four studies relied exclusively on survey data (Ghanbari-Homayi *et al.*, 2021; Hildingsson *et al.*, 2013; Jolly *et al.,* 1999; Preis *et al.,* 2020), while one study used birth register data (Joensuu *et al.*, 2023). Two studies combined questionnaire data with birth register data (Gottvall & Waldenström, 2002; Klint Carlander *et al*., 2014).

Joensuu *et al.* (2023) performed a retrospective analysis of 45,947 primiparous women in Finland over a seven-year period. Statistical analysis showed that the likelihood of women having another child in the seven-year follow-up period decreased by 21% if their first childbirth experience was perceived negatively (Joensuu *et al.,* 2023). Similarly, in a prospective cohort study of 617 primiparous women, Gottvall & Waldenström (2002) found that those who had a negative birth experience were less likely to have a second child (Gottvall & Waldenström 2002). Regression analysis showed that women with a positive birth experience were 1.7 times more likely to have a second birth within ten years following the first birth than those who had a negative birth experience (Gottvall & Waldenström 2002). Being over 35 years old or single was also associated with not having subsequent children (Gottvall & Waldenström, 2002), other possible influential factors such as maternal health or fertility were not measured.

Hildingsson *et al.* (2013) and Jolly *et al.* (1999) both conducted studies that investigated the impact that mode of delivery during first birth impacts upon future reproduction. Hildingsson *et al.* (2013) conducted a survey to compare birth outcomes and parents' feelings after both instrumental vaginal birth (IVD) and spontaneous vaginal birth (SVD). The sample included a total of 1,763 participants, 936 women, and 827 men (Hildingsson *et al*., 2013). Various variables were measured including experience of labour and attitude towards future birth (Hildingsson *et al.,* 2013). The author's primary findings were that IVD affected parents' birth experience negatively and was linked to women's views on their subsequent reproduction (Hildingsson *et al.,* 2013). In the IVD group (n=84), 25% (n=21) of women reported being fearful that the baby might be harmed during birth, and 6% (n=5)

stated that the birth experience influenced their decision not to have more children; both findings were statistically significant (Hildingsson *et al*., 2013). In contrast, only 1.8% (n=12) of women in the SVD group (n=682) indicated that their birth experience led them to decide against having future children (Hildingsson *et al*., 2013).

Similar findings were reported by Jolly *et al*. (1999) who conducted a survey with 476 primiparous women who had given birth to their first child five years prior to data collection. The authors reported that women who had an IVD (n=163) or CS (n=165) were more likely to report a negative birth experience (IVD n=46, 28.2%; CS n=37, 22.4%), and were more frightened about having another baby five years on (IVD n=41, 25.2%; CS n=43, 26.1%), than those who had a SVD (Jolly *et al.,* 1999). Of the 170 women who had no further children, 21 of them stated they would not go through childbirth again; however, it was only a statistically significant finding in the CS group (Jolly *et al*., 1999). It should be noted that 30% (n=50) of the women in the CS has unsuccessfully tried to have another baby (Jolly *et al.,* 1999). Other statistically significant reasons why women across all three delivery groups chose not to have more children included relationship problems and having originally planned to have only one child (Jolly *et al.,* 1999). The participants in both these studies were followed up between 1-5 years after their birth (Hildingsson *et al.,* 2013; Jolly *et al.,* 1999), and so they may have gone on to have subsequent children in the time after data collection.

Ghanbari-Homayi *et al*. (2021) conducted a cross-sectional survey of 800 Iranian primiparous women to determine the impact that negative childbirth experiences have on women's attitudes towards subsequent births. In the sample, 296 women (37%) had a negative childbirth experience (Ghanbari-Homayi *et al*., 2021). Analysis of the survey data shows a statistically significant relationship between negative birth experiences and a decreased desire to have more children (Ghanbari-Homayi *et al*., 2021). Overall, negative experiences decreased the desire for another pregnancy and child by 58% (Ghanbari-Homayi *et al*., 2021). Other predictive factors were being married for over six years or having a secondary school level education (Ghanbari-Homayi *et al*., 2021). A decreased desire may not signify an actual change in reproductive decision-making. Furthermore, the survey was conducted at 1-4 months postpartum (Ghanbari-Homayi *et al*., 2021), which may not have allowed enough time for participants to be certain about their fertility desires.

Klint Carlander *et al*. (2014) and Preis *et al.* (2020) did not find any association between birth experience and either fertility desires or realised future reproduction. Klint Carlander *et al*. (2014) conducted a prospective cohort study of 451 primiparous women to investigate what factors influence on subsequent reproduction within a five-year period. The majority of participants (n=344, 76%) had a second child within five years after the birth of their first child (Klint Carlander *et al*., 2014). Statistical analysis showed no significant associations were found between fear of childbirth, postnatal depression or a negative birth experience, and subsequent reproduction (Klint Carlander *et al*., 2014). Preis *et al.* (2020) carried out a longitudinal study of 1,163 pregnant Israeli women, they found that poor birth experience, age, fertility and socioeconomic status was unrelated to changes in the participant's desired family size. Both authors acknowledged that these findings may be specific to the samples studied (Klint Carlander *et al*., 2014; Preis *et al.,* 2020). Klint Carlander *et al*. (2014) note that the participants were recruited from a study site that had a postnatal debriefing care pathway and clinic for tocophobia. As the study site offered additional support for women who had a negative birth experience, it may have influenced the findings of the study. Preis *et al.* (2020) acknowledged that the findings may be specific to their study sample due to Israel's pronatalist policies and culture (Preis *et al.*, 2020). A combination of Israeli social norms, public policy, and religious beliefs strongly encourage women to have large families (Preis *et al.*, 2020). Due to these pressures, women may feel compelled to have more children despite their birth experience (Preis *et al.*, 2020).

Porter *et al*. (2006) conducted a mixed-methods study to investigate how mode of delivery during women's first birth impacts upon their decision to have subsequent children. The questionnaire data (n=2,879) reported that 71% (n=1182) of women had deliberately limited their fertility, the second most common reason for this was experience during the first birth (figure not provided) (Porter *et al*., 2006). In the interviews (n=82), the most frequently discussed influence over the decision to not have more children was the experience of pregnancy or childbirth or both;

> *Well there was no way on this earth I was having any more kids after that. It was just no. It was just no way was I going through that again and I mean I have still to this day, have not forgotten you know how bad her birth was.* (Porter *et al*., 2006, p. 1761).

The other reasons women did not have more children were infertility, physical and mental health, age, partner's influence, health and behaviour of their child (Porter *et al.* 2006). This employed large sample sizes in both stages of their study, notably interviewing 82 women however, Porter *et al.* (2006) acknowledge their results may be skewed as women who had a negative experience may be more motivated to participate.

The rest of the studies reporting on 'Limiting Family Size' employed qualitative designs (Aksu & Serçekuş, 2023; Allen, 1998; Chen *et al*., 2022, Dennis, 2015; Hofberg & Brockington, 2000; Lightfoot, 2017; Taghizadeh *et al.,* 2013). Aksu and Serçekuş (2023) interviewed 16 women who were less than 6 months postpartum and had experienced birth trauma. Several participants stated they had developed secondary tocophobia, as a result they did not want to become pregnant again (Aksu & Serçekuş, 2023). As one participant explains;

> *Moreover, I can say that I am not thinking about another child. I am very frightened. I am doing everything possible not to have a child. I can say that the thing that is the reason for this is childbirth.* (Aksu & Serçekuş, 2023, p.2)

Chen *et al*. (2022) interviewed women (n=26) who had a preterm birth (PTB) between 2 and 8 weeks postpartum. Participants described the experience of PTB as deeply traumatic leading some to express a desire to avoid future pregnancies (Chen *et al*., 2022). As outlined earlier, the fear of enduring another traumatic PTB, along with concerns about the long-term medical needs of their premature child, played a significant role in shaping their future reproductive decisions (Chen *et al*., 2022). Allen (1998) interviewed 20 women who had a traumatic birth experience at ten-months postpartum. They used the Revised Impact of Event Scale (IES) to measure PTSD symptoms (Allen, 1998). Thirteen out of the twenty interviewees stated they would not have more children; 8 women attributed this decision directly to their traumatic birth experience (Allen, 1998). Six of these eight women had clinically significant PTSD symptoms (Allen, 1998). The findings from Allen (1998) may have limited generalisability as the interviews utilised a small homogenous sample. In all three studies, the women were interviewed relatively soon after their traumatic birth experiences (Aksu & Serçekuş, 2023; Allen, 1998; Chen *et al*., 2022), and so their reproductive plans may change and evolve with the passage of time.

Dennis (2015) interviewed 20 women who previously experienced a traumatic childbirth. Among them, three women chose not to have any more children as a result of their birth experiences, and one even opted for a termination of pregnancy due to her secondary tocophobia (Dennis, 2015). One woman recounted the trauma of giving birth to her preterm baby, describing how nurses yelled at her to push while forcefully pressing down on her abdomen (Dennis, 2015). This experience instantly established that she would not have more children; "I was not the same. I will never be the same . . . I will never forget it. I thought then that I am not going to have another child" (Dennis, 2015, p.87). Similar findings were reported by Hofberg and Brockington (2000). Over a two-year period, Hofberg and Brockington (2000) interviewed 26 women with primary or secondary tocophobia, a total of 14 women developed secondary tocophobia after a traumatic birth experience (Hofberg & Brockington, 2000). Two women in the study did not have more children as a result of their birth trauma, one of which had a termination after an unplanned pregnancy (Hofberg & Brockington, 2000). Hofberg & Brockington (2000) also reported that 10 of the 26 participants disclosed that they either had been sterilised or were on a waiting list for either sterilisation or vasectomy; however, it was not made clear which of these participants had already given birth as the author did not differentiate between the primary and secondary tocophobia group. Taghizadeh *et al.* (2013) interviewed 23 Iranian women on their responses to birth trauma. Several women discussed avoiding future pregnancies and having fewer children than they had originally desired as a result of their traumatic birth experiences (Taghizadeh *et al.,* 2013). The authors commented that overall, that birth trauma impacted on women's social rapport leading to social isolation and changes in their reproductive decision-making (Taghizadeh *et al.,* 2013). In Lightfoot's (2017) experiential qualitative study that utilised secondary data from online forums, some commenters expressed they were so traumatised from their undiagnosed breech birth that they decided to not have more children.

Section Two: Contextualising the Relationship between Future Reproductive Decisions and Birth-Related Trauma

Section two of this review aims to provide further context and explanation to how birth-related trauma influences future reproductive decisions. Approximately one third of the included studies discussed how the participant's birth-related trauma influenced their decision-making. These influences were identified in the literature and four themes

emerged; ‘Fear and Lingering Trauma’, ‘Reclaiming Control and Safety’, ‘Desire for a Natural Birth’, and ‘Searching for Support’.

3.9 Fear and Lingering Trauma

The theme ‘Fear and Lingering Trauma’ highlights how past traumatic birth experiences leave women with fear and emotional scars that influence their reproductive decisions. This theme underscores the lasting impact of trauma on the decision-making process. Among the 82 women interviewed by Porter *et al.* (2006), 61 had one child, and 21 had two or more. Many of the participants described how it was nearly impossible to overcome the long-term effects of their negative birth experiences, either because they lacked the mental resilience, or did not feel sufficiently maternal to endure the experience again for the sake of having another child (Porter *et al.,* 2006). Dennis (2015) interviewed 20 women who reported a previous traumatic birth experience, many described a lingering sense of trauma following this birth and discussed how it influenced their reproductive decision-making. One woman still lived with feelings of trauma thirty-two years after her experience of childbirth (Dennis, 2015). Secondary tocophobia was also a common thread throughout the interviews, it impacted on future reproductive decisions like opting for ELCS or limiting fertility (Dennis, 2015). Secondary tocophobia also influenced decision-making in other studies. Allen (1998) interviewed 20 women in the UK 10 months after a traumatic birth experience and concluded that distress was relatively short-lived, the main consequence of their experience related to fear of future pregnancy. Some of the 23 participants interviewed by Taghizadeh *et al*. (2013) stated their decision to not have more children was due to fear from their traumatic birth experience.

Fear of another traumatic experience was central to the decision to opt for an ELCS after a traumatic or negative birth experience. Ryding (1993) interviewed twenty-eight multiparous women who stated their preference for an ELCS was due to a fear of labour pain, fear of repeat EMCS, fear of death, fear for their baby's wellbeing, and fear of developing postnatal depression. Similarly, Bryanton *et al.* (2022) interviewed nine multiparous women who were planning an ELCS due to tocophobia, many were fearful of experiencing another traumatic birth, they also feared being cared for by an obstetrician with whom they previously had a bad experience with. McGrath and Ray-Burruel (2009) interviewed 16 women who had a previous CS followed by a subsequent ELCS. Many of the

participants had an ELCS as they wanted to avoid the repeat trauma of an EMCS (McGrath & Ray-Burruel, 2009). Rhodes (2013) interviewed 13 women who had a previous traumatic birth experience. Women reported fear and avoidance of future childbirth due to their experience, an ELCS permitted thoughts of future childbirth (Rhodes, 2013). Pang *et al*. (2008) reported that 56 out of 235 women (23.8%) who originally preferred vaginal birth in late pregnancy changed to preferring an ELCS for future pregnancy by 6 months postpartum. The percentage of women reporting fear of vaginal birth as the primary reason for their preference for ELCS most important reason for their preference for ELCS in future pregnancies significantly increased from 7.7% at 37 weeks, to 24.4% at 6 months after delivery (Pang *et al*., 2008).

3.10 Minimising the Risk of Reoccurring Birth Trauma

The theme ‘Minimising the Risk of Reoccurring Birth Trauma' emerged from how participants made reproductive decisions as a way to avoid the possibility of experiencing another traumatic birth. For these women, the fear of re-living a similar experience heavily influenced their choices regarding future pregnancies, with some opting to forgo additional children in order to protect themselves from further emotional and physical trauma. As discussed in detail under ‘Fear and Lingering Trauma’, women in three studies opted for an ELCS to avoid the repeat trauma of an EMCS or vaginal birth (Bryanton *et al.,* 2022; McGrath & Ray-Burruel, 2009; Ryding, 1993). Conversely, in interviews with 12 women who had a HBAC, Keedle *et al.* (2015) found that participants were motivated by their determination to avoid a repeat traumatic CS experience.

Greenfield *et al.* (2019) interviewed nine pregnant women who had previously experienced a traumatic birth, each woman had strong desires for their next birth which were reflected in their birth plans. Planning was a way to ensure a different experience, and to protect themselves from another traumatic experience (Greenfield *et al.,* 2019). Jackson *et al.* (2020) interviewed 28 women who had a freebirth or homebirth in a medically high-risk pregnancy. Many of the participants experienced their previous hospital birth as traumatic, this experience was so life changing that they were not willing to risk returning to the source of their trauma (Jackson *et al.,* 2020).

Lightfoot (2017) found that some women who experienced a traumatic undiagnosed breech birth decided to forgo future pregnancies and children due to their fear of re-occurring trauma. Similarly, Taghizadeh *et al*. (2013) reported that some of the 23 participants chose not to have more children in order to avoid the possibility of another traumatic birth experience.

3.11 Reclaiming Control and Safety

This theme highlights the importance of having autonomy and control over the birth experience, as well as the need to feel safe throughout the entire process. Women often reported feeling robbed of their autonomy and sense of safety during their traumatic birth experience. Taking back control over their pregnancy and birth, as well as enhancing their perceived sense of safety, was reflected in decision-making (Baranowska *et al.,* 2022; Bernhard *et al*., 2014; Dennis, 2015; Feeley & Thomson, 2016; Floriano *et al.,* 2023; Greenfield *et al*., 2019; Hauck *et al.*, 2007; Hollander *et al.,* 2015; Jackson *et al.*, 2020; Johanssen *et al.* 2023; Muhandule *et al.*, 2024; Rhodes, 2013; Rigg *et al.*, 2017; Sassine *et al*., 2021).

Dennis (2015) interviewed 20 women who reported a previous traumatic birth experience, 3 women made the decision to not have more children to avoid the risk of losing control in future births. Greenfield *et al.* (2019) interviewed 9 pregnant women who had previously experienced a traumatic birth, they made various plans for birth that included homebirth, freebirth, and ELCS. Although no two birth plans were alike, all the participants made birth plans to best protect their choices and sense of control (Greenfield *et al.,* 2019).

The desire for greater autonomy and a sense of safety following a traumatic birth experience motivated women across several studies to choose homebirth, freebirth, or to be cared for by an UBW (Baranowska *et al.,* 2022; Bernhard *et al*., 2014; Feeley & Thomson, 2016; Floriano *et al.,* 2023; Hollander *et al.,* 2015; Jackson *et al.*, 2020; Johanssen *et al.*, 2023; Rigg *et al.*, 2017; Sassine *et al.,* 2021). Women who experienced a loss of autonomy and feeling out of control during their hospital birth reported this as a motivating factor for choosing homebirth or freebirth (Baranowska *et al., 2022;* Bernhard *et al*., 2014; Feeley & Thomson, 2016; Floriano *et al.,* 2023; Greenfield *et al*., 2019; Hollander *et al.,* 2015). Furthermore, traumatic birth experiences made women feel their sense of physical and

psychological safety was breached (Feeley & Thomson, 2016; Hollander *et al.,* 2015; Jackson *et al.*, 2020; Rigg *et al.*, 2017; Sassine *et al*., 2021). Freebirth and homebirth, with either a RM or UBW, offered women a sense of safety that had been damaged during their previous hospital birth (Feeley & Thomson, 2016; Hollander *et al.,* 2015; Jackson *et al.*, 2020, Rigg *et al*. 2017; Sassine *et al*., 2021).

Baranowska *et al*. (2022) interviewed 12 women who had at least one planned freebirth. All the participants had a previous negative birth experience, whether in hospital or at home, which prompted them to seek alternative birth environments. They believed that medical interventions, especially in hospital, increased their risk of becoming traumatised and so they were motivated to seek alternative birth environments that increased their sense of safety (Baranowska *et al*., 2022). Many women also felt they had little influence or control over the care they received in hospital, freebirth offered them a greater sense of control (Baranowska *et al*., 2022). Similar findings were reported by Feeley and Thomson (2016), and Johanssen *et al.* (2023). Feeley and Thomson (2016) interviewed 9 multiparous women who had a planned freebirth, it offered them a sense of control and safety after a traumatic hospital birth experience. Johanssen *et al.* (2023) also interviewed 9 multiparous women who chose to freebirth, the desire to give birth in a safe home environment was a vital motivator in their decision. They reported that their freebirth made them feel in control over their birthing process (Johanssen *et al.,* 2023).

Hollander *et al.* (2015) and Jackson *et al.* (2020) interviewed a combination of 56 women who had a freebirth or homebirth in a medically high-risk pregnancy. Many participants expressed a strong need for autonomy during labour and birth (Hollander *et al.* 2015). Many had been previously traumatised by the lack of autonomy and consent from midwives and obstetricians, leading them to reject medical advice and seek an alternative birth environment (Hollander *et al.* 2015). For 26 women, hospital birth had already proven to be psychosocially dangerous and could not offer them safety (Jackson *et al.,* 2020).

Floriano *et al*. (2023) interviewed 12 multiparous women who had a planned homebirth, part of what influenced their decision was the desire to ensure autonomy and safety for themselves. Bernhard *et al.* (2014) interviewed 20 women who had a hospital birth followed by a homebirth. Many of the participant's hospital experience resulted in a loss of

autonomy and feeling disempowered (Bernhard *et al.,* 2014). The desire for greater choice and an empowering birth experience motivated their decision to choose homebirth (Bernhard *et al.,* 2014). These sentiments were echoed in the quantitative data from a survey conducted by Sassine *et al.* (2021). They surveyed 1,681 women in Australia regarding their motivations for their most recent homebirth, 69.6% (n=1,170) were motivated by the lack of informed consent in the hospital, and 67.6% (n=1,137) felt coerced by hospital staff (Sassine *et al*., 2021). In the sample, 533 (32%) reported their hospital birth as traumatic (Sassine *et al*., 2021). Of these, 236 women left comments that stated their trauma was attributed to how they were treated by hospital staff, specifically, women felt out of control as their choices were not respected or they were disrespected and bullied by staff (Sassine *et al*., 2021). Homebirth was a way to ensure autonomy and emotional safety after a traumatic hospital birth experience (Bernhard *et al.*, 2014; Floriano *et al.*, 2023; Sassine *et al*., 2021).

Rigg *et al.* (2017) interviewed five women who had a UBW. They specifically chose UBW care as it allowed them to take full control over their birth which allowed for a comfortable and undisturbed experience (Rigg *et al.,* 2017).

Muhandule *et al.* (2024) interviewed 12 multigravida women who requested an ELCS, many of whom were influenced by a previous traumatic birth. An ELCS was seen as a way to regain a sense of control during childbirth. Similarly, Hauck *et al.* (2007) interviewed 9 multiparous women, with one expressing the desire to feel more in control and mentally prepared for her next birth by opting for an ELCS. Rhodes (2013) also found that women who requested an ELCS viewed it as a safer option compared to their natural births. Across these studies, ELCS was perceived as a way to plan and prepare for birth, increasing women's sense of control after previous feelings of helplessness (Hauck *et al*., 2007; Rhodes, 2013).

3.12 Desire for a Natural Birth

A desire for a natural birth was reported as an influencing factor by women who choose to have a freebirth or a homebirth (Keedle *et al*., 2015; Lou *et al.,* 2022; Rigg *et al*., 2017; Rigg *et al*., 2020; Sassine *et al*., 2021). This desire was often a consequence of experiencing a cascade of intervention during a previous traumatic birth experience (Sassine *et al*., 2021),

or as a result of being bullied or coerced by hospital staff to accept interventions (Rigg *et al*., 2020; Sassine *et al*., 2021).

Lou *et al.* (2022) interviewed 10 multiparous women who either planned for or had a freebirth. Previous negative experiences with medicalised hospital and homebirths led participants to seek birth options that aligned with their personal birth philosophy (Lou *et al.,* 2022). In order to have a holistic natural birth experience they choose to step outside the mainstream system and have a freebirth (Lou *et al.,* 2022). Similarly, Keedle *et al.* (2015) interviewed 12 women who had a HBAC, giving birth outside the hospital seemed to be the only way to achieve their desired natural birth experience, and avoid what was perceived as un-necessary interventions.

Rigg *et al*. (2017) interviewed four UBWs, and five women who gave birth with an UBW. The authors found that most of the participants believed mainstream maternity care options were limited, inflexible, disempowering, impersonal and unsupportive of women's natural birth choices (Rigg *et al*., 2017). Their experiences with such care had left them feeling traumatised (Rigg *et al*., 2017). Many of the women researched midwifery-led care but had difficulty finding a midwife who shared the same birth philosophy, they felt these midwives provided medically dominated care and so chose to be cared for by an UBW (Rigg *et al*., 2017). Women perceived giving birth with an UBWs as their best opportunity to achieve a natural undisturbed birth (Rigg *et al*., 2017). The same authors (Rigg *et al.*, 2020) also conducted a survey to further explore why women choose to give birth with an UBW. Of the 82 women surveyed, 57 (74%) described their previous hospital birth as traumatising (Rigg *et al.*, 2020). By choosing to give birth with an UBW women were avoiding the medical model of care (n=74, 90%), the clinical environment (n=77, 94%), intervention and associated risks (n=77, 94%), hospital staff that do not support natural birth (n=77, 94%), and feeling dominated by medical staff, rules, policies, and guidelines (n=77, 94%). Furthermore, women who chose to give birth with an UBW also reported feeling pressured and coerced by homebirth midwives, whose care was ultimately governed by policies and guidelines (Rigg *et al.*, 2020). Similar findings were reported by Sassine *et al.* (2020) who conducted a survey of 1,681 women in Australia regarding their motivations for their most recent homebirth; 78.2% (n=1,315) participants were choosing to avoid a hospital

environment that does not support a normal birth, and 74.4% (n=1,251) wanted to avoid hospital staff that do not support normal birth.

3.13 Searching for Supportive Care

The final theme, 'Searching for Supportive Care' spotlights the search for improved support in subsequent pregnancies and birth and how this influences decision-making. Unsupportive, dismissive, and disrespectful care often attributed to women's perception of their birth trauma (Feeley & Thomson, 2016; Greenfield *et al.*, 2019; Rigg *et al*., 2017; Rigg *et al.*, 2020; Sassine *et al.*, 2021). In subsequent pregnancies, the search for supportive care fuelled women's decision-making with every aspect of the birthing process; the mode of birth, where they would deliver, and who would provide care (Greenfield *et al.*, 2019; Hollander *et al*., 2017; Keedle *et al.* 2015; Rigg *et al*., 2017; Rigg *et al*., 2020; Sassine *et al*., 2021).

Keedle *et al.* (2015) interviewed 12 women on their decision to have a HBAC. The majority of the sample approached the hospital to discuss their desire for a VBAC and were met with no support, and so they opted for a HBAC. Hollander *et al.* (2015) interviewed 28 women who had a freebirth or homebirth in a medically high-risk pregnancy. Participants mentioned the need to feel safe, loved and respected during their delivery, they wanted to be surrounded by people who trusted in their ability to give birth unaided, which they felt would not be possible in the mainstream system of maternity care (Hollander *et al.,* 2015). In interviews with 13 women, Rhodes (2013) reported that those who had a positive ELCS experience linked this to the support and care they received during the procedure (Rhodes, 2013).

In studies conducted by Rigg *et al*. (2017) and Rigg *et al*. (2020), women who received care from an UBW reported feeling supported, loved, and respected, which significantly enhanced their overall birthing experience. Survey data showed that by choosing to be cared for by an UBW, women were seeking continuity of care (90%, n = 74) and services that were tailored to their needs (89%, n = 73) (Rigg *et al*., 2020). Women also wanted a flexible care provider (83%, n = 68) who they could trust to support them to make informed choices (88%, n = 72) (Rigg *et al*., 2020). The results indicated that women viewed their UBW as a safety net, a trusted figure who would fully support and respect their birth choices

(96%, n = 79) (Rigg *et al*., 2020). It was clear that participants idealised this birth choice when things went well, however when women experienced poor outcomes or neglectful care, they regretted their choice (Rigg *et al*., 2020).

3.14 Methodological Issues

Hermeneutic phenomenology values different ways of knowing and understanding and so traditional quality assessment tools are not suited to this method of research as they often reflect positivist assumptions. The focus of this literature review is to understand meaning and experience rather than methodological quality. Each piece of literature contributes to the broader understanding of the phenomenon under investigation. However, validity, reliability, and generalisability of research findings are often impacted by methodological limitations. As discussed earlier in Section 3.2, there is a tension between the philosophical underpinnings of hermeneutic phenomenology and the key components of a PhD literature review. While acknowledging these methodological points, this section provides a critical synthesis examining key methodological issues identified across the included literature and their implications for interpreting research findings.

A commonly reported limitation was sample homogeneity (Allen, 1998; Dennis, 2015; Feeley & Thomson, 2016; Greenfield *et al.*, 2019; Hofberg & Brockington, 2000; Hull *et al.*, 2011; Jackson *et al.*, 2020; Klint Carlander *et al.*, 2014). Studies utilising homogeneous samples present significant interpretive challenges as it limits the generalisability of findings to broader populations. Research findings derived from demographically similar participants may fail to capture the diversity of experiences and outcomes across different groups, potentially leading to interventions or conclusions that are not universally applicable. For instance, women of a higher social economic background may not have to consider financial or resource issues when it comes to their future reproductive decisions.

Selection bias emerged as an additional sampling issue across multiple studies (Hollander *et al.*, 2017; Jackson *et al.*, 2020; Johansson *et al.*, 2023; Keedle *et al.*, 2015; Klint Carlander *et al.*, 2014; Porter *et al.*, 2006; Rigg *et al.*, 2017; Sassine *et al.*, 2021). This may occur through convenience sampling, volunteer bias, or exclusion criteria that creates unrepresentative participant pools. As a result, findings may skew toward particular

outcomes or perspectives. In the studies examining why women chose a particular mode or place of birth, those who have had traumatic experiences may be more motivated to participate. Porter *et al.* (2006) conducted a mixed-methods study to establish how mode of first birth affects women's decision-making about having another child. The authors acknowledge that interview data may be biased toward those with negative birth experiences as these participants may be seeking to share their story. The findings from studies investigating homebirth, HBAC, birth with an UBW, and freebirth may skew more positively as they rarely were able to recruit participants who had poor outcomes or a negative experience of their chosen mode or place of birth (Baranowska *et al.*, 2022; Bernhard *et al.*, 2014; Feeley & Thomson, 2016; Floriano *et al.*, 2023; Hollander *et al.*, 2017; Jackson *et al.*, 2020; Johansson *et al.*, 2023; Keedle *et al.*, 2015; Lou *et al.*, 2022; Rigg *et al.*, 2017; Sassine *et al.*, 2021).

The practice of recruiting participants from a single study site, often a hospital, introduces institutional bias into the findings (Bracken *et al.*, 2008; Canbay & Çitil, 2023; Chen *et al.*, 2022; Chong & Mongelli, 2003; Floriano *et al.*, 2023; Klint Carlander *et al.*, 2014; Turnbull *et al.*, 1999). Results may disproportionately reflect site-specific protocols, organisational culture, or regional practices rather than representing broader issues in healthcare. For example, Klint Carlander *et al.* (2014) reported no significant associations between having a subsequent child and tocophobia, concerns related to childbirth, postnatal depression or negative birth experience. However, the authors report that the study site have a birth debriefing service and tocophobia clinic, and so the findings may have been impacted by the availability of these services (Klint Carlander *et al.*, 2014). Women in Chong and Mongelli's (2003) study reported changes in preferring a vaginal birth to an elective CS after a negative vaginal birth experience. As the participants were recruited from one hospital site, their experiences and subsequent reproductive decisions may be reflective of practices in that hospitals (Chong & Mongelli, 2003). This methodological limitation necessitates caution when interpreting findings and applying them to different healthcare systems or settings.

Another significant methodological issue identified in several studies, especially those studies that reported limiting family size as a findings, was the timing of data collection (Allen, 1998; Chen *et al.*, 2022; Ghanbari-Homayi *et al.*, 2021; Joensuu *et al.*, 2023; Preis *et*

al., 2020). In many of these studies, data collection arguably occurred too soon after birth. Chen *et al.* (2022) asked women about their future reproductive decisions between 2-8 weeks postpartum. Ghanbari-Homayi *et al.* (2021) asked participants to complete questionnaires on their attitudes towards future birth at 1-4 weeks postpartum. Participants' views may evolve substantially over time as they process their experiences, especially if they experience birth trauma. This suggests that findings representing early postpartum perspectives should be interpreted as potentially evolving rather than definitive.

Quantitative approaches, while valuable for identifying patterns and associations, inherently limit the ability to capture the nuances of lived experiences and contextual influences. The quantification of complex phenomena may result in the exclusion of factors that may significantly impact outcomes. This methodological limitation requires interpretive caution, particularly when quantitative findings contradict qualitative insights or lived experiences (nevertheless the opposite can also be argued).

3.15 Summary and Conclusions

The aim of this chapter was to review the literature pertaining to future-reproductive decisions after birth-related trauma and present the relevant findings. This review included a total of forty-seven studies employing qualitative, quantitative and mixed-method designs. Six reproductive decisions were identified and explored in section one of this review; 'Elective Caesarean Section', 'Limiting Family Size', 'Delaying Subsequent Pregnancies and Births', 'Homebirth with a Registered Midwife', 'Homebirth with an Unregulated Birth Worker', and 'Freebirth'. These reproductive decisions were identified in the literature as being directly influenced by birth-related trauma. Section two aimed to further contextualise decision-making resulting in four themes; 'Fear and Lingering Trauma', 'Reclaiming Control and Safety', 'Desire for a Natural Birth', and 'Searching for Support'.

Elective caesarean section was the most frequently reported reproductive decision. It can be hypothesised that this is due to the extensive research that focuses on investigating what influences women to opt for ELCS, as well as it being an easily accessible birth option in high income countries. Only one of the studies included participants based in Ireland as Weaver *et al*. (2007) interviewed and surveyed a sample of obstetricians who worked in

Ireland. Their findings did report a relationship between birth trauma and maternal request for ELCS (Weaver *et al.,* 2007). Anecdotally, I can also confirm from working in an Irish maternity hospital that sees some 8,500 births per year, that women do request and have ELCS due to previous birth-related trauma.

Homebirth with a registered midwife after a previous birth trauma was reported in eight studies. They were conducted in Australia, Brazil, the Netherlands, the United Kingdom, and the United States of America. The searches could not locate any research that investigated what influences women in Ireland to have a homebirth with a RM. Between 2018 and 2020, 848 women registered for a homebirth in Ireland, and 489 of these ultimately gave birth at home (San Lázaro Campillo *et al*., 2022). This results in an average of 0.275% of total homebirths in Ireland per year from 2018 to 2020 (San Lázaro Campillo *et al.*, 2022). Homebirth is a restricted service in Ireland, it is not available nationwide and only caters to a very specific low obstetric risk population (Gregory *et al*., 2023). Indeed, it has been argued that Ireland uses overly strict criteria for assessing obstetric risk for publicly funded homebirth in comparison to other countries (Gregory *et al.*, 2023; OBoyle, 2014). It is not possible to say from the results of this review whether women in Ireland are influenced to have a homebirth with a RM due to previous birth-related trauma, however it is evident this occurs in other territories.

A combination of eleven studies reported on freebirth or birth with an unregulated birth worker. All the studies reporting on UBWs were conducted within Australia. Both are controversial topics in mainstream discourse, and in some jurisdictions, they may entail legal ramifications. These issues may present challenges in recruiting participants to research exploring freebirth or the use of UBWs. In Ireland, there are currently no publicly available figures on freebirth or the use of UBWs.

Fifteen studies reported on the relationship between birth-related trauma and limiting family size. Two of the studies found no significant association between birth experience and either fertility desires or realised future reproduction, whereas ten studies reported findings that supported the relationship. However, despite there being research demonstrating that birth-related trauma can influence on the decision to limit family size, the evidence base is relatively thin. Furthermore, there were no studies located that solely

focused on exploring this phenomenon. Instead, it was observed in quantitative research or briefly discussed in qualitative interviews. These studies confirm that birth trauma does impact on individual's decision to limit their family size, however there are no studies documenting the lived experience of this phenomenon and so little is known about the decision-making process. There is a clear gap in the national and international literature on in-depth investigations on the relationship between birth-related trauma and limiting family size.

In summary, this literature review provides a thorough and contextual understanding of reproductive decisions made after experiencing birth-related trauma. It provides a foundation to base this piece of research upon. This review's findings demonstrate multiple gaps in the evidence base, particularly concerning research in Ireland. By connecting the findings to this study's aims, this research will explore the relationship between birth-related trauma and the decision to have less children than originally desired. Specifically, the aim of this study is to develop an in-depth understanding of the lived experience of limiting family size to less than desired as a result of birth-related trauma.

The following chapter will outline the philosophical grounding and methodological approach utilised in this research. The chapter starts with a discussion on ontology, epistemology, and paradigm. The chapter is then divided into two sections: the first outlines the philosophical foundations of hermeneutic phenomenology, while the second focuses on its application as a research method.

Chapter 4: Philosophical Grounding and Methodological Approach

4.1 Introduction

This chapter delves into the philosophical and methodological framework of hermeneutic phenomenological research. Hermeneutic phenomenology emerged as a philosophical movement which was then adopted as a methodology and applied to research. As a methodology, hermeneutic phenomenology is a qualitative research approach that seeks to uncover meaning in phenomena with the purpose of understanding human experiences (Crist & Tanner, 2003). At its core is the application of philosophical notions that underpin methodological decisions, but also reveal phenomena and illuminate findings (Crowther & Thomson, 2023) . This study is underpinned by the philosophy of Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002), both of whom will be discussed throughout this chapter.

The purpose of this chapter is to situate the theoretical, philosophical and methodological positions that frame this study. I first outline my ontological and epistemological stances, followed by situating the research within the interpretivist paradigm. The chapter is then broken into two sections to discuss hermeneutic phenomenology in relation to both its philosophical origins and its application as a research method. Section one discusses the philosophical field of both hermeneutics and phenomenology, including the key thinkers connected to this study's philosophical underpinnings. Section two addresses the methodological concerns, more specifically, qualities of hermeneutic phenomenological research, its application to midwifery research, and why this methodology was chosen. The chapter concludes with how the philosophical concepts discussed throughout are linked to and underpin the research.

4.2 Adopting a Qualitative Research Approach

This study has adopted a qualitative research approach which seeks to "discover and to describe narratively what particular people do in their everyday lives and what their actions mean to them" (Erickson, 2018, p.87). Qualitative research tends to be holistic, focusing on understanding the whole, and often requires researchers to be deeply engaged in the process (Polit & Beck, 2017). It allows researchers to pose questions that are difficult or

impossible to ask and answer with a quantitative approach (Hesse-Biber, 2017). There is a plethora of approaches to qualitative research, encompassing multiple epistemological positions, theoretical frameworks, and methodologies (Hesse-Biber & Leavy, 2004).

A qualitative approach was chosen for this study based on its capacity to explore a topic with limited prior knowledge, gather in-depth descriptive data, consider contextual factors, and seek meaning in lived experience (Liamputtong, 2019; Polit & Beck, 2017). As highlighted in the literature review, there is a scarcity of research on the relationship between traumatic birth experiences and the decision to limit family size. It appears as an incidental finding in qualitative research, or emerges as patterns and correlations in quantitative research. However there have been no published studies to-date specifically exploring this phenomenon, and so little is known about this experience. According to Creswell and Poth (2018), qualitative research is adopted when there is a necessity to explore a problem or an issue. As there is a deficit in research on this particular phenomenon, qualitative methods of research fits the purpose of exploring this topic further. It also facilitates researchers in gathering rich descriptions of participant's lived experiences (Liamputtong, 2019), which is particularly valuable considering the paucity of knowledge on this phenomenon. Furthermore, qualitative researchers considers the context in which events unfold and appreciates that people are living in dynamic and complex social arrangements (Rogers, 2000). Context refers to the surrounding environment, circumstances, and culture that influences individuals, groups, organisations, or systems of interest (Patton, 2015). Participant's lives unfold within larger contexts (Patton, 2015) which ultimately contributes to how they perceive and make meaning of their experiences. Context is central to both qualitative inquiry and analysis, as attention is given to the nuances of culture, history, politics, and institutions (Patton, 2015). A criticism of quantitative research is its reliance on measurable variables, often neglecting social and cultural context (Grix, 2010). Broad consensus exists in the literature that the circumstances of women's lives, and the system of care in which women give birth, plays a significant role in the experience of traumatic childbirth. To ignore or to diminish these important contextual factors would result in only uncovering a small portion of the lived experience. As a final point, qualitative inquiry is interested in how individuals make sense of their world and lived experiences (Merriam & Tisdell, 2015). It can illuminate the meaning people

attribute to their experiences, something that cannot be done in quantitative research (Patton, 2015).

4.3 Ontological and Epistemological Foundation

Ontology and epistemology, two branches of philosophy, are important to the conduct of research in the social sciences (Crotty, 1998). Ontology is a branch of metaphysics that is concerned with the nature of being and questions what constitutes reality (Hathcoat *et al*., 2019). Understanding one's ontological position when designing and conducting research is crucial as it influences the search for understanding (Creswell, 2014). Epistemology is the theory of knowledge, it considers assumptions on the nature of knowledge, and ways of acquiring and gathering knowledge (Holloway, 1997). Simply put, epistemology asks how can we know what we know (Hesse-Biber & Leavy, 2004)? One's epistemological position shapes the methods chosen to answer a research question and explicate understanding (Creswell, 2014). Ontology and epistemology are intertwined and, according to some, inseparable as to talk of meaning is to talk of meaningful reality (Crotty, 1998).

I have adopted critical realism as my ontological position to conduct this research. Philosophical debates on ontology centre on the dichotomy between realism and relativism (Hathcoat *et al*., 2019; Moon & Blackman, 2014). Realist ontology posits that one single reality exists independent from the human experience, and that it can be studied and understood as an objective truth (Moses & Knutsen, 2012). On the other hand, relativism proposes that no one true reality exists and that it is a human construct, therefore reality is relative according to each individual who experiences it at a given time and place (Moon & Blackman, 2014). Relativism may seem like an appropriate fit for a research project investigating experience, however ontologically this study recognises the world as a real entity regardless of experience. Critical realism agrees that reality exists independently of human perception; however, it recognises that our understanding of reality is mediated by our perceptions, interpretations, and social contexts (Bhaskar, 2008). For example, an apple can be broken down to its cellular components and measured in accordance with its nutritional value, it has an existence as an objective real entity. Two individuals may experience the apple in different ways, one may think it tastes good, whereas the other says it is too sour. These individuals are experiencing the apple differently; however, they have some sort of agreement on what the apple is and its existence in the real world. In

adopting a critical realist ontology, one recognises there is an external reality that can be studied through scientific and philosophical research, as well as acknowledging that individuals can experience the same phenomenon in different ways.

The breadth of epistemology is extensive and widely debated in the literature. To provide guidance to researchers within the social sciences, Crotty (1998) provides a succinct framework which outlines three epistemological stances; objectivism, constructionism, and subjectivism. Within the interpretivist paradigm, the epistemological stance emphasizes both subjectivity and intersubjectivity (Weaver & Olson, 2006). This study embraces a constructivist perspective on epistemology. Objectivism posits that meaning exists independent of human consciousness (Crotty, 1998), therefore phenomena have independent meaning which can be discovered through research (Scotland, 2012). Constructionism rejects that there is objective meaning to be discovered, instead meaning exist as a result of human engagement with reality (Crotty, 1998). The constructionist viewpoint does not outright deny the existence of a world independent of the mind, but rather argues that the meaning of the world is influenced by cultural, social, historical and political contexts (Hathcoat *et al*., 2019). Every individual may construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998). The recognition of multiple co-existing meanings in relation to the same phenomenon is vital to the epistemological perspective of this study.

4.4 The Interpretivist Paradigm

This study and its methodology are located within the interpretivist paradigm. A paradigm can be described as a set of basic beliefs that relate to one's worldview and represents the nature of the world, an individual's place in it, and the range of possible relationships to that world and its parts (Guba & Lincoln, 1994). Paradigms are characterised by ontological, epistemological and methodological differences in the approach to conceptualising and conducting research (Weaver & Olson, 2006). An important initial task in planning and designing a study, is to align the project with a paradigm and methodology that can best answer the research question (Welford *et al*., 2011). When researchers overlook or neglect to understand and recognise the principles and assumptions inherent to their discipline, it may jeopardise the integrity and the validity of their research design (Moon & Blackman, 2014).

Grix (2010) describes three general paradigms that underpin research within the social and human sciences; positivism, post-positivism and interpretivism. While Denzin and Lincoln (2018) describe six paradigms; constructivism, interpretivism, feminism, positivism, post-positivism and critical theory. Although there are numerous recognised research paradigms their categorisation is somewhat ill-defined, leading to contradictions in the literature (Kelly *et al*., 2018). In terms of similarities and differences, positivism and interpretivism are at opposite ends of the spectrum. Positivism focuses on achieving objectivity and attempts to provide explanations, while interpretivism champions subjectivity and seeks to interpret or understand (Grix, 2010; Kelly *et al*., 2018). The interpretivist tradition challenges the suitability of applying these positivist scientific methods to the study of social reality (Hesse-Biber & Leavy, 2004), and argues that the social world should be studied with different methods of inquiry (Grix, 2010). Interpretivist research focuses on culturally derived and historically situated interpretations of human and social reality (Crotty, 1998). It is based on the understanding that truth is not singular but rather consists of multiple realities that are holistic, local, and context-specific (Ford-Gilboe et al., 1995). The goal of research within this paradigm is to achieve understanding as opposed to explanation (Grix, 2010). Meaning is not pre-existing but is constructed through the interaction between the researcher and participants, occurring within the natural environment where the phenomena take place (Ford-Gilboe et al., 1995; Guba & Lincoln, 1994; Hinshaw, 1999). This interactive process allows for a deeper exploration of how individuals perceive and interpret their experiences. Denscombe (2002) summarises interpretivist research as follows;

> *The interpretivist's concern with subjectivity, with understandings, with agency and the way people construct their social world, introduces complexities that involve elements of uncertainty. There is even the possibility of contradictions and internal inconsistencies arising as part of the explanations that interpretivist produce.* (Denscombe, 2002, p. 21-2)

Interpretivism also recognises that achieving an entirely objective or value-free analysis is impossible (Grix, 2010). Knowledge is inherently shaped by theoretical and discursive influences, and researchers themselves inevitably bring their own opinions, attitudes and values to their work (Grix, 2010). Interpretivism can be criticised for this lack of objectivity, which some argue leads to researcher bias and a lack of generalisability. Later in this

chapter, the management of researcher bias and the challenge of objectivity will be thoroughly addressed throughout the discussion on methodology. Furthermore, multiple interpretations of the same phenomenon are possible due to the nature of the paradigm. This reduces the explanatory power of this type of research (Berger & Luckmann, 1990), however as stated previously, explanation is not the goal of research within the interpretive paradigm.

4.5 Hermeneutic Phenomenology: Philosophical Movement and Research Method

The tradition of phenomenological research is founded in the philosophical school of phenomenology (Kafle, 2011). Although the philosophical and methodological fields of phenomenology are separate disciplines, they are intimately intertwined as the philosophical tradition provides a framework for the methodological movement. The distinction between philosophy and method can cause confusion to those new to phenomenology, especially as the philosophical tradition features so heavily in the methodological movement. Furthermore, in some nursing research, there is a false assumption that all phenomenology is grounded in the same philosophy (Koch, 1995). There are decisive differences between Husserlian transcendental phenomenology and Heideggerian hermeneutic phenomenology (Koch, 1995). It is imperative that the chosen phenomenology aligns with and reflects the core philosophy throughout the course of the research (Osborne, 1994). Failure to distinguish between the underpinning philosophy and method of phenomenology leads to method slurring and poorly conducted research.

This research is situated within the hermeneutic phenomenological tradition and underpinned by the philosophy of both Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002). These thinkers did not create methodology for applied research, instead researchers draw upon their ideas to guide their methodological and analytical decisions. To undertake this form of inquiry, researchers are advised to initiate their endeavour by aligning themselves with the ontological aspects of this methodology through active engagement with the underpinning philosophy (Crowther & Thomson, 2023). The following section of this chapter delves into the development of hermeneutics and phenomenology as separate schools of philosophy, before being merged by Heidegger into hermeneutic phenomenology.

Section One: Philosophical Movement

4.6 Introduction to Hermeneutics

The following section provides a brief introduction to the hermeneutic movement. It is included in this chapter to highlight the contributions of various thinkers to the field, its development over time, and the range of different perspectives within it. Since the 17th century, hermeneutics has referred to the science or art of interpretation (Grondin, 1994). The word hermeneutics derives from the Greek word *hermeneuein* which means 'to interpret' or 'to understand' (Crotty, 1998), and the noun *hermeneia* meaning 'interpretation' (Palmer, 1969). Interpretation is "the most basic act of human thinking...existing itself may be said to be a constant process of interpretation" (Palmer, 1969, p. 8-9).

Theories of interpretation date back to antiquity (Blaikie, 2007); however, the earliest use of hermeneutics in the 17th century was in the context of biblical interpretation (Crotty, 1998). Throughout the historical development of hermeneutics, two separate foci have emerged; the theory of understanding and the exegesis of linguistic texts (Palmer, 1969). Although they are not completely independent of each other, it is best to understand them separately as one informs the other (Palmer, 1969). As outlined by Palmer (1969), the field has since evolved into six distinct areas; the theory of biblical exegesis, general philological methodology; the science of all linguistic understanding, the methodological foundation of *Geisteswissenschaften* (human sciences), phenomenology of existence and of existential understanding, and the systems of interpretation, both recollective and iconoclastic, used by man to reach the meaning behind myths and symbols.

Although many thinkers have contributed to the development of hermeneutics, Friedrich Schleiermacher (1768-1834) and Wilhelm Dilthey (1833-1911) are central to the development of modern hermeneutics. Given that their ideas and philosophy were not employed as the foundation for this study's methodology, a comprehensive and extensive discussion of their work is beyond the scope of this thesis. Instead, their main contributions to hermeneutics will be outlined to narrate the development of modern hermeneutics.

Friedrich Schleiermacher provided the foundation for modern hermeneutics (Blaikie, 2007). Schleiermacher's fundamental aim was to develop a general hermeneutics as the art of understanding (Palmer, 1969). He proposed a universal hermeneutics that was applicable to all texts, whether they are religious scripture, legal documents, or literary works (George, 2021). Schleiermacher's hermeneutics is multifaceted but tied to the idea that understanding and interpretation have two dimensions, grammatical and psychological (Blaikie, 2007; George, 2021). The grammatical is concerned with the linguistic aspect of understanding (Blaikie, 2007), such as syntax and use of language. Grammatical interpretation involves understanding the meanings as commonly used (Lawn, 2006). Psychological interpretation refers to the contribution of the individual author's mind, for instance, linguistic expression that would be associated with their style (George, 2021). Psychological interpretation attempts to understand the underlying nuances in the text that grammatical interpretation cannot capture, for example, humour, irony, sincerity or resentment (Lawn, 2006). Psychological interpretation involves the reader attempting to place themself in the mind of the author and reconstruct the creative act that produced the text (Blaikie, 2007).

The hermeneutic circle, a fundamental concept in hermeneutics, represents the process of understanding and interpretation. The circle invokes the idea that understanding as a whole is possible by reference to the individual parts, and the individual parts are understood within the context of the whole. The circle as a whole is defined by the individual parts, and the individual parts form the circle (Palmer, 1969). For example, when reading, we understand the meaning of a word in reference to the sentence, while the meaning of the sentence depends on the individual words (Palmer, 1969). Although the idea of the hermeneutic circle dates back to antiquity (George, 2021), Schleiermacher emphasised its importance making it a central concept in his theory of interpretation (Lawn, 2006). Schleiermacher writes that understanding is two-fold, understanding the unity of the whole by the individual parts, and the value of the individual parts in the context of the whole (Lawn, 2006). Understanding is not a vertical endeavour where beliefs are layered on top of a foundation, instead it is a circular movement back and forth between our pre-understandings and new discoveries (George, 2021).

After Schleiermacher, the most significant figure in the development of hermeneutics is Wilhelm Dilthey, a German philosopher and social thinker (Lawn, 2006). Dilthey aimed to establish hermeneutics as the foundation of *Geisteswissenschaften*, and to develop a method that would guarantee objectivity and validity (Palmer, 1969; Blaikie, 2007). *Geisteswissenschaften* is a German term that refers to the humanities and social sciences (Makkreel, 2021), disciplines whose topics and methodologies are different to those of the natural sciences. Dilthey distinguished between the natural and human sciences, rejecting the methods of the natural sciences as being inappropriate for the humanities (Blaikie, 2007). The main task of the natural sciences is to establish law-based causal explanations, whereas the human sciences look to provide an understanding of the structures and forces of human and historical life (Makkreel, 2021). Dilthey asserts that the purpose of the human sciences is to understand lived experiences, and that understanding can be achieved through interpretation (George, 2021), and that only by developing a methodology of their own could the human sciences achieve epistemological legitimisation (Grondin, 1994).

Lawn (2006) argues that Dilthey's most significant contribution to hermeneutics was his position on historicality. In this context, historicality refers to the assumption that meaning is horizontal, stretching into both the past and future (Palmer, 1969). Human's depend on history for self-understanding and self-interpretation, our history is inescapable and understanding is intrinsically temporal in nature (Palmer, 1969). The foundation for understanding human-beings lies in life itself, that is social and historical life (Blaikie, 2007). Hermeneutic understanding of the present is inextricably linked to the past, evoking the hermeneutic circle (Lawn, 2006), a concept adopted by Dilthey from Schleiermacher (Palmer 1969). Dilthey's work on historicity and hermeneutics influences both Heidegger and Gadamer (Lawn, 2006; Makkreel, 2021). Although criticised by both thinkers, his work laid the foundations for Heidegger's work on the temporality of self-understanding (Palmer, 1969). Dilthey was firm in his conviction to develop a universal method for the human sciences and believed that achieving objectively valid knowledge in the human sciences was possible (Lawn, 2006).

The ideas of Heidegger and Gadamer advanced contemporary hermeneutics beyond its traditional role as a science of literary interpretation or as a methodology confined to the humanities. The philosophical contributions of Heidegger and Gadamer will be explored

with more depth in subsequent sections of this chapter, but for the purposes of this section, a brief summary of their role in the development of hermeneutics will be outlined. Heidegger's work was concerned with the question of human existence, and posited that to explore existence, one must begin with a hermeneutic examination of the sense that human beings can be said to exist (George, 2021; Heidegger, 1962). In this context, hermeneutics refers to the phenomenological analysis of human existence itself (Palmer, 1969). Under Heidegger's influence, contemporary hermeneutics diverges from its modern historical roots with his reinterpretation of hermeneutics as a phenomenological investigation of human existence (George, 2021). Influenced by Heidegger's contribution to hermeneutics, Gadamer developed philosophical hermeneutics, a more general procedure for understanding that is characterised by the hermeneutic circle (Lawn, 2006). For Gadamer, all understanding is hermeneutical and all acts of interpretation are dialogical (Gadamer, 2004; Lawn, 2006). Gadamer's philosophical hermeneutics centres on an experience of truth that transcends the confines of scientific method (George, 2021). Gadamer maintains that hermeneutics is central to all forms of understanding, which serves as a radical rebuttal to a worldview governed solely by method (Lawn, 2006).

Originating as the art of biblical interpretation, hermeneutics has evolved beyond comprehending texts to encompass the nature of understanding itself (Palmer, 1969).

4.7 Introduction to Phenomenology

In philosophy, phenomenology is the study of structures of consciousness as experienced through the individual point of view (Smith, 2018). The term is derived from the Greek *phainomena* and *logos* (Gearing, 2004). *Phainomena* means appearance and, within the context of phenomenology, *logos* is translated to mean reason (*logos* is a polysemic word with multitude translations) (Gearing, 2004; Inwood, 1999). Phenomenology has been practiced in various forms throughout history; however, it reached its pinnacle in the early 20th century in the works of Edmund Husserl, Martin Heidegger, and Maurice Merleau-Ponty (Smith, 2018). Other notable thinkers associated with phenomenology are Franz Brentano, Hans-Georg Gadamer, Hannah Arendt, Emmanuel Levinas, John-Paul Sartre, and Jacques Derrida (Moran, 2000). While by no means is this a comprehensive list, it serves to illustrate the multitude of thinkers that have contributed to the field.

The following section will discuss some of the philosophical teachings attributed to Husserl, Heidegger, and Gadamer. Husserl is consider the father of phenomenology, and as the field developed from his initial ideas, an overview of his phenomenology will be discussed in order to situate the development of this philosophical field. Additionally, given that some phenomenological research draws on Husserl's concepts, understanding his perspective is useful for discerning the methodological distinctions among the varied phenomenological approaches used in research. A discussion on Heidegger's hermeneutic phenomenology will then follow, delving deeper into several of his key philosophical concepts. To conclude this section, Gadamer and his conception of philosophical hermeneutics, prejudice, the hermeneutic circle, and the fusion of horizons will be considered.

4.8 Husserlian Transcendental Phenomenology

Edmund Husserl (1859-1938), an Austrian-German philosopher and mathematician, is credited as the principal founder of phenomenology (Beyer, 2022). In the first decade of the 20th century, Husserl significantly refined his method into what he termed transcendental phenomenology (Beyer, 2022). Husserl's phenomenology developed as a reaction to the methods of empirical sciences being used in psychology and the social sciences (Blaikie, 2007). Despite their objective nature and framework, the empirical sciences lacked the capacity to uncover phenomenological meaning in lived experiences (Moran, 2000). Husserl rejected the idea that the world could be interpreted purely through scientific endeavours, as they produced artificial, superficial and decontextualised findings (Crowther & Thomson, 2023; Fleming *et al*., 2003).

The aim of Husserl's phenomenology is to undertake a rigorous and unbiased study of things as they appear in the world in order to achieve an essential understanding of experience and consciousness (Valle *et al.,* 1989). His philosophical approach brings attention to the essential structures that are usually taken-for-granted so they can establish themselves within consciousness (Beyer, 2022). In simple terms, Husserlian phenomenology seeks to uncover the essence and meaning of lived experience and study phenomena as they appear through consciousness (Koch, 1996; Laverty, 2003). At the core of this philosophical approach as discussed is the fundamental recognition that experience is the ultimate ground and meaning of knowledge (Koch, 1995). Husserl's work was positivist in nature (Dowling, 2007), and followed a traditional scientific approach that

demanded neutrality and objectivity (Fleming *et al*., 2003). His phenomenology is epistemological, asking epistemological questions of knowing and the conscious mind (Dibley *et al.*, 2020; Koch, 1995).

Husserl argued that we should " 'go back to the things themselves', the 'thing' being the content of conscious experience" (Smith *et al.*, 2009, p. 12). Understanding 'the things themselves' means delving into the essence of experience itself. Through careful and comprehensive examination of the 'things', we can uncover the meaning of lived experiences (Dibley *et al*., 2020). *Lebenswelt* (life-world) is an essential concept to Husserlian phenomenology (Dahlberg, 2011; Koch, 1996). *Lebenswelt* is what individuals experience pre-reflectively, without interpretation (Dowling, 2007; Husserl, 1970). It encompasses our immediate surroundings, social interactions, cultural norms, and the objects we encounter in our daily lives. The life-world is often disregarded and taken-for-granted, forming a backdrop to our conscious awareness (Dahlberg, 2011; Smith *et al*., 2009). This taken-for-granted manner in which we encounter our everyday is referred to as the *natural attitude*. The *natural attitude* means we do not question our perceptions and interactions with the world. Husserl's phenomenological method involves moving beyond the *natural attitude* in order to examine our everyday lived experiences and essential structures of consciousness (Smith *et al*., 2009). "To go back to the things themselves" involves breaking from the *natural attitude* and adopting the *phenomenological attitude* (Dowling, 2011, p.57).

The *phenomenological attitude* is an attempt to approach the world with fresh eyes by setting aside all prior assumptions and beliefs, it employs a reflexive stance while simultaneously suspending all pre-understandings (Dowling, 2011). Husserlian phenomenology encourages us to focus on our lived experiences exactly as we experienced them, while setting aside any interpretations of our experiences or how they relate to the goings-on in the world (Cerbone, 2008). *Epoché*, bracketing, and phenomenological reduction refer to the reflective process in which one puts aside all prior understanding of a phenomenon and goes directly back to the experience of that phenomena (Dibley *et al*., 2020). It is through *epoché* that one can describe an experience in its purest form, exactly how it is, thus revealing its essential structures (Cerbone, 2008). The essence of a phenomena can emerge when subjective perspectives and theoretical constructs are

suspended (Beyer, 2022). According to Husserl, this is fundamental to the practice of phenomenology (Cerbone, 2008).

4.9 Heideggerian Hermeneutic Phenomenology

Martin Heidegger (1889-1976) was a German philosopher and is considered to be one of the most influential thinkers of the 20th century. Published in 1927, his magnus opus *Being and Time* is one of the most significant texts in modern European philosophy (Wheeler, 2020). Husserl was Heidegger's mentor and teacher at Freiburg university, his work had a significant influence on the development of Heideggerian phenomenology and although Heidegger's work was critical of Husserl's transcendental phenomenology, *Being and Time* was dedicated to Husserl (Dowling, 2007; Wheeler, 2020). At the core of Heidegger's philosophy was his quest to understanding the nature of being, which he argued had been neglected by Western philosophy (Smith *et al*., 2009). His objective was to grasp the fundamental ways in which human beings understand, make sense, and be in the world with objects and other people. Heidegger does this by undertaking a phenomenological study of being.

Heidegger's work was originally written in German, and so English speakers are reliant on translations of the original text. Although translators strive to capture the author's unique voice and their intended emphasis and flow, translations may result in a loss of linguistic nuances or altered meanings. This is exemplified with Heidegger's work as he invented new terms and used compounded phrases to describe his philosophy (Wheeler, 2020), making translating his work a difficult endeavour. Furthermore, Heidegger's work is widely considered notoriously difficult to read. Given that my academic background is not grounded in philosophy, grappling with these texts posed a considerable challenge. I relied on secondary texts and commentaries in order to comprehend and interpret Heidegger's work, and I appreciate this ultimately influences my overall understanding of his writings.

Drawing on the phenomenological methods of Husserl, Heidegger proposed using phenomenology to investigate what it means to be (Cerbone, 2008). In *Being and Time*, Heidegger redefines phenomenology and provides a detailed discussion on the aetiological exploration of the term. As previously explained, phenomenology is broken into its two Greek constituents, *Phainomenon* and *logos*. For Heidegger, *Phainomenon* is "what shows

itself in itself" (Inwood, 1999, p. 159). *Logos* can be translated as "reason, judgement, concept, definition, ground, relation". However, within this context, its primary meaning is "making manifest" (Inwood, 1999, p.159). *Phainomenon* and *logos* are then combined as phenomenology to mean "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1962, p.58; Inwood, 1999).

Heidegger's phenomenological inquiry is ontological in nature, ontological inquiry concerns itself with what it means to be (Van Manen, 1997). Heidegger refers to ontology as the phenomenology of being and declares "the task of ontology is to explain Being itself and to make the Being of entities stand out in full relief" (Heidegger, 1962, p.49). This distinctly contrasts Husserl's epistemological approach to phenomenology. Husserlian phenomenology asks epistemological questions of knowing, focusing on a way of knowing and understanding, whereas Heideggerian phenomenology asks questions of the meaning of being (Koch, 1995; Laverty, 2003).

Heidegger's phenomenology is an interpretation of experience and an exploration of the meaning of being (Cerbone, 2008; Horrigan-Kelly *et al*., 2016; Moran, 2000). The goal of phenomenology is to examine what is implicit in understanding through analysing our interactions with the world and others (Cerbone, 2008). According to Heidegger (1962), a comprehensive picture of human beings must start with an exploration of our ordinary existence in the world and our everyday interactions. Heidegger united phenomenology with hermeneutics, his phenomenological study of Being is presented as the "hermeneutic of *Dasein*" (Heidegger, 1962, p. 62; Palmer, 1969). Heidegger asserts that understanding and interpretation constitute foundational modes of existence for human beings (Palmer, 1969). Furthermore, phenomenology is hermeneutics as it is an interpretation of Being (Wheeler, 2020). Heidegger's inquiry is both methodologically and thematically rooted in hermeneutics (Palmer, 1969). The phenomenological approach articulated by Heidegger in *Being and Time* is occasionally referred to as hermeneutic phenomenology (Palmer, 1969).

Heidegger describes a phenomenon as "that which shows itself in itself, the manifest" (Heidegger, 1962, p. 51). Crowther & Thomson (2023) explain that phenomena are hidden, forgotten, or even disguised, they are taken-for-granted and go unnoticed in everyday lived experience. Phenomena exist in this way not because they are undiscovered, but because

they are too familiar to us to notice or are hidden under traditional concepts or ideals (Inwood, 1999). Phenomena can show themselves in many ways, depending on what kind of access we have to it (Heidegger, 1962). Heidegger uses three terms to help define the ways in which phenomena present themselves; announcement, appearance, and semblance. Phenomena can *announce* themselves directly to us, they tell us exactly what they are. For example, an ultrasound announces a pregnancy, it shows us a picture of the fetus. *Appearance* refers to the way a phenomenon may show itself through another means (Heidegger, 1962), for instance, measles appear through pock marks (Inwood, 1999). A pregnancy may appear through nausea and vomiting, it is making itself known through the appearance of another phenomenon. *Semblance* occurs when a phenomenon "shows itself as something which it is not" (Heidegger, 1962, p. 51), it is an illusion or distortion. A woman may believe she is pregnant due to nausea and vomiting, however she is really ill from food poisoning. While a phenomenon is never entirely disclosed, embracing a phenomenological attitude allows for its unconcealment and illumination (Crowther & Thomson, 2023). For researchers using hermeneutic phenomenology, the objective is to elucidate the phenomenon of interest and bring it into language (Crowther & Thomson, 2023).

4.9.1 Heidegger's Concept of *Dasein* & *Being-in-the-world*

To carry out a fundamental ontology and thus answer the question of the meaning of being, Heidegger introduced the concept of *Dasein* (Wheeler, 2020). Literally translated, *Dasein* means 'being-there'. It is used by Heidegger to highlight the distinct and unique mode of being by which human beings exist (Wheeler, 2020). Heidegger wanted to avoid using terms that had pre-existing connotations attached to them, such as human being or homo sapiens, as they may mislead or distract the reader (Cerbone, 2008).

In the introduction of Being and Time, Heidegger writes "*Understanding of Being is itself a definite characteristic of Dasein's Being.* Dasein is ontically distinctive in that it is ontological" (Heidegger, 1962, p. 32, italics in original). To say *Dasein* is ontological is to say that *Dasein* questions what is means to be (Wheeler, 2020). Human beings are uniquely placed as *Dasein* as they are aware of their own existence, and ask questions on the meaning of being (Cerbone, 2008). *Dasein*'s primary endeavour is their exploration of being, particularly their capacity to question and focus on personal existence (Horrigan-

Kelly *et al.,* 2016). *Dasein* operate within their everyday world with an understanding of being, although often in a pre-ontological state (Wheeler, 2020).

Heidegger uses the concept of *Being-in-the-world* to describe the inseparability of *Dasein* and the world. Heidegger explains that *Being-in-the-world* is a "*unitary* phenomenon" which "must be seen as a whole" (Heidegger, 1962, p. 78; Horrigan-Kelly *et al.,* 2016). As *Dasein* we are always 'there', we are always existing and so there is always a world in which we exist. As Thomson (2011) explains, our 'there' is so essential that there is no 'being-there' without a world to exist within. *Dasein* are always immersed and interconnected to their lifeworld and so *Being-in-the-world* is the foundational state of Dasein (Crowther & Thomson, 2023; Wheeler, 2020). By presenting *Dasein'*s foundational state as *Being-in-the-world*, Heidegger highlights the inseparability of humans and their lifeworld. The world itself is part of the fabric of human existence and what is means to be human, as *Dasein* we are our world (Critchley, 2009). The world is not merely a backdrop to human existence and understanding, but an integral part to that existence and understanding.

According to Heidegger, the ability to understand the world from a particular perspective is made possible by *Dasein's Being-in-the-World* and historicity (Heidegger, 1962). As Laverty (2003) explains, Heidegger does not view consciousness as separate from the world but as a formation of historically lived experience. *Dasein*'s understanding of their being and the being of others is formed through their ordinary everyday interactions and serves as a starting point for *Dasein*'s investigation of being (Cerbone, 2008; Heidegger, 1962; Horrigan-Kelly *et al.*, 2016).

In presenting being and understanding as inseparable from the world, Heidegger challenged Husserl's method of bracketing and phenomenological reduction. Human beings cannot separate themselves from their world and still retain an understanding of being (Cerbone, 2008). From a Heideggerian perspective bracketing is unattainable, it is impossible to position oneself outside the pre-existing understandings and historical context of one's own experiences (Laverty, 2003).

4.9.2 Heidegger's Concept of Thrownness

Heidegger introduced the concept of thrownness to describe how *Dasein* finds themselves thrust into the world without having chosen the circumstances of their existence. "As something thrown, *Dasein* has been thrown into existence. It exists as an entity which has to be as it is and as it can be" (Heidegger, 1962, p.321). Thrownness is a basic characteristic of *Dasein*, as human beings we find ourselves in a predetermined historical, cultural, and social context (Healy, 2011). *Dasein* is always already in a world (Horrigan-Kelly *et al.,* 2016). However thrownness encompasses more than just situatedness. As Dibley (2023) explains, our thrownness into a certain place, space and time, establishes us on a path where our past continually lies ahead of us. *Dasein*'s historicity provides a point of origin and future trajectory (Dibley, 2023). Heidegger's notion of thrownness is complex, it relates to the care structure which is a fundamental aspect of the analytic of *Dasein*. The care structure characterises the existential condition of *Dasein*. Wheeler (2020) explains, Heidegger presents the care structure as having three temporal dimensions; past (thrownness), future (projection), and present (fallenness). *Dasein* find themselves in a world that matters to them, this is thrownness (Wheeler, 2020).

4.9.3 Heidegger's Concept of the Fore-structures

The fore-structures of understanding is a threefold structure used by Heidegger to describe *Dasein*'s pre-existing knowledge of the world, and how this influences all understanding and interpretation. The fore-structures are linked to our Being and are often unexamined (Barrett-Rodger *et al*., 2022). Fore-having is "something we have in advance" (Heidegger, 1962, p.191), it is what we already know (Smythe, 2011). Fore-having is the pre-existing knowledge we possess on a subject due to our Being-in-the-world, it makes interpretation possible. Dibley (2023) describes fore-having as the social, cultural, and individual concerns that are pre-existing in our world. Fore-sight is "something we see in advance" (Heidegger, 1962, p.191). It is our ability to imagine how something might be (Smythe, 2011). Fore-conception is "something we grasp in advance" (Heidegger, 1962, p.191). Our fore-conception is the meaning we attribute to something in advance, or the ideas we bring with us (Dibley, 2023; Smythe, 2011).

> *Whenever something is interpreted as something, the interpretation will be founded essentially upon fore-having, fore-sight, and fore-conception. An interpretation is never a presuppositionless apprehending of something presented to us.* (Heidegger, 1962, p.191-2).

The fore-structures make interpretation and understanding possible, they constitute a foundational aspect of Heidegger's ontological understanding of how we acquire knowledge (Crowther & Thomson, 2023). They provide a point of departure and shape the way we perceive and comprehend all that we experience (Dibley, 2023).

4.10 Gadamerian Philosophical Hermeneutics

Hans-Georg Gadamer (1900-2002) was a German philosopher and pivotal figure in the development of contemporary hermeneutics. His magnus opus *Truth and Method* was published in 1960 and introduced philosophical hermeneutics. Gadamer met Heidegger at Freiburg University and was subsequently influenced by Heidegger's work (Malpas, 2022). In *Being and Time*, Heidegger (1962) initiated the conversation on philosophical hermeneutics but it was Gadamer who, embracing his mentor's ontological focus, further developed this concept into a systematic work (George, 2021; Palmer, 1969). *Truth and Method* delves into the development of hermeneutics, relating it to aesthetics and the philosophy of historical understanding (Gadamer, 2004; Palmer, 1969). As a whole, philosophical hermeneutics is concerned with the theory of interpretation, and seeks to uncover the nature of how we interpret texts, language, art, and phenomena.

Gadamer considered the work of hermeneutics not as devising a framework of understanding, but to elucidate the conditions in which understanding itself takes place (Laverty, 2003). Fundamental to Gadamer's hermeneutics is the principle that "understanding and interpretation are indissolubly bound together" (Gadamer, 2004, p. 400). If all understanding is interpretation, then hermeneutics is involved in all acts of understanding (Lawn, 2006).

In *Truth and Method*, Gadamer argues that truth and method are at odds with each other (Gadamer, 2004). The domination of the scientific method means that reason has become the ultimate test of truth, resulting in positivist testing and verification becoming the

authority (Lawn, 2006). Gadamer argues that the search for a methodology to equalise the humanities with the natural sciences is fundamentally misguided, there is no one method that can adequately describe how one arrives at an understanding of human or historical issues (Malpas, 2022). Therefore, Gadamer's philosophical hermeneutics focuses on a hermeneutical experience of truth that does not derive from the scientific method (George, 2021).

4.10.1 Gadamer's Concept of Prejudice

In everyday contemporary use, prejudice is associated with preconceived judgements or opinions, usually adverse or hostile in nature. It is widely agreed that prejudices should be avoided and quashed. Gadamer disputes these negative associations and incorporates the concept of prejudice positively into his hermeneutics (Malpas, 2022). During the Enlightenment, prejudice was branded with negativity, the consequences of which still prevail (Gadamer, 2004). In his writings, Gadamer redefines prejudice as an enabling conditions that facilitates understanding (Bhattacharya & Kim, 2020).

Prejudices are pre-reflective judgements we acquire through our everyday involvement with the world (Lawn, 2006). They are not something we can part with as they are the basis of understanding (Palmer, 1969), and any attempt to separate from one's prejudices to achieve complete objectivity is impossible (Bhattacharya & Kim, 2020). Gadamer (2004) writes "The recognition that all understanding inevitably involves some prejudice gives the hermeneutical problem its real thrust" (p.272). Understanding and interpretation cannot be without presuppositions, as the basic structure of understanding is both historically accumulated and operated (Palmer, 1969). Gadamer argues that our prejudices can open us up to understanding (Gadamer, 2004). All interpretation concerns prejudgements as interpretation is inherently directed towards present concerns and interests, and it is these concerns and interests that enable us to engage in a dialogue with the subject at hand (Malpas, 2022). Furthermore, our prejudices come to the fore throughout the dialogue of understanding as they open us up to understanding or even become evident to us (Malpas, 2022). Prejudice is essential to understanding as it represents the primary condition for the hermeneutical situation (Bhattacharya & Kim, 2020). From a Gadamerian perspective,

acknowledging our prejudice is a way of becoming aware to the presence of our preunderstandings and connectedness to the world (Dibley *et al.*, 2020).

However, Gadamer (2004) warns us of the "tyranny of hidden prejudices" (p.272) as they can impede our understanding of a text or subject. Understanding can only reach its full potential when the interpreter's fore-meanings or prejudices are not imperious (Gadamer, 2004). Gadamer (2004) advises that an interpreter should consciously examine their prejudices in an attempt to be aware of one's own biases, and to open themselves up to the otherness of what is being examined. In Truth and Method he writes "the important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p.271-272). By becoming aware of one's prejudices, the interpreter aims to understand a subject or text by what it is telling them, as oppose to what the interpreter chooses to understand from it. Gadamer (2004) calls this a "hermeneutically trained consciousness" (p.271), it is a sensitivity to otherness rather than a neutral objective stance.

4.10.2 Gadamer and the Hermeneutic Circle

In *Truth and Method*, Gadamer recalls the rule of the hermeneutic circle as "we must understand the whole in terms of the detail and the detail in terms of the whole" (Gadamer, 2004, p.291). Originating in ancient rhetoric, Gadamer acknowledges that modern hermeneutics has adopted the analogy of the hermeneutic circle to describe the art of understanding (Gadamer, 2004). Gadamer's conception of the hermeneutic circle is similar to Schleiermacher’s, however there is basic agreement between Gadamer and Heidegger that the circle ultimately describes an ontological structure of understanding (Grondin, 2002).

For Gadamer, the anticipation of understanding evokes every interpretation (Grondin, 2002, 2003). The hermeneutic circle describes a constant process of interpretation based on the anticipation of understanding in order to reach a greater understanding as a whole (Grondin, 2002, 2003).

4.10.3 Gadamer's Concept of the Fusion of Horizons

The fusion of horizons is a metaphor utilised by Gadamer to depict the process of understanding. A horizon (*Horizont*) is "the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer, 2004, p. 301). As a result of our embeddedness in a linguistic, social, and cultural world, we acquire a certain perspective or horizon of the world (Lawn, 2006). As Malpas (2022) explains, understanding and interpretation always happen from within a particular horizon that is determined by our historically-determined situatedness. The horizon of understanding is never inert, but instead susceptible to change at all times (Malpas, 2022).

According to Gadamer, a person who is lacking a horizon may have limited vision and overestimate the value of what is familiar or nearby (Laverty, 2003). A person with a horizon is able to see beyond one's immediate surroundings, as Gadamer (2004) explains "The concept of the 'horizon' suggests itself because it expresses the superior breadth of vision that the person who is trying to understand must have" (Gadamer, 2004, p.304).

The process of understanding can be seen as a fusion of horizons. Understanding is achieved through a hermeneutic dialogue, the process of understanding involves the fusion of horizons. The horizon of the interpreter and the text, or other person, are fused together as a result of dialogue and ultimately results in a new altered understanding. A fusion of horizons embodies a measure of agreement and this in turn a partial understanding (Lawn, 2006). However, Gadamer warns that a finalised complete fusion is not possible as "the fusion of horizons of interpretation is nothing that one ever reaches' because the horizon of interpretation changes constantly, just as our visual horizon also varies with every step that we take" (Gadamer, 2006, p. 61).

Section Two: Hermeneutic Phenomenology as a Research Method

4.11 Introducing Hermeneutic Phenomenology as a Research Method

As a methodology, hermeneutic phenomenology is a qualitative research approach that seeks to uncover meaning in phenomena with the purpose of understanding human experiences (Crist & Tanner, 2003). It investigates interpretive structures of experience by collecting stories of lived accounts that capture the meaning of 'being there' (Smythe,

2011). Through interpretive analysis of these lived accounts, it aims to reveal, enhance, and broaden understanding of phenomena (Dibley *et al.* 2020). It is informed by the philosophical thinkers that have been discussed throughout the first section of this chapter. The widespread adoption of phenomenological research has resulted in a myriad of approaches (Dowling, 2011) with hermeneutic phenomenology gaining traction in the realms of health, education, and the social sciences (Crowther & Thomson, 2023).

Hermeneutic phenomenology does not aim to generalise, problem solve, or to provide irrefutable evidence and fixed truths (Dibley *et al*., 2020; Smythe *et al*., 2008). Embracing this methodology means moving away from the idea that objectifying human experience is achievable or desirable (Crowther & Thomson, 2023). Instead the objective is to shed light on or uncover the meaning of a phenomenon through the interpretation of lived experiences (Dibley *et al*., 2020). It is descriptive in nature, focusing on structures of experience (Van Manen, 1997). This type of research requires openness and consideration for everyday experiences that typically go unquestioned and are taken-for-granted (Finlay, 2013). The researcher can only offer their interpretation of a participant's experience which may provoke thinking in the reader and invite them into a conversation of understanding (Smythe, 2011; Smythe *et al*., 2008).

Within recent years, this methodological approach has gained much traction within midwifery and maternity care research. Thomson & Downe (2010) explored women's experiences of positive birth following a traumatic birth experience using hermeneutic phenomenology. Ohaja & Murphy-Lawless (2017) utilised it to explore traditional birth attendants' discourses of their pregnancy and birthing practices in southeast Nigeria. Farsaci (2022), Healy (2012), and Kelly and Millar (2019) have all employed this methodology to investigate various aspects of women's experiences in the Irish maternity care system. The growing popularity of this research method within midwifery and maternity care could be attributed to the alignment of midwifery philosophy with hermeneutic phenomenology, that is, the holistic approach to care that considers women as individuals within a biopsychosocial model, which is reflected in the concept of *Dasein* and *Being-in-the-world* (or lifeworld) (Feeley, 2019; Miles *et al*., 2013; Thomson *et al*., 2011). Furthermore, Thomson & Crowther (2019) note that maternity care research often fails to prioritise women's experiences, resulting in their voices becoming lost or hidden.

Hermeneutic phenomenological research offers an opportunity to gather in-depth and meaningful qualitative data of women's lived experiences of pregnancy, birth, and motherhood (Thomson & Crowther, 2019).

4.12 Choosing Hermeneutic Phenomenology

With the multitude of qualitative methodological approaches to choose from, what influenced my decision to conduct hermeneutic phenomenological research? In my search for the right method, I considered grounded theory and case study. Both methodologies have significant advantages, for instance, ground theory has a structured approach to data analysis which would benefit any novice researcher, it also allows for theory generation. Case study facilitates an intensive examination and various data collection methods from interviews to secondary data analysis. However I ultimately chose hermeneutic phenomenology methodology for several reasons.

From engaging with the wider literature on limiting family size as a result of birth-related trauma, it was clear that women's experiences of this phenomenon had not been explored in any depth. I felt it was imperative that this piece of research focused on the lived experience of the participants and provided an opportunity for them to give an in-depth account of their experiences. Although many qualitative research methodologies fulfil this criteria, I was also drawn to the philosophical underpinnings associated with hermeneutic phenomenological research. As Thomson & Crowther (2019) explain, the philosophical underpinnings of this method requires rigorous reflexivity and an appreciation of the seminal philosophical texts that is not associated with other qualitative methodologies. The philosophical underpinnings align with my worldview that lived human experience is always happening in and relating to the wider social and cultural world. I felt it was important to highlight and appreciate this within the research, especially as the experience of birth is greatly influenced by place of birth and care provider. Furthermore, I have always recognised that although individual's perceptions of the same experience may differ, one experience does not hold more value or truth than the other. The underpinning philosophy of this approach recognises and allows for a multiplicity of meaning. Thus, hermeneutic phenomenology was deemed as an appropriate methodology to answer my research question.

4.13 Positionality

As a practicing midwife, I occupy an insider position in relation to this research. My clinical experience grants me privileged access to the specialised vocabulary, procedural knowledge, and professional culture surrounding childbirth. This insider position facilitates deeper engagement with participants' narratives through shared understanding of practices, context, and culture within the maternity services. However my status as a midwife has the potential to both enhance or undermine rapport with the participants, their prior experiences within the maternity services may have cultivated either confidence in or mistrust towards midwives. I discuss this issue with rapport further in Section 5.9.4 The Interviews.

Furthermore, my midwifery experiences and philosophy has resulted in feeling a moral responsibility to advocate for systematic improvements in maternity care. This ethical imperative, while motivating my research, requires careful methodological management to ensure findings reflect the data as opposed to other interests.

This proximity to the research subject necessitates heightened reflexivity to mitigate the risk of imposing preconceived interpretations based on professional assumptions or overlooking aspects that have become normalised in my clinical practice. Reflexivity is also a key methodological tool within hermeneutic phenomenological research. Philosophical issues relating to positionality are discussed in the following section.

4.14 Placing Philosophy within the Research

A clear understanding of and appreciation for the philosophical tradition of hermeneutic phenomenology is essential to any researcher wishing to conduct this form of inquiry. As previously stated, my academic background has not been in philosophy and so acquainting myself with the philosophical writings of Heidegger and Gadamer has been a gradual process. Over the duration of my doctoral studies, I have consistently immersed myself in these texts, developing my philosophical literacy and seeking deeper understanding. There is no ultimate endpoint in this endeavour, as this type of intellectual study constitutes a lifelong project. Nevertheless, my current philosophical understanding has allowed me to be firm in my ontological position, frame the research design and methodological decisions, and attune myself to a phenomenological attitude characterised by openness and

reflexivity. In order to relate the philosophical concepts addressed in this chapter, in the grounding of the research. The more practical application of philosophical concepts to methodological decisions is weaved throughout chapter five on methods.

To begin this discussion, I wish to clarify my stance on *Epoché*, bracketing, and phenomenological reduction, a key differentiator in Husserlian Transcendental Phenomenology. While it is possible to appreciate Husserl's desire to clear consciousness of external forces, it is challenging to imagine a consciousness devoid of all external influences (Blaikie, 2007). Critiques of this approach question the ability of humans to suspend their understanding of the world and undertake a phenomenological enquiry without any preconceived ideas (Dibley *et al*., 2020; Koch, 1996). I would argue it is not possible to achieve epoché or bracketing as Husserl intended it as the influences of the world around us are so embedded in our understanding of phenomena. In the context of this study, I would have to brack*et al*l that I know of birth and suspend all cultural and historical influences. How would it be possible to explore experiences of traumatic birth and divulge meaning without any prior knowledge or understanding of birth? Furthermore, all the participants recruited for this study have given birth in the Irish maternity services. As a practising midwife within these services, I do not believe it is possible for me to set aside my experiences and hear the participant's accounts without relating them to their wider context. Koch (1996) contends that researchers cannot exist outside their social world, and as interpreters of data, they inevitably apply their own set of background expectations and frames of reference to the act of understanding. The ability to see essential characteristics without preconception is the subject of much contention in the phenomenological world, often directing the selection of a specific phenomenological method (Dibley *et al.,* 2020). I opted to not adopt a phenomenological approach underpinned by Husserlian philosophy due to my conviction that human beings cannot completely detach themselves from their world and preunderstandings.

Instead I am aligned with Heidegger's concept of *Dasein*, *Being-in-the-world,* and the fore-structures, as well as the Gadamerian concept of prejudice. Heidegger's fore-structures of understanding and Gadamer's prejudices recognise that as human beings, we cannot exist and interpret outside of our social world, experiences and preunderstandings. To attempt to interpret without prejudices or preconceptions ultimately contradicts the way in which

understanding operates (Palmer, 1969). When we conduct research, we are placed in a hermeneutic situation to which we bring our presuppositions and prejudices (Bhattacharya & Kim, 2020). Our prejudices are at play as soon as we begin to engage with a topic, formulate the research question, read the literature, design the study, collect and analyse the data, and even when we present the findings (Dibley *et al.,* 2020). The prejudices and assumptions of the researcher are not set aside, but rather embedded into the interpretive process (Laverty, 2003). The researcher must engage in a reflexive attitude at every step of the research process, they must be explicit in the way their position and experiences relates to the topic (Laverty, 2003). Research participants also bring their own set of prejudices and assumptions to the research, both of which bring value to the final interpretation. Gadamer (2004) advises that an interpreter should actively examine their prejudices and open themselves up to the otherness of what is being examined in order to achieve a hermeneutically trained consciousness. Researchers engaging with hermeneutic phenomenology should not dismiss their preunderstandings and prejudices, but make efforts to see them within a larger context. Understanding begins when one authentically exposes their biases, thereby opening oneself to the perspective of the other's horizon (Bhattacharya & Kim, 2020).

Furthermore, *Dasein'*s *Being-in-the-world* means their reality is formed as a result of their embeddedness within the world. The world is part of human existence and forms an integral part of our reality as human beings (Critchley, 2009), thus constituting an integral part of understanding. As a researcher, I acknowledge and value the participant's embeddedness within their respective realties. This is key to hermeneutic phenomenological research as it is appreciative of different world views and their ability to shed light on our shared humanity (Crowther & Thomson, 2023). Each participant will bring a unique and informed experience to the research, however within their uniqueness is understanding and meaning that resonates with others (Smythe, 2011).

Both the researcher and the participant bring their own horizon of understanding to the study (Dibley *et al*., 2020). Gadamer's (2004) fusion of horizons represents the point of new understanding during the interpretive process. Incorporating this concept into research means the participant and researcher both bring their own perspectives which fuse into a new shared understanding. The process of interpreting the interview data involves

engaging with the hermeneutic circle, which involves a dynamic movement between the parts and the whole, and a process of reading, rereading, writing, rewriting, and continuous reflexivity. Ultimately, researchers engaging with hermeneutic phenomenology can only offer their interpretation of the participant's story (Smythe, 2011). Gadamer (2006) warns that a finalised complete fusion is never possible. The research findings can never claim to be complete or the finalised truth, but instead capture meaning at that specific point in time.

4.15 Conclusion

When adapted as a research method, hermeneutic phenomenological research engages deeply with meaning and human experience. To conduct this type of inquiry requires researcher to fully embrace the philosophical concepts that underpin the methodology. The combination of Heideggerian and Gadamerian philosophy provides an opportunity to delve deeper into lived experiences and to illuminate meaning that may not be initially obvious (Crowther & Thomson, 2023). The philosophical concepts outlined within this chapter effectively elucidate how humans are interconnected with their world and how they derive meaning from this. The next chapter detailed the methods used in conducting this study. It describes the research design, data collection, and analysis procedures employed to address the study's objectives. Philosophical concepts are weaved throughout to show how they influenced methodological decision-making.

Chapter 5: Methods

5.1 Introduction

This chapter outlines the methods used to carry out this research study. It serves not only as a manual of the research procedures used in this study but also as a narrative that links the conceptual and philosophical frameworks to their practical application in the research process. Given the importance of philosophy in hermeneutic phenomenology, examples of where certain philosophical notions have been used to underpin the conduct of the study are woven throughout. I begin the chapter by discussing the importance of identifying my pre-understandings and prejudices on the research topic. The research aims are then stated, followed by an explanation of the sampling and recruitment procedures. I then proceed to data collection and data analysis. To finish, ethical considerations and issues around research integrity are discussed.

5.2 Pre-Supposition Interview

The philosophy of Heidegger and Gadamer recognise that as human beings, we cannot exist and interpret outside of our social world, experiences and preunderstandings. In the previous chapter, the philosophical concepts of *Dasein, Being-in-the-World*, fore-structures, and prejudice were discussed. Examining my fore-structures and prejudices is essential to understanding their nature and potential influence on the conduct of this study. In practical terms, this entails conducting a thorough examination of my own preconceived notions regarding the phenomenon of interest, which is accomplished through a pre-supposition interview. The aim of a pre-supposition interview is to enable researchers to take a closer look at what they know and gather insights into the researcher's lifeworld (Barrett-Rodger *et al*., 2022). It also prevents interpretations being generated by what is already known, rather than uncovering what lies beneath (Crowther & Thomson, 2020). Pre-understandings should be examined prior to data collection and analysis, however they are not fixed entities and will evolve through the research process (Thomson, 2011). These changes were recorded regularly in my reflexive journal in order to maintain an open and reflective attitude (Thomson, 2011).

The presupposition interview was conducted prior to data collection. I was interviewed by a fellow PhD student who is also a midwife and familiar with this study's focus. The

interview was approximately an hour long, the audio was recorded and then transcribed using Sonix software. Transcription errors were corrected while I listened to the audio recording.

5.3 My Pre-Understandings

My experience of pregnancy and birth is from the perspective of a midwife. My philosophy as a midwife is to be with-woman, promote autonomy, and recognise childbearing as a profound experience. I recognise childbirth as a normal physiological event and that normal birth with minimal intervention should be promoted and protected. However, I am also appreciative of evidence-based medical intervention when necessary.

As a midwife I have only ever worked within a highly medicalised setting, and this has profoundly impacted my perception and understanding of birth-related trauma. I came to this research topic with a clear picture of what traumatic birth *is*. My personal experience had shown me that birth-related trauma usually involved intervention, obstetric emergencies, or poor outcomes (or a combination of all three). The women in my care who had disclosed previous traumatic experiences usually described a cascade of intervention that ended in an instrumental or surgical birth. Although the evidence highlights the significant role of intervention and poor obstetric outcomes in shaping women's perceptions of birth trauma, other factors also contribute, such as interactions with caregivers and pre-existing social issues. I can now reflect on this very definite way of understanding birth-related trauma as completely biased, limited, and over-simplified. From engaging with the literature and women's testimonies, I came to understand the complexities of birth-related trauma and the plethora of contributing factors. Although my understanding has evolved, I cannot deny that I am still negatively biased against the largely medicalised maternity care system in Ireland and how it contributes to traumatic birth experiences.

I have a limited pre-understanding of the phenomenon of limiting family size to less than desired size as a result of birth trauma. Professionally I do not meet women who have made this decision as I work with women who are pregnant or are in the immediate postnatal period. On multiple occasions when discussing my PhD research with various acquaintances and colleagues, they have mentioned individuals within their social networks who did not

have subsequent children following a traumatic birth experience. Therefore my exposure to this phenomenon is limited, my pre-understandings are based off academic literature or my own contemplation. What I have frequently encountered are women who opt for an elective CS following a traumatic birth experience. This has become somewhat normalised to me, especially as I work in a maternity hospital with a high CS rate. Although I did not initially realise, this experience has led me to believe that CS is a quick fix to subsequent birth following a traumatic birth. It is important to acknowledge this black and white biased thinking as I approach data collection and analysis.

As a woman of childbearing age, I am currently childless by choice although I envision having children in the future. When asked by the interviewer what my ideal family size would be, I replied 'definitely more than one'. I have two siblings with whom I have close bonds and, as a result, I place significant value on sibling relationships. In the context of this study, I assume there is some emotional turmoil relating to the inability to provide siblings for one's child. I recognise that this statement has been completely coloured by my personal values and life experiences. It is not to say that one or more of the participant's do not share this position, however it is important not to assume or project my own views on the participant's experiences. As *Dasein*, we are unable to completely rid ourselves of our preunderstandings and so any act of interpretation can never be from a purely neutral stance (Horrigan-Kelly et al., 2016). Instead, being reflexive and open is key to managing the impact that my preunderstandings may have on the research.

5.4 Research Aims and Objectives

The aim of this study is to develop an in-depth understanding of the lived experience of limiting family size to less than desired as a result of birth-related trauma. In order to provide meaning to this aim, specific objectives were identified:

→ To gather rich descriptions of the lived experience of parents' who have chosen not to have more children as a result of birth-related trauma.

→ To uncover meaning in these experiences through hermeneutic analysis.

5.5 Sampling

In accordance with hermeneutic phenomenological research, participants should have experience of the phenomenon of interest as they are most able to provide insights and

data that addresses the research question (Dibley et al., 2020). Purposeful criterion sampling was adopted as it allows researchers to select information-rich cases whose study will illuminate the research question (Patton, 1990). Purposeful sampling is a non-probability sampling technique used in qualitative research where researchers intentionally select participants based on specific criteria relevant to their research aims (Patton, 1990). Patton (1990) list 16 forms of purposeful sampling including criterion sampling, which is the technique of selecting all participants that meet some predetermined criterion of importance, and is often used to identify participants from quantitative questionnaires to participate in qualitative research.

The population of interest was women and men who have had at least one child and have decided not to have more children directly as a result of a traumatic birth experience. As family planning decisions are often made as a couple, it was deemed important to gather information from the perspective of both people in the relationship where possible. However, it was decided that women could participate without a partner as not to exclude those who were single, may not feel comfortable disclosing their participation to a partner, or those whose partners were not interested in the study.

The sample was drawn from the Maternal Health and Maternal Morbidity in Ireland (MAMMI) study, which is a longitudinal study exploring the health and health problems experienced by 3,047 first-time mothers in Ireland. It is primarily a quantitative study that collects data through surveys, but several qualitative studies have been conducted based on the content of the surveys (Daly *et al*., 2022). Samples for the qualitative studies have been recruited from the original survey participants with great success. The MAMMI study team were initially approached to consider the inclusion of a question in one of their follow-up surveys regarding women's experiences of birth-related trauma and its impact on reproductive decision-making, with the intention of recruiting those who identified themselves as being affected by this phenomenon. By the time this proposal was made, the five-year follow-up surveys had already been developed and distributed to the participants. However, this survey did ask participants to provide free-text answers to an open-ended question on their reproductive history and decision-making;

> "Question A4: Is there anything you wish to tell us about trying to become pregnant, choosing not to become pregnant or any subsequent pregnancies and/or births in the years since you had your first baby?"

I then discussed with the MAMMI study team that participants for this study could be recruited using criterion sampling as a result of analysing the women's responses to question A4. A thematic analysis of the responses to question A4 showed that within the MAMMI study five-year follow-up sample there are women who have limited their family size as a result of their experience of childbirth (Unpublished at present). However, MAMMI study participants have never been recruited for qualitative research based on their survey responses, instead email invitations have been sent to the entire cohort which has yielded high response rates. To keep in tradition with how the MAMMI study operates, participants for this research project were recruited through a general email invitation.

5.6 Inclusion and Exclusion Criteria

Women could participate if they:

- had experienced a birth-related trauma, either diagnosed PTSD or self-defined trauma,
- had at least one child,
- currently had no intention of having another child, or
- had made the decision to not have another child and later had an unplanned pregnancy.

Women were excluded from this study if they:

- were under 18 years of age,
- unable to communicate in English,
- were currently pregnant or trying to become pregnant,
- could not attend an interview in-person or online,
- their decision to not have more children was not influenced or partly influenced by a birth-related trauma.

5.7 Recruitment

An ethics amendment was submitted by the MAMMI study team to allow this study to access and recruit from the MAMMI study sample. It was agreed that an email from the MAMMI study gatekeeper would be sent to all the participants who had previously consented to being contacted by the MAMMI study team. The recruitment email (appendix 3) briefly introduced the study and the researcher, and made reference to the five-year follow-up survey question on reproductive decision-making. Those who were interested in participation or wanted further information on the study were asked to make contact through email. The first recruitment email was sent in October 2022, with subsequent emails sent in January 2023 and March 2023.

Those who made contact were sent a digital letter of invitation (appendix 4), a participant information leaflet (appendix 5), and an informed consent form (appendix 6). They were also encouraged to seek clarification or ask questions about the study, offering them the choice to do so via email or by phone. Follow-up emails were sent to those who did not respond after seven to ten days after initial contact. If they did not respond to the follow-up, they were not contacted again. Women's partners were recruited through the women themselves, this meant it was their decision whether they would ask their partner to participate.

In total, thirty-six women from the MAMMI study sample made contact. Five women were excluded as they either were not available for an interview, or their decision to not have more children was not influenced or even partly influenced by their experience of birth. Interviews were arranged with 17 women but two of these women decided to cease participation as they felt the interview would have a negative impact on their wellbeing and possibly retraumatise them. In the end, 15 women and four of their partners were interviewed.

Table 4: Recruitment Figures					
Date of Emails	**Responses**	**Interviewed**	**Excluded**	**Pulled-Out**	**Did Not Respond**
24/10/22	27	13 (+4 partners)	3	2	9
19/01/23	8	2	1	-	5
29/03/23	1	-	1	-	-
Total	36	15 (+4 partners)	5	2	14

The eleven recruited women whose partners did not participate were asked if they had informed their partners about the study and, if so, what influenced their decision to not participate. The reasons provided included a lack of interest and concerns about the potential negative impact participation may have on their wellbeing. One participant chose not to disclose her own participation to her partner.

5.8 Sample Size and Saturation

Sample size is linked to study design and therefore to both research question and purpose (Dibley *et al.,* 2020). In quantitative research, sample size is calculated statistically with the aim of producing a generalisable result. However in phenomenological research and other qualitative methodologies, sample size cannot be calculated causing much variation in appraisals of sample size sufficiency (Vasileiou et al., 2018). In a systematic analysis of single-interview-per-participant designs, data saturation was the most commonly used concept to justify sample size (Vasileiou *et al.,* 2018). Data or theoretical saturation originates from the methodology of Grounded Theory which involves the development of theory through the collection and analysis of data (Glaser & Strauss, 1967). In Grounded Theory, data saturation is reached once gathering additional data no longer provides new theoretical insights or contributions to the emerging theory (Glaser & Strauss, 1967). Data saturation has since evolved from its origins to mean information redundancy, meaning the point at which no new information, codes or themes are generated from the data (Braun & Clarke, 2019). However, the meaning of data saturation in other qualitative approaches is

often not clearly defined (Malterud et al., 2015) and the reporting of sample size sufficiency is limited (Vasileiou *et al.,* 2018).

In hermeneutic phenomenological research, data saturation is not possible as it conflicts with the philosophical underpinnings and purpose of the methodology. Dibley *et al.* (2020) argue this methodological incompatibility stems from hermeneutic phenomenology's recognition that participants may not have experienced everything relevant to the topic, they may not choose to reveal everything about their experiences, and the methodology's purpose is not to provide definitive answers or generalisations. van Manen (2016) suggests there is no rule for sample size in phenomenological research, and that data saturation implies a search for patterns within the data which is not the objective of the methodology. It is typical for phenomenological research to employ a small sample size as the ultimate goal is to achieve a rich understanding of a phenomenon, as opposed to quantifying or generalising the lived experience under investigation (Englander, 2012; Mason, 2017).

Malterud *et al.* (2015) propose the concept of *information power* as an alternative to data saturation in qualitative interview-based research. Simply put, information power means that the more relevant and detailed data a study sample holds, a smaller number of participants are required (Malterud *et al,.* 2015). The author's developed a five-point model that aids appraisal of the information power of a sample; "(a) study aim, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy" (Malterud *et al.,* 2015, p. 1754). According to this model, this study's characteristics indicate its sample has higher information power and so a smaller sample size is justified. To summarise, the study's aims are precise and concern a distinct experience to which purposeful sampling was adopted to recruit suitable participants. Malterud *et al*.'s (2015) model supports a smaller sample size when the study aim is narrow, concerns a specific experience, and the participants have experiences or knowledge relating to the aims. Furthermore, the model favours smaller sample sizes in studies that apply specific theory to planning and analysis (Malterud *et al.,* 2015). In hermeneutic phenomenological research, philosophy and theory are applied throughout from study design to data analysis (Dibley *et al.,* 2020). The last two points of the model are concerned with the quality of dialogue between participant and researcher, and the approach to analysis. Strong, in-depth dialogue with participants favour a smaller sample size, as well as case by case

analysis (Malterud *et al.,* 2015). Data was collected through in-depth interviews that produced detailed and high-quality dialogue. Each interview was individually analysed, a rigorous and in-depth process that is detailed in Section 5.10. According to the model, the sample demonstrates substantial information power, thereby justifying the sample of 19 participants within the framework of this research and methodology.

5.9 Data Collection

Data were collected through in-depth un-structured interviews. Each participant was interviewed once, Smythe (2011) asserts that one interview per participant is sufficient especially when discussing distinct non-everyday events such as childbirth. In the event that I required to clarify information or ask further questions, consent was sought to contact participants for follow-up.

5.9.1 Setting and Timing

Both in-person and online 'Zoom' interviews were approved by the Research Ethics Committee. Permission to conduct interviews online was originally sought due to the Covid-19 pandemic, however once recruitment had started there were no public health guidelines advising against in-person gatherings. Despite this, participants were still offered the choice to be interviewed in-person or remotely. When conducting research in trauma-exposed individuals, Jefferson *et al.* (2021) recommends providing participants with safe opportunities and spaces to discuss their experiences. I hoped that by offering the choice of interview setting, it would contribute to building a safe space and encourage participation.

The four couples who chose to participate were given the option to be interviewed together or separately. In offering this choice, I hoped it would maximise openness and encourage more partners to participate. The presence of one's partner changes the dynamic of the interview, although whether it is a negative or positive influence can be debated. Individuals may not speak as openly when their partner is present (Taylor & de Vocht, 2011). Joint interviews may also expose conflicts or tensions within the couple's relationship (Valentine, 1999). However, requiring separate interviews may generate anxiety within the couple as it implies there are secrets between them (Taylor & de Vocht, 2011). Richer data may be

collected from joint interviews as couples co-create meaning, and corroborate and supplement each other's accounts (Valentine, 1999; Taylor & de Vocht, 2011). Considering the methodology, I felt it was appropriate to offer participants the choice between joint or separate interviews. Those who conduct hermeneutic phenomenological research recognise that no two interviews will ever be the same, even with the same participant recounting the same experience twice. Furthermore, hermeneutic phenomenology does not aim to generalise or look for patterns in the data. Conformity across the interviews is not required to gather rich descriptions of experience as long as each interview is approached by the researcher with the phenomenological attitude.

In terms of scheduling, I informed participants that I was flexible and available to meet them on a day and time that suited them best. I advised my participants that the interview did not have a set length but it would be best to allow two hours so they were not rushed.

5.9.2 Preparing for the Interviews

A significant aspect of interview preparation was exploring the conduct of interviews within hermeneutic phenomenological research. Although there are distinct differences in the character and execution of interviews in hermeneutic research (Moules & Taylor, 2021), interviews across qualitative methodologies share similar characteristics (Vandermause & Fleming, 2011). However, it is key that the conduct of interviews, as with all aspects of the research process, is determined by the methodology. The aim of hermeneutic phenomenological research is to "return as closely as possible to the primordial experience" (Smythe, 2011, p.42) which is elicited through rich descriptions of participant's own experiences (Vandermause & Fleming, 2011). Meaning emerges from participant's experiences through the telling of their stories (Dibley *et al*., 2020). Hermeneutic interviewing requires a shift away from positivist thinking as the researcher must adopt an open and flexible attitude (Vandermause, 2008). Smythe *et al*., (2008) advises researchers to embrace Heidegger's understanding of Dasein as being-there, being-open, and allowing things to un-fold. Gadamer (2004) states that "... the more genuine a conversation is, the less its conduct lies within the will of either partner. Thus a genuine conversation is never one that we wanted to conduct" (p. 385). Malpas (2022) explains that conversation that seeks agreement on a particular issue is never under the control of either conversational

partner, but rather by the matter being discussed. To say we *conduct* interviews is to freeze the phenomenological spirit (Smythe *et al.,* 2008). Moules *et al*., (2015) disagree and argue that hermeneutic interviews are conducted as they are not genuine conversations between equals as researchers define and control the interview (Kvale & Brinkmann, 2009). While Smythe *et al.* (2008) caution against conducting structured interviews with pre-planned questions, they do advocate for approaching an interview with intention and openness that allows for immersion into a dynamic conversation. With these methodological considerations, unstructured interviews were used as they provide participants with the opportunity to freely discuss experiences that were meaningful to them (Taylor, 2023). In the absence of an interview schedule, I read methodological texts that detailed the process of conducting hermeneutic phenomenological interviews in preparation for data collection (Dibley et al., 2020; Geanellos, 1999; Moules & Taylor, 2021; Smythe, 2011; Taylor & De Vocht, 2011; Vandermause & Fleming, 2011; Walker, 2011).

Other forms of preparation involved developing a distress protocol (appendix 7) and reviewing Lone Worker Guidelines (Trinity College Dublin, 2017). Discussing sensitive topics has the potential to cause distress or harm to participants, and so all researchers conducting qualitative interview-based research should devise a distress protocol (Dempsey et al., 2016). A distress protocol is a predefined set of guidelines that researchers utilise to address and mitigate any potential emotional and/or psychological distress experienced by participants during the course of data collection.

5.9.3 Gaining Consent

Gaining informed consent from study participants is vital to the conduct of all research. Informed consent means that participants receive sufficient information about the research, understand that information, and possess the capacity to voluntarily accept or decline participation (Polit & Beck, 2017). This process involves ensuring participants understand the purposes and processes of the research, their rights as a participant, and potential risks and benefits to them. The process of gaining informed consent is a continuous process, meaning I regularly checked with each participant that they remained comfortable with their participation and made sure they understood they could withdraw from the study at any time.

Those who opted for a virtual interview were asked to send a completed and signed copy of their informed consent forms via email prior to the interview. A small number of the participants required assistance with adding a virtual signature to their informed consent form. Once received, the consent forms were immediately saved to my TCD OneDrive account and then deleted from my email inbox. Not only is my TCD OneDrive password protected, each PDF form requires a password to be accessed. The informed consent forms contain the participant's name, address and contact details, so it is of the utmost importance to respect the participant's data and store it securely. At the start of each virtual interview, while the audio was recording, I asked each participant to confirm that they had returned a signed copy of the informed consent form, and that they were still happy to participate. This confirmation was sought to reinforce the ongoing process of gaining consent and establish that each participant had completed their own informed consent form by their own volition. It should be noted that prior to starting the audio recording, I informed the participants that I would ask for confirmation so they were not confused about my question.

For in-person interviews, I advised participants that they could complete the informed consent form immediately before starting the interview. However to ensure my presence did not put pressure on the participants to read and sign the form, I emailed them a copy far in-advance of the interview and asked that they familiarise themselves with it. On meeting the participants I asked them to complete two hard copies of the informed consent form, one for the research project and another for their own records. Once I returned home from an interview, I scanned and saved the completed form as a PDF file and stored it under password protection on my TCD OneDrive account. All hard copies were then shredded and disposed of accordingly. A copy of the informed consent form is attached in Appendix 6.

The last section of the informed consent form was optional as it asked permissions for future contact. I asked participant's consent to contact them to clarify any information relating to their interview, and if they were interested in being contacted in regards to any future research relating to the topics covered in this study. These were two separate optional questions which meant that participation was not affected if they did not agree to future contact.

5.9.4 The Interviews

Seventeen interviews were conducted between November 2022 and March 2023. Of the four sets of couples who participated, two were interviewed as pairs, while the other two were interviewed separately. Overall, that means fifteen of the interviews were on a one-to-one basis, and two interviews were with pairs. Thirteen of the participants were interviewed virtually as only four participants opted for in-person interviews. Three of the in-person interviews were in participant's homes, and one in the School of Nursing and Midwifery. All the couples were interviewed online. The longest interview was two hours and ten minutes, with the shortest being 23 minutes. The average length of the seventeen interviews was 57 minutes.

Prior to commencing each interview, I engaged in casual conversation with the participant(s) and discussed aspects of the study. I reiterated the purpose of the study and outlined how I planned to conduct the interview (for example, that my questions would be based on the content of the interview as opposed to having a list of pre-prepared questions). I advised participants that they could take breaks throughout the interview or terminate it at any time, as well as emphasising their right to withdraw at any point. For the couples who interviewed separately, I highlighted that the subject of their individual interviews would not be discussed with their counterpart, and that any questions or probes that I posed were only influenced by the content of their own interview. I then asked participants if they had any questions, I was mainly asked about my background, why I was interested in this subject, and how many others were taking-part. Once the participant was satisfied with their questions, the audio recording was started and the interview officially began. Online interviews were recorded through the Zoom application whereas in-person interviews were recorded using a laptop.

In addition to communicating important information to the participants, beginning the interview process in this manner contributed to rapport-building. Seidman (2006) refers to rapport as "getting along with each other, a harmony with, a conformity to, and affinity for one another" (p.96). Rapport underpins an effective researcher-participant relationship so that participants feel at ease and are able to share their experiences or disclose sensitive information (Dempsey et al., 2016; Dickson-Swift et al., 2007). Dickson-Swift *et al.* (2007) suggest that rapport-building begins as soon as the researcher enters the life of the research

participant. With this in mind, I was conscious to be open and conversational in every interaction with participants whether it was an email or a phone-call. This conversational tone was also adopted in the interviews as a way of rapport building. It also meant that participants did not feel pressure to use formal language when they may be more comfortable to recount their experiences in their own words. Often participants used profanity, some even sought approval to do so, I reassured participants that they were free to express themselves in whatever way they felt appropriate to them. Patton (2015) emphasises that rapport is built by "conveying empathy and understanding without judgement" (p.671). Conveying empathy and openness as an interviewer is particularly important when interviewing trauma-exposed individuals. Participants should feel safe during the interview process and be able to share their experiences without fear of judgement or scrutiny. Von Knorring *et al*. (2019) describe empathy as both a skill and personality trait, being empathetic can be intuitive and means one is able to resonate with others, it can also be a conscious act shown through one's body language and communication style. It is difficult to describe how one conveys empathy as it is part of one's nature and how they relate to others. I felt it was important to express gratitude for participant's time and acknowledging the difficulty in discussing such a sensitive subject. During the interview I was mindful to keep my body language open and use active listening cues, and when in-person, eye-contact.

As part of adapting an open attitude, when asked by participants I shared details on my own background. Seidman (2006) warns that sharing one's own experiences may distort what participants share in the interview, and although contributing to rapport building, to be mindful of this. I was anxious that my background as a midwife may impact upon the participants' willingness to be open about their experience, particularly if they had been treated poorly by midwives or other maternity care professionals. Essentially, my main concern was that participants might perceive my status as a midwife as a sign of blind loyalty to the profession, assuming that I might be unable to acknowledge its issues or incidences of poor conduct or practice. However, this concern quickly dissipated, as it became clear within the first four interviews that the participants were very open and honest about their experiences, including instances where they had been mis-treated by midwives. Instead, it appeared that starting and conducting the interviews in this manner put the participants at ease. I can only speculate that the participants may have

understood that my interest in birth trauma is linked to my experiences as a midwife, and as a result I am particularly empathetic to those who have suffered such trauma.

Furthermore, identifying my background meant the participants focused on discussing their experiences rather than explaining the workings of maternity services or defining specific terms. For example, if a participant mentioned having a postpartum haemorrhage, she did not need to explain what it was; instead, she could concentrate on describing her experience and the emotions it evoked. For the few participants who did not inquire about my background, it did not seem like it impacted on the flow of the interview. Again I speculate that the participants were aware I was familiar with the maternity services as I was associated with the School of Nursing and Midwifery. Additionally, as the interview progressed, I sensed that they recognised my familiarity with maternity services based on the questions I asked and the clarifications I sought.

Every interview began with the same open-ended question, 'tell me about your experiences of pregnancy and childbirth'. I anticipated that by asking participants to tell their story from the beginning of their journey to parenthood, that the meaning of their experiences would unfold within the narrative. Furthermore, I wished to avoid immediately focusing on their traumatic experiences and the phenomenon under investigation, and instead encourage participants to describe their lifeworld and the context in which these events took place. Smythe *et al.* (2008) suggest that removing a narrative from its rich textual background may alter its meaning and the potential of understanding an experience as it was lived. The point at which participants chose to begin their narrative varied, some chose their first pregnancy whereas others started from their decision to conceive. For the most part, the participants easily entered a state of flow and rarely required prompting or encouragement. For others it did not come as easily, and so I asked further open-ended questions to prompt the telling of their story. Occasionally the interviews strayed and I had to redirect the conversation back to the research topic. Nonetheless, I was cautious not to immediately interrupt as I appreciated these deviations may be relevant later or were important to the participant. As I gained confidence with each interview, assessing when and how to redirect the participant became easier and somewhat intuitive.

I was initially concerned that the couples who opted for separate interviews might recount contrasting accounts of the same events. While I anticipated their lived experience would be different, especially considering one partner had been pregnant and given birth, I was worried that major discrepancies in their overall timelines and recollections might undermine the reliability of their testimonies. Despite my concerns, this issue did not arise. Each individual brought their own unique perspective to the interview, however their accounting of events aligned with their significant other.

Once the participants had finished recounting their experiences, prompts were used to further explore key issues that had previously been discussed. I was careful to formulate the prompts as open-ended questions such as 'earlier you mentioned X, can you tell me more about that?', or 'how does Y make you feel now?'. Clarification or agreement was sought by asking direct questions or providing a brief summary of what I had understood from the interview. It can be argued that questioning in this way is leading or introducing bias; however, what is crucial is that the researcher does not introduce new notions to the interview, but formulates questions based on what the participant's words (Dibley *et al*., 2020). When I felt the interview coming to a natural end, I invited the participant to share additional thoughts that had 'come-up' for them while talking, or if there were topics, they did not have the opportunity to discuss. Often this sparked ten to fifteen more minutes of conversation before the interview officially came to an end.

As expected with the subject matter, participants often became upset during the interviews. When this occurred, I asked participants if they would like to take a break from the interview and pause the audio recording. All opted to forgo a break and instead proceed uninterrupted. Although I was concerned that continuing without a break may not be in their best interest, I appreciated their autonomy and capability of judging their own limits and emotional well-being. I made a point to reiterate that we can take a break whenever necessary.

Overall, the interview process went smoothly. The only issues I encountered were related to internet connectivity. Virtual interviewing depends on both parties having reliable internet connections that allow for uninterrupted conversation. On multiple occasions the audio distorted or lagged however these issues never continued for a prolonged period of

time and did not interrupt the flow of the interview. During one interview my internet connection completely dropped twice causing interruptions lasting a few minutes. The participant was very understanding, and as she had remained in the Zoom meeting room, the audio recording from the start of the interview was not lost.

5.9.5 Field Notes and Reflective Journaling

Throughout data collection, I recorded my field notes and reflections in one notebook. During the interviews I wrote quick notes on issues to follow-up later as to not interrupt a participant's flow or derail the current topic being discussed. I also documented key points of the participant's story so that I had a clear narrative of their experience to refer to during the interview. Occasionally I also made notes on changes in tone or body language. After each interview, I recorded my initial thoughts and reflections without paying much attention to formulating points or coherent paragraphs. Sometimes I wrote several pages, and other times just a handful of sentences. I mainly recorded my initial impressions, how it made me feel, what stood out to me, and similarities or differences to other interviews. Periodically I critiqued my interviewing skills, especially when I felt I had not performed well. The purpose of this was to facilitate further reflection, improve my skills as an interviewer, and to have a record of my initial interpretations.

5.10 Data Analysis: Enacting Interpretation in an Iterative Way

The purpose of analysis in hermeneutic phenomenological research is to uncover meaning from the in-depth descriptions of participants' lived experiences. It can be argued that we initiate the interpretive process the moment we come to a research question, signifying our entry into the hermeneutic circle. This stage of analysis involved becoming completely immersed within the participant's experiences and repeatedly engaging with the data. It is a iterative non-linear process that involves reading, writing, re-reading and re-writing (Smythe *et al.,* 2008). The principle of the hermeneutic circle recognises that understanding is not a one-time event, but a circular process that involves moving back and forth between the whole and the parts while considering one's own position and preunderstandings. As a guideline for analysis, elements of Dibley *et al.*'s (2020) guide to interpretive analysis were used. This guide is not intended to be prescriptive but rather provides scaffolding to the iterative process of hermeneutic phenomenological interpretation. Furthermore, although

it is presented as a linear process, the actual process of interpretation was circular and iterative.

5.10.1 Transcribing Interviews

Transcribing interview recordings can be seen as the first step in the analytic process, as it involves immersing oneself in the data, which in turn initiates interpretive thinking. As Bird (2005) explains, when researchers transcribe interview recordings themselves, it allows for greater familiarity and immersion in the data, providing an opportunity to gain deeper insights directly from the raw data. However, transcription can be extremely time-consuming, particularly for those who are new to the process. Taking this into consideration, Sonix software was used to transcribe the audio recordings. The software is compliant with data protection regulations and it was approved for use by the TCD Research Ethics Committee. Each transcript was ready within a few minutes of uploading audio to Sonix. All the transcripts were checked against the recordings to eliminate any errors. The software was not entirely accurate as often the speakers and vocabulary was incorrect. Amending the transcripts took many hours, however it allowed complete immersion within the data. During this process, I added important details such as pauses, changes in tone, and emotional responses such as crying and laughter. Incorporating such details may facilitate deeper thinking on what is being expressed by the participant (Vandermause & Fleming, 2011). Once I was satisfied the transcript was correct, it was anonymised and saved to my TCD OneDrive.

5.10.2 Creating Narratives

To begin the process of analysis, I started with creating narratives from the verbatim data. A narrative is an account of events, and they are derived directly from a participant's account of their experiences (Caelli, 2001). I began by reading and re-reading each interview to become familiar with the data and the participant's experience. During these readings, I made notes on the timeline of the participants' experiences, as the interviews rarely followed a linear progression. Instead, the participants often jumped around as new thoughts emerged. Following from this, as recommended by Caelli (2001), I removed superfluous sections of conversation that wandered away from the phenomenon and listening sounds such 'uh-huh' or 'mm'. The majority of interview questions were also

removed with the exception of those that provided context to the dialogue. The aim was to keep the data that tells the story of the participant's lived experience. I then proceeded to ensure the story flowed by adding conjoining words and reordering sentences to create a chronological story (Caelli, 2001; Crowther et al., 2017). I was careful to use the participant's own words and only made changes if it was grammatically or contextually required. When it came to creating narratives of the couple's data I elected to create one narrative per couple that accounted for both individual's perspectives. This approach proved particularly appropriate for couples who participated in joint interviews as they naturally co-constructed their lived experiences while simultaneously highlighting their individual perspectives. For the two couples who were interviewed separately I initially considered creating separate narratives, however as their experiences were fundamentally intertwined, I ultimately decided that combining their transcripts into a unified narrative would better facilitate interpretation. These narratives chronicled the couple's shared experience of events while incorporating their individual perspectives. The benefit to crafting stories, or narratives, is that they can present a clear narrative of the phenomenon in a succinct and easily readable format (Crowther et al., 2017).

5.10.3 Coding the Narratives

Creating the narratives allowed me to become familiar with each participant's lived experience. Dibley *et al.* (2020) recommend that once researchers have become familiar with the data, they should proceed to make notes on what evoked thinking in the format of codes and comments. During this process, I also highlighted verbatim quotes that related to the codes and comments. I was aiming to identify pieces of data that uncovered meaning in the participant's accounts of their lived experiences.

I then created a rudimentary lists of emerging themes based on these codes as a way of gathering my initial insights in one place. Dibley *et al*. (2020) describe emergent themes as something of significance that necessitates thinking and deeper reflection. The purpose of formulating these lists was not to count the frequency in which they appeared or to create subcategories of themes, instead they facilitated interpretation and writing. According to van Manen (2016) "grasping and formulating a thematic understanding is not a rule-bound process but a free act of "seeing" meaning" (p.79). As a novice researcher, grasping a

thematic understanding aided my interpretative journey by providing structure especially as I was working with large amounts of data.

5.10.4 Writing Interpretive Summaries

Following Dibley *et al.*'s (2020) guidance, I proceeded to write interpretative summaries. An interpretive summary condenses and captures the participant's lived experience while identifying salient points from their interview (Dibley *et al.,* 2020). The purpose of such summaries is to facilitate writing, thinking and dialogue with the stories (Dibley *et al.,* 2020). Although they did not have a set structure, the summaries were descriptions of the phenomena and findings that were supported by verbatim data and excerpts from the stories. I was engaged in the hermeneutic rule of movement from the whole (story) to the part (word or sentence) and back to the whole (Gadamer, 2004), in other words, how did certain excerpts relate to the overall meaning of the story, and how does the overall meaning of the story relate to particular excerpts or quotations. The summaries were written and rewritten many times, constantly changing as my interpretations developed. They also provided somewhat of an audit trail as they clearly documented my thinking and analytical decisions.

5.10.5 Dwelling with the Data

The interpretive summaries served as a foundation from which the final interpretations and findings emerged. This step in the interpretive process is difficult to describe as it involved long periods of meditative thinking, and many iterations of the "final" interpretations. It was easy to feel overwhelmed with the data as there were so many different aspects of experience to explore. Smythe and Spence (2023) explain that the phenomenological way is to start writing and to simply trust the writing itself will lead to insight. I wrote many versions of interpretations and findings, refining them with each draft. This stage of working with the data is an experience of thinking (Smythe *et al.*, 2008). Influenced by Heidegger's work, Dibley *et al.* (2020) explains that one has to dwell with the data;

> *while we are dwelling with the material, our mind is moving from one part to the next, making links through and between the voices of participants. While we are*

dwelling, we are building the meaning and understanding that are contained within the material, thus leading us to an interpretation of the data. (p. 125)

There is no clear ending to the interpretative process, as human experiences can have infinite meaning and so no single correct interpretation exists (Crist & Tanner, 2003; Healy, 2011). Gadamer refers to human experiences as having a multiplicity of meaning, and so there is never one single meaning, only a meaning that is revealed within a particular context of time, place, people and events (Crowther & Thomson, 2020). However eventually the interpretive process results in a fusion of horizons (Gadamer, 2004), the point of new understanding. The horizon of the interpreter and the text, or in this case the researcher and the verbatim data, are fused together as a result of dialogue and ultimately results in a new altered understanding. The findings that resulted from the interpretive hermeneutic analysis are presented in Chapter 7.

5.11 Reflective Account

The use of a reflexive diary aided in developing my pre-understandings as well as tracking my methodological decision-making and interpretive journey. This account highlights the key issues I dealt with during sampling, data collection, and data analysis, and how they informed decision-making.

Prior to data collection, I examined my pre-understandings of birth trauma and the decision to not have more children (Section 5.3 My Pre-Understandings). My understanding of birth trauma was overly simplified, only thinking of it as a consequence of medical intervention, obstetric emergency, and adverse outcomes. While these factors are known causes of traumatic birth experiences, this perspective failed to acknowledge the significant impact that interactions with care-givers and social issues can have on the birthing experience. Furthermore, as a midwife I have only worked with women who were pregnant or had recently given birth. Professionally, I had never met women who had definitively chosen against subsequent pregnancies following a traumatic birth experience. Instead, I frequently met women who were opting for elective CS due to their previous traumatic birth experiences, resulting in elective CS representing a solution for those impacted to grow their family. The research process has fundamentally transformed my conceptualisation of birth trauma and its long-term implications. From engaging with the

literature to conducting interviews, my perception has evolved to embrace the multifaceted nature of traumatic birth. I acknowledge the more nuanced and complex aspects of traumatic birth experience, and how this emerges in data analysis and the findings. I have included extracts from my reflective diary that illustrate this development;

> *'Eilish's births were two and five years ago but she spoke about them as if they were last week. From the start of the interview I could hear in her voice the emotional toll this has taken on her. I have read so much about birth trauma but hearing Eilish talk about her experience is so much more intense and emotional. From what I heard, Eilish really suffered from being dismissed during her first pregnancy and birth, when she was dismissed again during her second, it really triggered her trauma. I think she was very articulate about her feelings, especially with her grief.'*

> *'Her body and mind were so effected by the sounds and sensations during the CS, her descriptions are so clinical and disconnected, she could be describing a dental extraction as opposed to a birth. After going through this traumatising experience twice, it is no surprise she cannot do it [CS] a third time.'*

> *'I am so shocked and disappointed to hear Lucy was treated this way by midwives. I feel really embarrassed for my profession right now. I especially do not understand why they did not facilitate her to visit the NICU and then later act like this was her decision. I am not naive about how some midwives behave however this really shocked me, I wonder where their empathy has gone. This is a stark reminder of how important it is to treat every woman in my care with kindness.'*

Throughout data collection, I found it necessary to consciously cultivate openness towards accounts that challenged my preconceived notions of birth trauma, particularly during sampling. This required reflexivity to ensure I remained open to narratives that diverged from my pre-understandings, allowing unexpected dimensions of traumatic birth experiences to emerge and inform the research process. When I was unsure on whether to include a participant during the recruitment process, I discussed their experience with my supervisors to minimise my own bias. Ultimately anyone who defined their birth experience as traumatic was included as it aligned with the chosen definition of birth trauma as well as

the methodological philosophy underpinning the research. This methodological choice resulted in richer and more diverse narratives that yielded more comprehensive insights into the phenomenon of limiting family size after traumatic birth.

> *'I enjoyed talking with [participant] and appreciated her time but I think I am a bit frustrated. I offered many times to discuss the study over the phone with her which never happened. She assured me over email that she read the information leaflet and understood the study so I took her word for it. I realised pretty quickly into the interview that I may have excluded her as she always wanted two children and now has two children. She did say that her pregnancy and postpartum experience did make her think she would not have a third child. I think I need to be more open to a wide variety of experiences. So far all the participants I have spoken to are devasted that they are not having more children. Maybe I am closing myself off to [participant's] experience because she did not seem distraught? She did say that she was lucky to have a boy and girl as she would be more upset if she did not have a daughter. I will be able to reflect better on her experience when I am transcribing this interview. I have to remember she suffered a massive birth trauma and subsequent postnatal depression. I have to remember the phenomenological attitude and stay OPEN!'*

During the process of data analysis, insights from the participant's experiences guided how I wished to present the findings. A sense of journey or temporality emerged from the participant's experiences. In other words, their traumatic experiences had set them on a difficult decision-making journey, this journey was non-linear as they often went back and forth on previous decisions. The decision-making process did not always signify a resolution or endpoint, rather, the persistent effects of trauma continued to appear in the participants' lives. This influenced my analytic choices as I wanted to reflect this temporal aspect of the narratives in how I presented the findings.

This account illustrates the importance of reflexivity in the research process, particularly the impact researcher preconceptions may have on methodological decisions. Although this is not a complete account, it highlights the key issues that were present in my reflexive diary during data collection and analysis.

5.12 Ethics

All research that involves human subjects has ethical implications and so researchers have an obligation to apply ethical principles to all their research activities to ensure participants are protected at all times. Ethical approval was granted by the TCD Faculty of Health Science Research Ethics Committee (appendix 8). As part of the recruitment process, the MAMMI study also submitted an amendment to their ethical approval which allowed me access to their database.

5.12.1 Protecting Participants

All research should be conducted in a way that protects participants, however extra considerations may be warranted when conducting research in a trauma exposed population. Published in 1979, The Belmont Report remains the most widely used set of principles when it comes to conducting research with individuals who have been exposed to trauma (NCPHSBBR, 1979). The report outlines three basic ethical principles that are particularly relevant to research involving human subjects; respect for persons, beneficence, and justice (NCPHSBBR, 1979). In the absence of up-to-date gold standards for trauma-informed research, Jefferson *et al.* (2021) conducted a scoping review to identify recommendations for conducting public health research with trauma-exposed populations and developed several recommendations. When conducting research with trauma-exposed individuals, it is important to focus on creating positive change, such as advocating for these communities and working toward de-stigmatization (Jefferson *et al.*, 2021). Equally essential is centring the agency and growth of participants by continually assessing and adapting to their needs for autonomy and safety (Jefferson *et al.*, 2021).

The principle of respect for persons recognises that individuals should be treated as autonomous agents who are capable of self-determination (NCPHSBBR, 1979). The decision to participate has to be voluntary and free from coercion or undue influence (LoBiondo-Wood & Haber, 2014). The recruitment and consent process has previously been discussed in detail. To summarise, anyone who registered interest in participation were sent a letter of invitation, a participant information leaflet and informed consent form. They were all written in plain English to ensure that their contents were easily understood by everyone. Informed consent was sought from each participant and was maintained on an ongoing

basis, participants were aware they could withdraw at any time. The principle of beneficence entails the duty to prevent harm and maximise possible benefit (LoBiondo & Haber, 2014). Before conducting any research, it is important to consider it's necessity as well as it's benefit to research subjects and society. The phenomenon of interest is understudied and not well understood in the literature. Although this study does not have any direct benefits to the participants, they may find sharing their experiences to be a cathartic process. They may also benefit from the knowledge that their participation contributes to building the area of birth trauma research, and that it may aid in future research, services and supports. In a review of recommendations on research with trauma-exposed populations, Jefferson *et al.* (2021) found that research participation can be meaningful and participants may have a desire to improve things for others. During data collection, some women shared that they were relieved to learn that their experience was shared with others as they had felt completely isolated and alone in what they had gone through. Furthermore, some women thanked me for conducting research on this topic and hoped that their participation would prevent harm to others.

Despite these perceived benefits, it remains crucial to recognise and address possible risks to the participants. My main concern was the possibility that discussing their birth-related trauma may cause emotional distress. When conducting research with trauma-exposed individuals, it is recommended to be transparent on both the potential risks and benefits associated with participation (Jefferson *et al.,* 2021). These were highlighted in the participant information leaflet (appendix 5) so that individuals could make a fully informed decision on whether participation was right for them. To minimise the possibility of harm to participants it is recommended to provide quality resources either through guidance or referral, and to monitor emotional wellbeing during and after data collection (Jefferson *et al.,* 2021). As this research was not funded, it was not possible to provide follow-up counselling services to participants. Instead I provided details for a birth trauma support group as well as the webpage for The Birth Trauma Association (UK based charity). Distressed participants were encouraged to talk with family, friends, or a trusted healthcare professional.

Based on the right to fair treatment, the principle of justice requires equal and fair treatment to all persons (LoBiondo & Haber 2014). Researchers have an obligation to treat

participants fairly and equitably throughout all research processes (Nursing and Midwifery Board of Ireland, 2015). Historically, injustices within research have a occurred as a result of social, cultural, racial and gender bias (LoBiondo & Haber 2014). To eliminate such bias and unfair treatment, participants from any social class, culture, race, religion, or sexual orientation were welcome to participate. Participant selection should be based on study requirement only (Polit & Beck, 2017), and so the inclusion criteria was centred on the phenomenon of interest and participation was open to those who identified themselves as eligible. Due to financial constraints, participation was limited to those literate in English. The principle of justice also extends to how participant's data is used and stored. To ensure equal and fair treatment of participant's data, legislation such as GDPR and Data Subject Rights were adhered to at all times.

5.12.2 Privacy and Confidentiality

A participant's right to privacy is protected through confidentiality. Anonymity is the most secure means of protecting confidentiality, and occurs when a subject's data cannot be linked to the participant in anyway including by the researcher (LoBiondo-Wood & Haber, 2014; Beck & Polit, 2017). Due to the study's design, anonymity from the researcher was not possible as data was collected through face-to-face interviews. When full anonymity is not possible, confidentiality must be guaranteed. Confidentiality in research means that individual's identities cannot be linked to any publicly reported data (LoBiondo-Wood & Haber, 2014). It also means that researchers should not discuss information relating to participants with anyone (Beck & Polit, 2017). There are exceptional circumstances where confidentiality may be breached (NMBI, 2015), for instance in cases where there is a risk of harm to an individual and it requires reporting to the relevant authorities. Participants were advised of the limits to anonymity and confidentiality in the participant information leaflet.

I implemented various measures to ensure confidentiality and to anonymise data. From the outset, I did not discuss participant’s identities or identifying information with others. Once the interview audio was fully transcribed, I anonymised the transcripts by removing all identifying information. Pseudonyms were adopted and place names changed. Each participant was assigned an identification (ID) number which was linked to the anonymised transcript. A document containing both the participant's name and ID number was kept in

the event that a participant wanted to withdraw from the study or request a copy of their transcript. This document was encrypted and stored on my TCD OneDrive under double password protection. The participant's identifier is completely anonymous in all reports, publications and presentations arising from this study. When direct quotes are used, identifiable information has been removed.

5.12.3 Data Protection

The process to receive ethical approval involved the completion of a Data Protection Impact Assessment that was reviewed by the TCD Data Protection Officer. GDPR and Health Research Regulation training was also completed. Both of these courses addressed the legislative responsibilities of researchers regarding the collection, storage, use, and assessment of personal and sensitive data from research participants.

5.13 Rigour

Rigour is the means by which researchers ensure consistency and quality in their research studies. In qualitative research, rigour is traditionally demonstrated through the principles of trustworthiness; credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Applying a generic set of qualitative rigor criteria to interpretive phenomenological studies poses a challenges as it conflicts with the methodology's underlying philosophical principles (De Witt & Ploeg, 2006). De Witt and Ploeg (2006) provide a "framework of expressions" (p.216) for establishing rigour in interpretive phenomenological research. These expressions of rigour are balanced integration, openness, concreteness, resonance and actualisation (De Witt & Ploeg, 2006). These expressions are used to invite the reader to assess the expression of these components in a study, rather than to assign a measure of quality (Dibley *et al*., 2020).

Balanced integration is concerned with the congruence between the philosophical underpinnings of the study, the research topic, and the researcher (De Witt & Ploeg, 2006). When appropriate, I have intertwined philosophical concepts throughout this chapter, highlighting how they underpin the conduct of this study. Openness emphasises the importance of a systematic and transparent process for documenting the numerous decisions made throughout research process (de Witt & Ploeg, 2006). I have achieved this

through detailing the methods and procedures used to conduct this study throughout this chapter. Furthermore, I recorded my interpretive decisions in my reflexive journal, this serves as an audit trail. Concreteness refers to when study findings are presented in a way that situates the reader in the context of the phenomenon (de Witt & Ploeg, 2006). Chapter 6 contains summaries of the participants' lived experiences, providing readers with the context of their birth trauma and decision to limit family size. In Chapter 7, in-depth descriptions and verbatim quotes are used to present the findings. Resonance is the "phenomenological nod", a gesture of agreeing, an acknowledgement of understanding from the reader (Crowther & Thomson, 2023; van Manen, 2016, p.27). Although I cannot ensure that the findings will resonate with readers, I presented them in a way that brings the reader on the journey of the lived experience and shows meaning. The fifth proposed expression of rigour is actualisation (de Witt & Ploeg, 2006), essentially what is produced from the study. I have not yet presented my findings in a public forum or submitted them for publication, however I have plans for dissemination.

5.14 Conclusion

In conclusion, this chapter has provided a detailed overview of the methods employed in this research study, blending procedural guidance with the conceptual and philosophical foundations that shape its design. The integration of philosophical concepts, particularly those central to hermeneutic phenomenology, has been highlighted throughout, demonstrating their influence on the study's approach and interpretation. The chapter also outlined the research aims, as well as the sampling, recruitment, data collection, and interpretive processes, offering a comprehensive view of the study's structure. Considerations regarding ethics and research integrity were addressed to ensure a responsible and respectful approach to working with participants. With these foundations laid, the following chapter will present the findings of this study.

Chapter 6: Introducing the Participants

6.1 Introduction

The following chapter presents an introduction to each participant and their lived experience. Each introduction provides information about the participant's age and family, as well as a brief description of their subjective lived experience of pregnancy, birth, and their decision to limit family size. These descriptions do not contain any of my own interpretations, instead they are based on the participants' own descriptions. The purpose of these introductions is to familiarise the reader with each participant. Furthermore, they aim to highlight the events that contributed to each participant's birth trauma, offering important context for the findings.

Relating back to the underpinning philosophy, Heidegger's concepts of *Dasein* and *Being-in-the-World* emphasise that each participant's reality is shaped by their embeddedness in the world. Smythe *et al*. (2008) emphasises that removing a story from its rich textual background is to remove meaning, making it impossible to fully understand the experience as it was lived. Phenomena need to be examined within the context of their existence in the living world, where people naturally find themselves (Smythe *et al.,* 2008). By providing a brief overview of each participant's lived experience, I aim to provide the context in which the phenomenon of interest occurs.

To ensure privacy and protect anonymity, all identifying information has been altered and pseudonyms are used throughout. Three of the participants are not of Irish origin but gave birth and live in Ireland, their countries of origin have been changed to further protect their anonymity.

6.2 Eilish

Eilish is 36 years-old, she is married and has two sons aged 5 and 2. Eilish's labour was induced for postdates on her first baby. Her induction experience was long and exhausting, she experienced intense, frequent contractions for hours before requesting an epidural. Eilish had wanted a physiological drug-free birth. Her expectations were unmet, resulting in feelings of personal failure. Her transition to motherhood was also difficult, her baby had ongoing feeding issues, and she experienced an overall heightened level of anxiety. Her

birth experience coupled with her transition to motherhood contributed to her birth trauma.

It took two years before Eilish was ready for another baby. Throughout her second pregnancy, Eilish felt constant fear and anxiety about the upcoming delivery resulting in physiological stress symptoms. Eilish's labour was induced for suspected fetal macrosomia. This induction was longer and more painful than her first resulting in a traumatic forceps delivery. During labour and birth, Eilish was treated poorly by the midwife and obstetrician. She felt dismissed and unsafe in their care and was given an episiotomy without her consent. The pregnancy and delivery, as well as the detrimental treatment from staff and loss of autonomy, all contributed to Eilish's birth trauma. After this birth, Eilish and her husband decided to not have more children. They had originally dreamed of filling their home with children, with Eilish especially hoping for a daughter.

6.3 Emma

Emma, 47, is married and has a 9 year-old son. Emma's pregnancy was an unpleasant experience, marked by constant nausea and intense discomfort with the changes in her body. Emma feared vaginal birth and doubted her ability to give birth. Emma's labour was induced for postdates. After labouring for hours with an epidural, her baby became tachycardic and labour was not progressing. A decision was made to perform an emergency caesarean section (CS). Emma was relieved to avoid a vaginal birth, however the reality of a CS did not meet expectations resulting in a traumatic experience. Emma felt breakthrough pain and recounts the sensation of the doctor's scalpel on her skin followed by him pulling at her abdomen. She cried in distress throughout, becoming so overwhelmed with fear that she did not even want to see her baby once he was born.

Emma's transition to motherhood was challenging. She felt inadequate in her ability to care for her baby and feared being left alone with him. Becoming a mother was a shock to the system, as the changes to her life were hard to accept. On reflection, Emma believes she was struggling with postnatal depression. Emma always thought she would have more than one child, however her experience made her reconsider and decided that one was enough.

6.4 Lucy

Lucy, 39, is a married mother to twins; a boy and a girl aged 6. Lucy had a positive pregnancy experience. At 36 weeks, she began to feel unwell and presented herself to the maternity hospital. Lucy was quickly diagnosed with HELLP (haemolysis, elevated liver enzymes and low platelets) syndrome, a life-threatening condition of pregnancy. She was rushed to theatre to have an emergency CS under a general anaesthetic. Lucy haemorrhaged during surgery and her blood pressure was hypertensive, however she felt immense relief that both her and the twins were alive and well. Lucy's birth trauma did not stem from the birth itself, instead she was traumatised from the treatment she received from staff on the postnatal ward.

Lucy describes how she was undermined, 'gaslighted', judged, and criticised by the midwifery staff. Lucy's daughter was in the NICU after birth and as walking was difficult, she requested a wheelchair to visit her daughter, however assistance was not provided. The midwifery staff later referred Lucy to the mental health team as Lucy seemed disinterested in her daughter. They passed comments that questioned Lucy's ability to care for her babies, judged her emotional reaction to her birth and for wearing make-up. The midwives lacked empathy and were unsupportive. Lucy was made to feel like she had to prove herself. Lucy endured a week of this until reaching her breaking point and fought to be discharged. As a result of this experience, Lucy made the decision to not have more children.

6.5 Aisling and Conor

Aisling, 38, and Conor, 43, are a married couple. They have a 5 year-old daughter. Aisling's pregnancy went smoothly. She planned to use a birthing pool and avoid intervention to ensure a natural birth experience. Aisling's labour was induced as her membranes ruptured and she did not go into spontaneous labour. When presenting to hospital, Aisling was told very little about the care plan. She was not allowed to use the pool, eat, or even move around during labour. She was given very painful vaginal examination. Conor and Aisling describe one midwife as abrasive, domineering, and bullyish. Conor witnessed her mocking Aisling's birth plan with other staff members. Aisling was pressured into an oxytocin infusion, an epidural, and eventually a CS. Aisling's epidural did not work on one side of her abdomen, she felt the excruciating pain of being cut open during the CS.

On the postnatal ward, Aisling felt neglected as the midwives were too busy to provide basic care. She was pressured to give formula top-ups to her baby, and due to lack of proper guidance, damaged her breast tissue with a breast pump. Aisling suffered with postnatal depression and attended a counsellor that specialised in PTSD therapy. Harmful and unsupportive care compounded with unmet expectations resulted in a traumatic experience for both Aisling and Conor. They both agreed to not have more children as a result. Although the couple did not have a specified plan for their family size, Aisling said that she wanted at least two children.

6.6 Maria and Peter

Maria, 46, and Peter, 53, are a married couple with two sons, aged 10 and 6. Maria strongly desired a natural birth, but her obstetrician recommended she have an elective CS due to uterine fibroids. Maria was traumatised by her CS experience. Being surrounded by strangers, cut open, and then handed her baby felt invasive. She felt helpless and completely out of control. In contrast, Peter describes the CS as a magical experience. He sat beside Maria's head, and before he knew it, their baby appeared, filling him with instant love. In the immediate postnatal period, Maria struggled with pain and had difficulty caring for her baby. She had postnatal depression as she adjusted to motherhood. Peter tried his best to support her but admits he did not fully understand her trauma.

The couple had fertility issues when trying to conceive their second baby, but Maria became pregnant without any treatment. Maria was suicidal during this pregnancy, she was seen by the psychologists and psychiatrists in the maternity hospital, however she did not feel supported or appropriately cared for. The obstetricians felt the safest option for birth was another CS which left Maria devastated. The lead up to the procedure was particularly difficult this time as she knew exactly what to expect. During the CS, every sensation and sound triggered a traumatic reaction for Maria. It was a physically and mentally traumatic experience. The postnatal experience was difficult for both parents. Peter worried for Maria again, he was afraid of what she might do. He knew her mental state was fragile and did everything he could to best support her. Maria would have liked more children, especially a daughter, but a third CS was out of the question. Peter supported this decision.

6.7 Niamh

Niamh is 40 years-old, she is married with two children; an 8 year-old son and a 5 year-old daughter. It took two years and fertility treatment to conceive her first baby. Niamh's pregnancy was straightforward. Her labour started spontaneously and lasted hours. After pushing for approximately an hour, the obstetrician unsuccessfully tried to deliver the baby with a ventouse. He then performed a forceps birth. Niamh had wanted to avoid an instrumental birth, especially the forceps. After the delivery Niamh and her husband were in shock. Niamh was exhausted, she fainted on the postnatal ward and even suffered with memory loss in the days after the birth. In the first year after birth, Niamh had severe postnatal depression, intrusive thoughts and flashbacks from the birth. She eventually saw a psychiatrist and had cognitive behavioural therapy.

On her second pregnancy, Niamh chose a private obstetric consultant on the basis that she could have a CS for a previous traumatic birth. She was booked for a CS at 39 weeks but went into spontaneous labour at 37 weeks. Niamh chose to have a vaginal birth which was a healing experience. She also suffered with postnatal depression but had a mental health plan in place. Although she had a healing birth experience, the trauma from her first birth and her challenges with postnatal depression influenced her decision to not have more children.

6.8 Hannah

Hannah, 49, is originally from South Korea. Her partner is from Belgium. They have two children, a son aged 10, and a daughter aged 5. During her first pregnancy at 39, she was referred for genetic testing, the results of which were clear. However, Hannah's partner and his mother was not reassured, setting off a series of events that left her feeling traumatised. They put immense pressure on her to have more testing in Belgium and encouraged her to have an abortion if the baby had any abnormalities. Hannah objected profusely. While on a trip to Belgium, Hannah's partner organised for them to have a 3D scan. However, on arrival to the clinic, Hannah discovered he had also booked additional genetic tests. This was deeply upsetting and intrusive for Hannah, she felt like a vessel. Overall, pregnancy was a stressful experience. Hannah went into spontaneous labour but had an emergency CS when labour did not progress, it was not a traumatic experience.

Hannah was hesitant to have a second baby because of her partner's behaviour during the first pregnancy. As the years passed, she wanted another baby. Her second pregnancy ended in a miscarriage, and it took considerable time to conceive again. During her third pregnancy, her daughter was diagnosed with a congenital heart defect. Understandably, this was very stressful, but Hannah also feared that her husband and his family would reject the baby. She had an elective CS and her baby was transferred to a children's hospital. Hannah's daughter had surgery and is living a healthy life. Hannah's decision to not have more children was influenced by her pregnancy experiences, but her age and daughter's health also influenced this decision.

6.9 Leah

Leah is 42 years-old, she is married with two children; an 8 year-old son and a 6 year-old daughter. Leah describes her journey to motherhood as traumatic. She had two miscarriages in short succession of each other. After these losses, she sought fertility treatment and became pregnant with her son. This pregnancy was textbook. Labour was induced for post-dates and Leah's baby was born with vacuum assistance. Overall, Leah's experience was positive.

Approximately thirteen months later Leah was pregnant again. The pregnancy was straightforward except her baby was breech. Leah wanted to avoid a CS and so she opted for an external cephalic version. It was painful and unsuccessful, causing distress to her baby. She was admitted as an inpatient for monitoring and during the night she went into labour. Panic ensued, she was progressing quickly and her baby was coming feet first. Leah's husband arrived just in time for the CS. During the procedure, Leah felt everything and screamed throughout. This experience left her traumatised and unwilling to have more children. While she initially envisioned a house of full of kids, she thought she'd have at least three children. Leah also felt that her baby was traumatised by the birth, as she was unsettled, often sick, and slept poorly.

6.10 Ruth and Michael

Ruth, 42, and Michael, 37, were a married couple when they had their son. They have since separated but co-parent amicably. Their son is 6 years-old. They never planned to have children, but Ruth became pregnant accidentally. Earlier in her life, Ruth wanted four children, but this changed after a traumatic abortion experience.

Pregnancy was a physically and emotionally traumatic time for her. She had severe hyperemesis gravidarum which made day-to-day living difficult. She felt unsupported and isolated, resulting in antenatal depression. Michael did not cope well with his new responsibilities; he describes feeling resentful during this time. Both Ruth and Michael state their relationship suffered during the pregnancy.

Ruth's labour was induced at 37 weeks which resulted in an emergency CS. She describes the CS as the only positive part of her whole pregnancy experience as she made the decision to have a CS, giving her back the control she had lost during the pregnancy. Ruth and Michael found the transition to parenthood difficult. Ruth felt pressured to breastfeed by midwifery staff, however breastfeeding was a struggle. Unable to breastfeed, she felt like a failure, triggering the start of her postnatal depression. Michael also struggled with depression and fatigue, passing out from exhaustion on several occasions. Although Ruth and Michael never planned to have children, they both contemplated whether they should have more so their son would have a sibling. However, their experience of pregnancy and the breakdown of their relationship cemented their decision to not have more children.

6.11 Aileen

Aileen, 39, is married with three children; a 10 year-old daughter and two sons, aged 7 and 4. Aileen hated being pregnant, she had hyperemesis gravidarum which made it difficult to manage her daily life. She was miserable and eagerly awaited birth. Aileen's first labour was induced as her membranes ruptured and she did not go into spontaneous labour. The birth was a traumatic experience. The obstetrician initially attempted a ventouse delivery, but when that failed, it resulted in a forceps-assisted birth and a postpartum haemorrhage. After this traumatic experience, Aileen was hesitant to have another baby, but she gradually warmed to the idea.

Due to a personal bereavement and tocophobia, Aileen was in a heightened state of anxiety during her second pregnancy. Her second labour was induced after she had a significant antepartum haemorrhage on the pre-labour ward. Aileen's anxiety about the birth intensified, as the medical staff could not identify the source the bleeding. Her second baby was born with vacuum assistance. Both of Aileen's births were traumatic experiences, she decided with her husband to not have any more children. It was a difficult decision to accept, but she slowly accepted it. Three years later, Aileen had an unplanned pregnancy. This pregnancy was emotionally and physically draining, ending in a distressing birth experience.

6.12 Siobhán and Diarmuid

Siobhán and Diarmuid are a married couple in their mid-forties. They have two sons, ages 6 and 4. Siobhán's second pregnancy and birth were straightforward. The couple were overjoyed with the birth of their second baby, Siobhán describes being in a postpartum bubble of love. At 11 weeks postpartum, Siobhán had a cardiac arrest and was diagnosed with a life-threatening cardiac event. Siobhán was admitted to the ICU and separated from her baby due to infection control concerns. She also had to suddenly stop breastfeeding, and she could not pump and dump as the medication would be in her system for approximately 18 months. Siobhán said this was particularly heartbreaking as breastfeeding held deep meaning for her.

Siobhán and Diarmuid planned to have more children, but as the cardiac event was likely caused by pregnancy, Siobhán was strongly advised to never become pregnant again. Almost four years later, Siobhán still struggles with accepting that she will not have more children whereas Diarmuid has found it easier.

6.13 Gráinne

Gráinne, 42, is married with two children, a daughter aged 9, and a son aged 7. Her first pregnancy ended in a miscarriage, after taking time to emotionally heal, she became pregnant again one year later. Gráinne enjoyed being pregnant and prepared for labour with yoga and breathing techniques. Her labour was induced for postdates and she had a straightforward vaginal birth. However, Gráinne was given an episiotomy which caused her

to excessively haemorrhage. Staff filled the room and the atmosphere became panicked. They tried to stop the bleeding by repairing the episiotomy, this was excruciating for Gráinne as she did not have an epidural and the local anaesthetic did not work properly. Once the bleeding had stopped, the room looked like a war zone. In the days after birth, Gráinne was extremely weak and had two blood transfusions. Both Gráinne and her husband were traumatised by this experience and hesitant to have another child.

The couple eventually decided they wanted another baby and Gráinne became pregnant about a year later. Pregnancy went well but Gráinne was anxious about delivery. She went into labour spontaneously. The birth was complicated by a shoulder dystocia, however it was not a traumatic experience. The midwives acted quickly, guiding Gráinne through it to safely birth her son. In the following weeks, Gráinne became extremely anxious and obsessive, unable to cope properly. Her GP diagnosed her with postnatal anxiety, she started medication and counselling. Gráinne believes it was a delayed reaction to her first traumatic birth. The couple originally wanted three or four children, but they limited their family size as Gráinne feared her mental health would deteriorate again.

6.14 Carmen

Carmen, 41, is an Italian woman living in Ireland with her husband and children. She has two daughters, one aged 6 and the other 6 months. Tragically, her son died at 14 weeks gestation due to a fatal fetal abnormality. Carmen's eldest daughter was born preterm at 27 weeks' gestation and subsequently spent three months in the NICU. During this time, Carmen feared for her baby's wellbeing and endured many highs and lows. When her daughter was discharged home, Carmen was overjoyed but also filled with anxiety and fear. She did not sleep properly as she feared her daughter would stop breathing during the night. Carmen was not coping well, she eventually went to her GP who diagnosed her with PTSD. Carmen started taking medication to manage her PTSD symptoms and eventually she got better.

Carmen and her husband wanted another baby but feared another preterm birth. After much reassurance from the GP, Carmen became pregnant again. At her first scan, the sonographer found an anomaly and further testing diagnosed her baby with a fatal fetal abnormality. Carmen gave birth to her son at 14 weeks after he died in-utero. After the

trauma of both pregnancies, Carmen and her husband decided not to have more children despite originally planning to have at least three children.

The years passed and Carmen became pregnant with a surprise baby. Carmen's surprise baby was born at 34 weeks, she spent 10 days in the NICU before being discharged home. During the pregnancy, obstetricians found Carmen's cervix was shortening prematurely which caused her to go into preterm labour. Despite being very happy with the outcome of this pregnancy, Carmen still did not want more children as she'd likely have another preterm birth.

6.15 Cara

Cara, 41, is married with three daughters, ages 11, 6, and 1. Cara's first pregnancy and birth was an overwhelmingly positive experience. She did not have an exact plan for her family size however she knew she wanted more than one child. Cara's second pregnancy was straightforward, she went into labour spontaneously and progressed quickly. There was no time for an epidural before Cara gave birth to her second daughter. Approximately an hour later, Cara noticed she was losing an excessive amount of blood. Before she knew it, Cara was surrounded by midwives and doctors who were trying to stop the bleeding. Cara believed she was dying, all she could think about were her children being left without their mother. The bleeding finally stopped after a doctor manually removed placental lobes from Cara, the pain was excruciating.

Cara was left completely traumatised, suffering from flashbacks, nightmares and postnatal depression over the following months. Cara decided not to have more children due to this traumatic experience. Three and a half years passed before Cara accidentally became pregnant. It was a tough pregnancy as Cara was extremely anxious about the birth and the possibility of another haemorrhage. She was reassured by the hospital staff and told they would give her extra medication to prevent another haemorrhage. The birth of her third daughter was a positive experience however Cara says she will never forget the trauma from her second birth.

6.16 Orla

Orla, 38, is a Polish woman living in Ireland with her partner and two daughters, aged 6 and 4. During her first pregnancy she prepared herself for a physiological birth by reading holistic birth material. Orla laboured at home, using natural methods to help alleviate her pain. Eventually she went to the hospital and had a straightforward vaginal birth. Orla's birth was a fulfilling experience. She struggled with breastfeeding for the first few months before it eventually became enjoyable.

Orla became pregnant again about 14 months later. During the third trimester, the obstetricians increased monitoring as they were concerned with her baby's weight. At the end of her pregnancy, she was admitted when doctors became concerned with her baby's heartbeat. They wanted to induce labour, but Orla refused, instead she negotiated to stay over the weekend for monitoring. Orla felt completely dehumanised, especially as the staff discussed her as if she was not present. The doctors never offered explanations or rationale for the interventions they were suggesting, despite Orla asking and being open to a conversation. During the night, the obstetric consultant was called as staff became increasingly concerned for her baby's wellbeing. After this everything happened quickly, Orla agreed to a CS as she did not have energy to fight anymore. The procedure itself was not traumatic for Orla. Her second daughter was born safely and healthy which was a massive relief for Orla and her partner.

Orla was traumatised by the treated she received as she felt the doctors treated her like a vessel. Orla's birth trauma manifested itself as physiological symptoms, thinking about the birth would cause shortness of breath, palpitations, nausea, and shaking. She attended a therapist to process her trauma. Orla always thought she would have three children, but due to her experience, Orla and her partner decided not to have anymore.

6.17 Conclusion

This chapter has provided succinct summaries of the participants' subjective lived experiences. The participants' traumatic experiences were defined by significant illness during pregnancy, insufficient social support, obstetric interventions, emergencies, mental health struggles, and disrespectful or neglectful treatment from maternity care givers. Their accounts highlight the personal nature of traumatic birth experiences, illustrating how each

person has a distinct threshold for what they consider traumatic. The next chapter presents the findings that emerged from hermeneutic analysis of these lived experiences.

Chapter 7: Findings

7.1 Introduction

This chapter presents the findings that resulted from the iterative hermeneutic analysis of the transcripts. The findings are presented through passages, emerging themes, and a constitutive pattern. My aim was to present the findings in a way that conveys the lived human experience and resonates with the readers (Crowther et al., 2017). van Manen (2016) states that good phenomenological writing reawakens a fundamental experience of a phenomenon, allowing the reader to gain a deeper understanding of it as a lived experience. Hermeneutic phenomenology researchers seek the "phenomenological nod," a response that occurs when the narratives evoke emotions and provoke contemplation or reflection in others (Livermore, 2023; van Manen, 2016, p.27).

7.2 Overview of the Findings

The findings are presented through passages, emerging themes, and a constitutive pattern. Passages are used to narrate the lived experience and illustrate how the emerging themes relate to one another. The use of passages to present findings, to my knowledge, is unique to this thesis. Selecting this term involved a brainstorming process, during which I was especially mindful of the tone I aimed to convey. "Stages" or "steps" felt overly structured and definitive, lacking the narrative quality I aimed for. “Chapters" or "episodes" implied an overarching story and enhanced the sense of narrative; however, they still implied a level of structure and limited movement. “Passage” conveys fluidity, progression, and a broader journey. Each passage represents a different stage in the participants’ evolving experiences. Although this approach to presenting findings may be unconventional, it aligns well with the interpretive nature of hermeneutic phenomenological research.

Common meanings in the participant’s lived experiences were identified and interpreted as emerging themes (Diekelmann, 1992). The emerging themes highlight the unique aspects of the phenomenon as experienced by each participant (Dibley et al., 2019), meaning that some themes were not present across all transcripts. However, the constitutive pattern expresses the relationship among the themes and is reflected in all the transcripts (Diekelmann, 1992). A constitutive pattern aims to represent a common meaningful experience shared by the participants (Dibley *et al*., 2019).

The passages are used as a narration device. They illustrate the three phases of the participants' lived experiences from when they made their decision not to have more children, to when they were interviewed. The emerging themes are organised into these three passages and represent unique aspects of the phenomenon experienced by the participants. The constitutive pattern represents the overall common meaning that emerged from the narratives of the participants' lived experiences. The relationship between passages, emerging themes, and a constitutive pattern is illustrated in Figure 1.

Figure 1: Presentation of Findings

Passage one, 'Confronting a Difficult Decision', deals with the how and why of decision-making. It consists of three emerging themes; 'Instinctive Knowing', 'Eliminating Risk', and 'Preventing Mental Anguish'. 'Instinctive Knowing' describes with how many of the participants arrived at their decisions, whereas 'Eliminating Risk' and 'Preventing Mental Anguish' outlines the specific influences over decision-making.

Passage two, titled 'Bearing the Burden in the Aftermath', describes the emotional consequences that many of the participants experienced after making their decision to limit family size. The emotional impact of this decision is captured in the emerging theme 'Navigating Emotional Turmoil', whereas 'Enduring Unfulfilled Expectations' deals with the emotional consequences of unmet expectations.

As the participants reflected on their experience, many described reaching a level of acceptance with what had happened and their decision to limit family size. However, acceptance did not imply they had moved past or completely overcome their trauma. Instead, they chose to move forward while acknowledging that their experiences remained deeply ingrained within them. Some participants, mainly their partners, even opted for sterilisation to help them move forward from their experience.

Passage three, ‘Moving Forward, But Not Moving On’, describes how participants feel about their experience and decision after the passage of time. The emerging theme 'Reaching Acceptance' describes how some of the participants have come to terms with their decision through a neutral lens of acceptance. 'Lingering Trauma' outlines how, for many of the participants, their trauma remains a constant presence even if it does not cause daily distress or disruption in their lives. 'Making it Permanent' details how some of the participants chose to make their decision permanent through sterilisation, and how this offered a way for them to move forward with their healing process.

The three passages and eight emerging themes are interconnected together through the constitutive pattern. The constitutive pattern aims to reveal the meaning of limiting family size as a result of a traumatic birth experience. The decision to not have more children was ultimately an act of self-preservation, forming the constitutive pattern: 'Acting on Self-Preservation'. An illustrated overview of the findings is presented in Figure 2.

Figure 2: Overview of the Findings

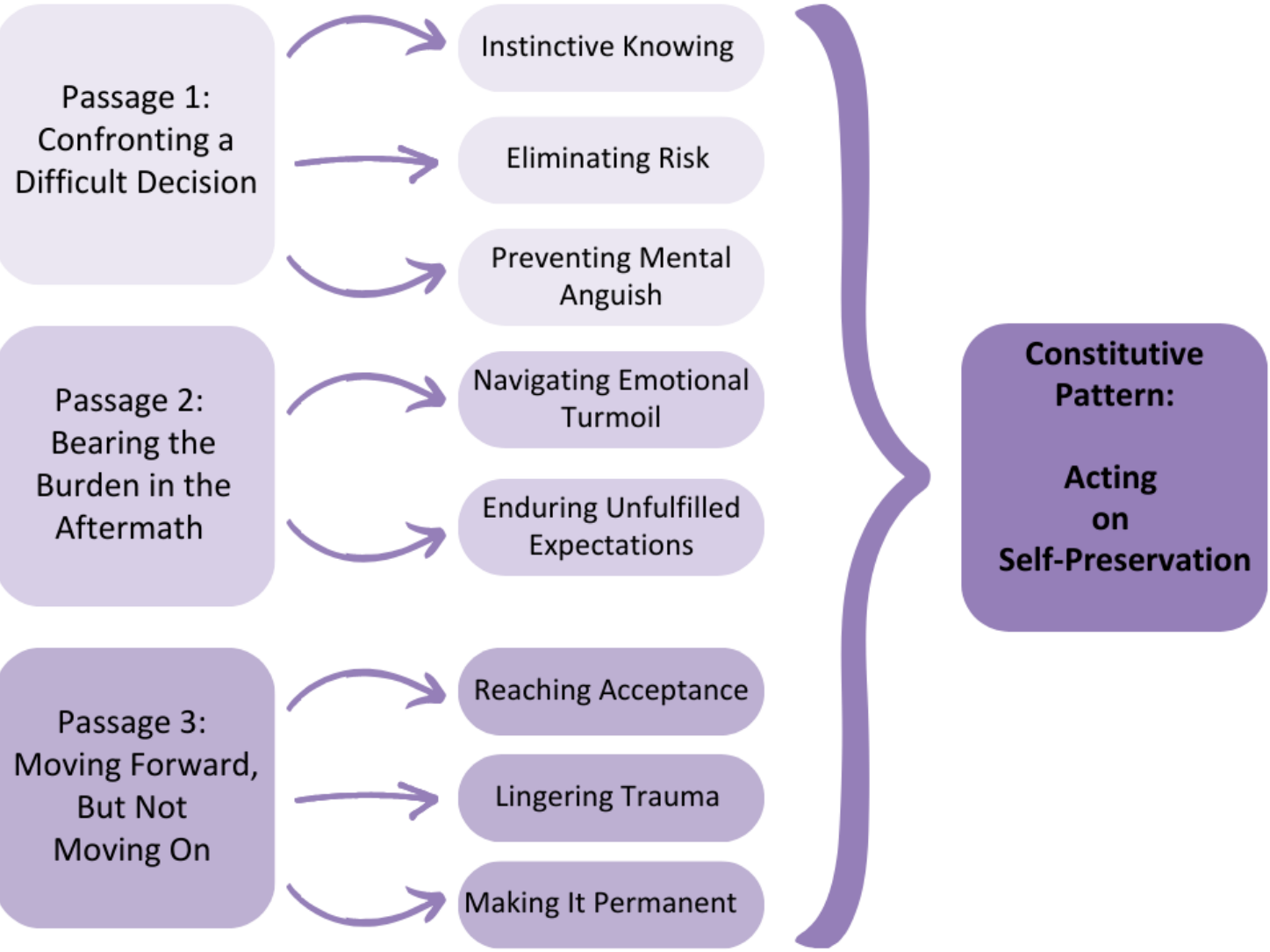


Table 5: Participant Characteristics			
Participant(s)	**Child(ren)**	**Mode of Birth(s)**	**Participants' Perceptions of their Birth Trauma**
Eilish	Two children; son, *age 6* son, *age 5*	1st Birth: SVD 2nd Birth: Forceps Birth	1st Birth: Long and painful IOL, unmet expectations, difficult transition to motherhood, postnatal anxiety. 2nd Birth: Long and painful IOL, forceps birth, episiotomy without consent, insufficient support and mistreatment from care providers.
Emma	One child; son, *age 9*	EMCS (spinal analgesia)	Pain during EMCS, difficult transition to motherhood, postnatal depression.
Lucy	Two children (twins); son , *age 6* daughter, *age 6*	EMCS (general anaesthetic)	HELLP syndrome, insufficient support and mistreatment from care providers.
Aisling & Conor	One child; daughter, *age 5*	EMCS (spinal analgesia)	IOL, pressure to consent to interventions, pain during EMCS, PPH, mistreatment from care providers, and neglectful care.
Maria & Peter	Two children; son, *age 10* son, *age 6*	1st Birth: ELCS (spinal analgesia) 2nd Birth: ELCS (spinal analgesia)	1st Birth: invasive experience of ELCS, postnatal depression. 2nd Pregnancy and Birth: suicidal ideation during pregnancy, repeat traumatic ELCS, postnatal depression.
Niamh	Two children; son, *age 8* daughter, *age 5*	1st Birth: Forceps Birth 2nd Birth: SVD	1st Birth: Failed ventouse birth, forceps birth, postnatal depression, intrusive thoughts.
Hannah	Two children; son, *age 10* daughter, *age 5*	1st Birth: EMCS (spinal analgesia) 2nd Birth: ELCS (spinal analgesia)	1st Pregnancy: Lack of social support, controlling behaviour from partner. 2nd Pregnancy: Baby diagnosed with congenital heart defect.
Leah	Two children; son, *age 8* daughter, *age 6*	1st Birth: Ventouse Birth 2nd Birth: EMCS (spinal analgesia)	2nd Birth: Failed ECV, EMCS due to breech presentation, pain during EMCS.
Ruth & Michael	One child; son, *age 6*	EMCS (spinal analgesia)	1st Pregnancy and Birth: Unplanned pregnancy, hyperemesis gravidarum, lack of social support, postnatal depression.

Aileen	Three children; daughter, *age 10* son, *age 7* son, *age 4*	1st Birth: Forceps Birth 2nd Birth: Ventouse Birth 3rd Birth: SVD	1st Pregnancy and Birth: Hyperemesis gravidarum, IOL. forceps birth, PPH, postnatal pain. 2nd Pregnancy and Birth: Prenatal Anxiety, APH, IOL, ventouse birth. 3rd Pregnancy and Birth: Symphysis pubis dysfunction, difficult labour.
Siobhán & Diarmuid	Two children; son, *age 6* son, *age 4*	1st Birth: SVD 2nd Birth: SVD	2nd Birth: Cardiac arrest 11 weeks postnatal.
Gráinne	Two children; daughter, *age 9* son, *age 7*	1st Birth: SVD 2nd Birth: SVD	1st Birth: PPH, severe pain. 2nd Birth: Postnatal anxiety
Carmen	Three children; daughter, *age 6* son, *deceased at 13 weeks' gestation* daughter, *age 6 months*	1st Birth: SVD 2nd Birth: Miscarriage at 14 weeks 3rd Birth: SVD	1st Birth: Preterm birth at 27 weeks, CB-PTSD. 2nd Birth: Baby died at 13 weeks' gestation due to a fatal fetal abnormality.
Cara	Three children; daughter, *age 11* daughter, *age 6* daughter, *age 1*	1st Birth: SVD 2nd Birth: SVD 3rd Birth: SVD	2nd Birth: PPH characterised by severe pain.
Orla	Two children; daughter, *age 6* daughter, *age 4*	1st Birth: SVD 2nd Birth: EMCS (spinal analgesia)	2nd Birth: Dehumanising and mechanical care, pressure to consent to EMCS, painful recovery.

7.3 Passage One: 'Confronting a Difficult Decision'

Passage one outlines how the participants came to the decision to limit their family size. This passage was purposefully named 'Confronting a Difficult Decision', as to confront is to face something or someone, especially as a challenge (Merriam-Webster, n.d.). The participants' traumatic birth experiences forced them into a situation where they had to face the difficult decision of whether they would have more children. In other words, their traumatic experiences confronted them with the question, could they possibly go through this again?

This passage is explored through three emerging themes; 'Instinctive Knowing', 'Eliminating Risk', and 'Preventing Mental Anguish'. 'Instinctive Knowing' deals with the instinctive nature of how participants arrived at their decisions, whereas 'Eliminating Risk' and 'Preventing Mental Anguish' outlines their individual reasons behind decision-making.

7.3.1 Emerging Theme: 'Instinctive Knowing'

For many participants, the decision to limit family size was instinctual, and came from a desire to prevent further trauma and protect themselves from further harm. The emerging theme 'Instinctive Knowing' refers to the deep, intuitive nature of how participants arrived at their decision. The women's experiences of birth trauma catapulted them into a state of being that ignited an instinctual need to protect themselves from further trauma by not becoming pregnant again. For almost all the participants, the decision to not have more children was difficult and often painful. They desired more children but instinctually knew they had to protect themselves from further trauma. The timing of reconciling with their decision varied, some were able to acknowledge it soon after their traumatic experience, whereas others needed time to process it and come to terms with it.

Many women recalled that, in the immediate aftermath of their traumatic experience, they experienced a realisation that they would never become pregnant again. Cara was still in the delivery room after a traumatic PPH when she knew she could not have another child. Her husband supported her, and they never discussed it again;

> *I knew I didn't want more children kind of straight away. My husband was even like that, he said he couldn't see me going through anything like that again. There's no*

way we could go again. And I was like; not a chance, not a chance. . . We were both in agreement, but it never really came up in conversation again because that was it. (Cara)

Both Leah and Aisling were debriefed by their obstetricians after traumatic EMCSs, they were both already sure they would never be pregnant again;

The doctor came to me afterwards. He goes, oh so the next one we'll do it vaginally regardless. I was like, there won't be a next one (Leah),
And after the section the surgeon said I'd give your body two years before conceiving. But I remember thinking in my head, no no, you don't have to tell me this because I won't be convinced in two years. I just knew then. (Aisling)

For others, it took a while to come to terms with their decision. The women instinctually knew that their traumatic experience would prevent them from having more children; however, it took time for these women to fully realise it or come to terms with it. Subconsciously, Lucy knew immediately after the birth of her twins that she would not have any more children. However, it took years to fully acknowledge this and come to terms with her decision. She was a first-time mother, looking after twins and going back to work at seven months postpartum. Her life was busy, and she likely did not have the mental capacity to deal with this difficult and emotional decision;

I think on a very cellular level, I knew straight away I couldn't go through it again, but I think my head probably didn't catch up with that for a couple of years. Like it was my first time obviously being a mum, I was looking after twins. So I think it was probably only actually formulated properly in my head, like when they were around three or so. (Lucy)

Maria innately knew while pregnant with her second baby that it would be her last, however, the journey to fully reconciling with this was a much slower process that continued long after the birth of her second child;

Ehh...I think a bit of both. It was immediate I can't do this again, physically and mentally. Emotionally can't do this again. But then that I think it is a much slower em process of realising that was it, there was going to be no more children. (Maria)

7.3.2 Emerging Theme: 'Eliminating Risk'

In the case of potential future pregnancies and births, certain actions can be taken to minimise the risk of another poor obstetric outcome or birth trauma or both. However, the risk of a repeat trauma can never be fully eliminated. For the participants, simply minimising risk was unsatisfactory, they wanted to eliminate it entirely. They understood that eliminating risk was impossible, and so the only way to fully protect themselves from another traumatic birth was to avoid future pregnancy and birth altogether. Thus, for some participants the decision to limit family size was motivated by their desire to eliminate the risk of another traumatising event.

Orla's second birth ended in an EMCS. The circumstances that led to the EMCS, as well as the immediate postnatal period, contributed to Orla's birth trauma. She felt dehumanised and pressured by the hospital staff, reducing her to a vessel rather than a person. Orla said that she eventually 'gave in' to the pressure to have an EMCS as she was tired of fighting. Her recovery was excruciatingly painful as she avoided strong painkillers due to breastfeeding. To protect herself from further trauma meant eliminating the risk of another CS. Orla understood that the likelihood of another CS was high and that is not a risk she was willing to take;

And when I think about it, there's a very high chance if you have had a caesarean that you'll be going for another caesarean, especially now that I'm older. And I know that there are people who are willing to give natural birth a chance. But now my options are even more limited, if you know what I mean. My percentage is much worse . . . And the thing is, I'm blessed that wasn't my first experience, because I might have only had one child. (Orla)

Lucy was traumatised by the treatment she received from her caregivers on the postnatal ward. She wanted to eliminate the risk of mistreatment, and so she made the decision to

not have more children. Furthermore, minimising the risk of mistreatment by attending another maternity hospital was not an option, as Lucy has heard anecdotal evidence of similar issues occurring in multiple maternity hospitals. For Lucy, the only way to eliminate the risk of further traumatising care, was to avoid ever being in a situation where she would need it again. In Lucy's words;

> *My experience has put me off (having more children). It has put me off ever having to put myself in the care of other people in that context ever again. Like I could never, I just wouldn't do it to myself . . . I've heard negative stories about all the close-by maternity hospitals from very close friends. So I guess, you know I wouldn't. If I could have even gone somewhere else that I hadn't heard negative stories from, I still wouldn't be overly convinced [laughs] that it would be even a neutral experience. You know so, I wouldn't go em down that path*. (Lucy)

Similarly, coercive treatment and un-supportive care compounded with unwanted interventions and an EMCS resulted in a traumatic experience for both Aisling and Conor. The couple's decision to not have more children was a direct result of their shared trauma. Conor explained that if they did have another baby, they would not attend the same maternity hospital and would prefer to avoid maternity hospitals in general. Like Lucy, the couple do not feel they would receive satisfactory maternity care in any institution. Ideally, they would have a homebirth, but as Aisling had a CS, it is not a viable option for her in the current system. Since they cannot guarantee satisfactory care, they have chosen to eliminate the risk entirely by deciding not to have another child. Conor explains his perspective;

> *To go into that system again, uhh, you know, would be ehh, we'd obviously do it very differently. We wouldn't choose the same hospital. We would choose the local hospital, and maybe try to have a homebirth. But then I think that that's unlikely after the CS, they wouldn't allow it, you know, even entering into that with the system, would be a nightmare.* (Conor)

However, for Aisling, even the guarantee of a homebirth would not be enough to convince her to have more children. Her traumatic experience eroded her trust in her body, leaving

her feeling disempowered. She no longer believes she could manage labour and birth without medical intervention. Given her experience in a maternity hospital and of obstetric interventions, the risk of being re-traumatised felt too great. By choosing to not become pregnant again, Aisling not only avoids the need for medical care but also eliminates the possibility of experiencing further trauma.

Cara also tried to eliminate the risk of experiencing further birth trauma. During a traumatic PPH, Cara believed that she was going to die and that her daughters would be left without their mother. Both the pain from the PPH and fear of impending death contributed to Cara's birth trauma. By not becoming pregnant again, Cara eliminated the risk of any future births ending in similar circumstances and causing further trauma. It should be noted that Cara is one of three participants who had an unplanned pregnant several years after making the decision to not have more children. She explains her original decision;

> *I remember looking over at my baby saying, well she's never going to remember me. And I remember saying like, Oh my God, what about my other daughter, what will she do without me? . . . I thought I was going to die. And that is no exaggeration . . . I didn't want to feel the way I did when I had her so it was okay. I didn't want to- I fully thought I was going to die, fully thought I was going to die. So I don't want to feel that way again, so it was the best decision for me at that time.* (Cara)

The other two participants who had an unplanned pregnancy after making their decision are Aileen and Carmen. Although the circumstances of their pregnancies were dissimilar, they both felt after two consecutive birth-related traumas that a third pregnancy was bound to end in more trauma. They both decided against a third pregnancy to eliminate the risk of further trauma completely. Carmen's first baby was born prematurely at 27 weeks' gestation, her second baby died in-utero due to a fatal fetal abnormality. Carmen explains her fears about future pregnancies;

> *Am I not supposed to have a normal pregnancy? Like, am I not supposed to have just a normal pregnancy, delivery, a normal baby at home, you know. Just like every other woman. [laughs] Why, why, like why?. . . I mean, I obviously always wanted more, and so did my husband but we were so afraid, you know? And every time we spoke*

about it was always the same conversation. It was like, what if, you know? Look at what happened. Look at what happens, you know, two pregnancies, two different stories. I mean. Not as good as we wanted. (Carmen)

The belief that their spouse may die was experienced by some of the women's partners. Diarmuid and Conor both discussed this in their interviews. Diarmuid recounted how Siobhán came close to death after suffering a cardiac arrest, while Conor feared for Aisling's life when she began haemorrhaging during an EMCS. Although their circumstances were extremely different, the lived experience of believing their wives were at risk of death informed their decision-making. In Diarmuid's case, a cardiologist confirmed that another pregnancy would be too dangerous for Siobhán, leading the couple to eliminate the risk of another traumatic event and possible death. Aisling and Conor were both in agreement after their shared traumatic experience. Conor's desire to eliminate the risk of losing Aisling shaped influenced the couple's overall decision;

I felt there was a genuine risk of ehh, that she might of died you know? Because of eh the section and seeing (the bleeding). You know being in the room when, when that happened. I was kind of, I was thinking I am not eh, I'm not willing to lose her just for the sake of having another child. (Conor)

As there were only four male participants, their perspectives are limited. However, many of the women interviewed spoke about the impact the traumatic birth experience had on their partners. Eilish, Cara, Orla, and Gráinne all recounted how their partners thought they were at risk of death at some stage during labour or birth. Their partners were deeply affected by these experiences and felt that having more children was not worth the risk. Eilish explains her husband's perspective;

He was like, well I don't want another baby, I don't want to go through this again. He was like, I was scared enough as it was when we had one child, that I was going to be left on my own because it felt like they weren't in control and you weren't in control and there was things happening to you that...didn't feel right. Both of us just felt like things were going very wrong, especially in the second birth . . . And he was like, I'm not taking the risk again. (Eilish)

7.3.3 Emerging Theme: 'Preventing Mental Anguish'

For the majority of participants, the experience of birth-related trauma caused them to struggle with their mental health. Anxiety and depression, in both the antenatal and postnatal periods, were commonly discussed. However, for some women their mental health struggles after their traumatic experiences were so significant that it influenced their family-planning decisions. Limiting the size of their family size became a way to protect their mental health and emotional wellbeing. This is conveyed through the emerging theme 'Preventing Mental Anguish'.

Maria's first ELCS was both physically and psychologically traumatic, and she experienced postnatal depression for several months afterward. During her second pregnancy, her mental health deteriorated further, and she became suicidal. The second ELCS was tougher than the first, as she knew what to expect and her mental health was already fragile. Maria would have liked more than two children, however a third CS was out of the question. The trauma of each CS was physically and mentally debilitating, and so she feared a third would break her mentally;

> *We would have liked to have had more children, but ehm, the doctor said, if you get pregnant again you'll definitely have a C-section for the third child. And so the idea of having another C-section was just way too much for me to have to put myself through. It's just too traumatic every time. It's too much on my body. It's too much on my head. And I suppose... ehm the idea of going back and having another baby and having to go through all of that stuff again was just way too much for me . . . There was just no possibility of doing it again for a third child. It was just my body was not going to. My mind was not going to survive. I knew that I was that fragile, afterwards I knew that it was not going to ever be an option for me because it was going to break me mentally.* (Maria)

Similar sentiments were expressed by Emma in her interview. Despite her desire for another child, she feared her mental health would not withstand another pregnancy and birth, she explains "I just wouldn't be able for it mentally". Her fear was so overwhelming that when she had a pregnancy scare it nearly drove her to have a panic attack. The decision

to not have more children was difficult for Emma, but she recognised her own limitations and the importance of preserving her mental wellbeing.

Niamh and Gráinne's traumatic birth experiences both caused them to suffer with postnatal mental health issues. After Niamh's first pregnancy, she struggled with depression and intrusive thoughts, resulting in her attending a psychiatrist. After the birth of her second baby, Niamh experienced postnatal depression again, she felt that preventing the potential repetition of postnatal mental health issues was more pressing than having a third child;

> *I would have to say that the delivery and the postnatal depression were two issues that kind of fed into me not wanting anymore . . . after my daughter [second baby], I had bad postnatal depression again, but this time it was really well-managed. I was seeing the psychiatrist in the hospital from the very start and I took medication after she was born. And even though I'd kind of already made the decision, I was like it actually wouldn't be responsible to have another one because I know now what I'm like in pregnancy. I know now what I'm like postnatally so I wouldn't do it. Like it just wouldn't be the right thing to do for the family.* (Niamh)

Gráinne was worried that another birth could possibly cause more trauma and catapult her back into a heightened state of anxiety. She feared her mental and physical health would not endure;

> *Em and then after having the second one and what happened to me, I just said, I would be terrified that I would go back to the state of anxiety again. Em the one and only time- that that was enough for me . . . Em I just didn't want to take any more chances. . . I don't think mentally, physically, I would have been able for it.* (Gráinne)

7.4 Passage Two: 'Bearing the Burden in the Aftermath'

Passage two depicts how the participants were impacted by their decision to limit family size. Figuratively speaking, when someone is bearing a burden, they are enduring a challenging situation, responsibility, or weight. 'Bearing the Burden in the Aftermath' emerged from the participant's descriptions of carrying the emotional weight of their decision to limit family size. While many participants acknowledged that their decision was

best for their own and their families' wellbeing, it was still devastating and left them navigating a flood of negative emotions.

This emotional burden was exacerbated by the perceived lack of autonomy over the decision-making process felt by many participants. The circumstances in which they made their decision left some feeling it was made *for* them as opposed to *by* them;

> *It's a massive decision and it doesn't feel like our decision. It feels like it feels like a decision of circumstance. Now it's the right decision for us. But it's still a tough pill to swallow* (Eilish),
> *For me having no control over it, the decision is taken away em yeah. Absolutely it's much more difficult.* (Siobhán)

The emotional consequences of the decision to limit family size are depicted in the emerging theme 'Navigating Emotional Turmoil', whereas 'Enduring Unfulfilled Expectations' illustrates the emotional weight of losing their envisioned family and the struggles of failing expectations.

7.4.1 Emerging Theme: 'Navigating Emotional Turmoil'

In dealing with the fallout from their traumatic experiences and decision-making, the participants navigated a range of difficult emotions that ranged from despair and grief to anger and jealousy. Many developed coping strategies that helped them navigate their emotional turmoil. This is captured in the emerging theme 'Navigating Emotional Turmoil'.

Emma's emotional turmoil has been deeply internalised. She feels guilty for 'wasting' her fertility, especially as she had a friend who had struggled to become pregnant. Additionally, she feels entirely isolated, as she does not know other women who have deliberately chosen to only have one child. Her guilt is further intensified by a sense of being judged for her decision, leading to fears that she is perceived as selfish;

> *I don't know anyone that chooses not to have another child. Like even now, when I saw the recruitment email, like are there other people that just couldn't handle another child? Because I know people that went through terrible pregnancies, but*

they still have two or three kids . . . You kind of feel you can't even tell anyone. Especially because some people can't have children, you know? My friend actually had to go through IVF. And ehm I remember giving out about my son and moaning and she was probably thinking, well at least you have a child . . . A lot of people do judge you, well other women unfortunately. There's some people just look at you like God you're so selfish, you're a horrible person, you know you're so lucky. And I know, I love him to bits and I'd never be without him. But yeah, I did feel guilty, especially with my friend when she couldn't have kids . . . I probably would have been able to [fertility wise] have another no bother. And you just feel terrible because I mean [inhales]... I don't think people understand I suppose. (Emma)

Lucy expressed anger at the hospital staff who contributed to her traumatic experience and ultimately influenced her decision to not have more children. To have strangers play such a significant role in a deeply personal decision was violating;

I think it makes me quite angry. I would hate that anyone else, other than me or my husband or my kids or my circumstances or whatever, would play a role in such a personal decision. Like, I feel like it's a deeply personal decision for everyone. To have the external factor of people that I don't know, that probably haven't really given a second thought to anything that they did that time, probably not something that they ever think about. But yeah I just think it's a lot of anger that, that they would kind of get to have that influence. (Lucy)

Aisling also felt anger towards the hospital staff, she trusted them to care for her but instead their behaviour traumatised her. They dismissed and belittled her birth plan, pressured her into interventions, performed painful internal exams, and exerted control by restricting her movement and limiting her food and drink options. She was also plagued with jealousy for those who had a positive birth experience and were having more children. Aisling had envisioned a holistic water-birth, but had a cascade of interventions that started with an induction of labour and ended in an EMCS. She could not help but compare herself to them;

Initially I was really angry and disappointed and kind of, I suppose jealous of other people who had better experiences and were having more kids. It was like kind of

how come they can do it, you know, and they're able to have more and they're able to have two and three and like, how come this didn't happen to them? (Aisling)

Peer support helped Aisling navigate the emotional turmoil of her experience;

And em pff, then I suppose the Facebook support groups really helped me, listening to other people's stories and reading other people's similar stories and the processes they're going through. (Aisling)

Carmen also compared herself to others, feeling immense envy and despair when confronted with pregnant women or newborn babies. However, episodes of jealousy or crying would be fleeting as Carmen always reminded herself of what she had been through and why she had made her decision;

And then your friends are having babies and, you know, people around you are having babies and you're looking at them and you're crying because you want another baby. But when you really think about it, you cry again because it's like, no, I can't do it again. . . Sometimes I was jealous seeing other people pregnant or with babies. You know, I wish it was me. But then again, only if I knew that the baby was going to be perfectly healthy with no issues. When you think like that, and all your fears come back. That 30 seconds of jealousy, gone instantly. (Carmen)

Eilish also expressed having emotional reactions to news of other women's pregnancies, she describes being engulfed by "a dark cloud". Eilish believes this response is connected to the grief she carries from her experience;

I also don't like hearing when people are pregnant. I don't know why because it's not I don't want to be pregnant. I don't want another baby. I don't. I'm not jealous of them. It's none of that. I don't know what it is, but it's just a horrible feeling that comes across me when I hear someone's pregnant. It's horrible. It's like it encases my entire body. It's like a dark cloud that just takes over my entire body when I hear someone's pregnant. [pause] And I don't I don't know what it is. And it's not a nice feeling and it is. I think it's grief. (Eilish)

Several participants dealt with feelings of grief following their traumatic experience and decision-making. For Maria, the grieving process began during her second pregnancy as she instinctively knew she would not be mentally or physically capable of having a third baby. She had always dreamed of having a daughter, so when she learned her baby was a boy, it triggered a sense of grief. Maria likens this to anticipatory grief, as she was grieving for the daughter she would never have;

> *There's no more girls on my side, that's, I'm the last girl. There will be no more. Em so while my sons may have children and they may have daughters, it's not the same as mine. So I was grieving that part for, as I say, the moment that I found out my second child was a boy, it was like a [pause] there was something about losing that connection back through generations of women that have gone before me. Ehm so I suppose I don't take that [pause] grief lightly.* (Maria)

Although 6 years have passed since the birth of Maria's youngest son, her grief still has a significant impact on her. The enduring impact of trauma and grief is evident in her words and lived experience;

> *I noticed that my grief em, there was very intense periods of it. It will come in like a wave, or it will be triggered by something else that's happening around me. You never get over grief. It's not something to get over. It's not something that you move around or leave behind or get past or any of those horrible phrases that people use. Grief is something that you just learn to [pause] hold in your heart. It's just a space that's there. And we adapt, I adapt around it. And it comes and goes and. Em that's how I see it, that how I experience my grief.* (Maria)

Conor also identifies with the grief of losing a child that never was;

> *It is a... I think if we had had a different experience in birth, then we could be, we could possibly have two kids or three kids by now. So yeah, there is a little bit of grief around the possibility being sort of taken away.* (Conor)

The participant's grief was not always for the children they would never have. For instance, Aisling grieved for the positive birth experience and transition to motherhood she had envisioned for herself. She recalls a woman's words from a peer support group and how deeply they resonated with her own feelings and experience;

> *Like one woman said, I'm not grieving another child. What I want is to go back in time and relive my daughter's birth and childhood. And I think that's what I really wanted, was to go back and have a different birth and do it all again with my daughter as opposed to have a new child.* (Aisling)

7.4.2 Emerging Theme: 'Enduring Unfulfilled Expectations'

To endure is to remain firm under suffering or misfortune without yielding (Merriam-Webster, n.d.). The emerging theme 'Enduring Unfulfilled Expectations' captures the participants' reflections on the emotional impact of losing their envisioned family or grappling with feelings of failing the perceived expectations placed upon them. Despite their struggles with unmet expectations, the participants did not change their decision regarding more children, instead they endured this hardship.

Almost all the participants expressed they originally had expectations for the number of children or the gender of their children or both. Although these were only aspirations, they were still experienced as a significant loss. Furthermore, the participants felt they had also failed the expectations that had been put upon them by their spouses or close relatives. In many examples, these were only perceived expectations as no one had explicitly voiced them. Rather, the participants sensed that such expectations were implied in their roles as mothers or wives.

Participant's expectation for their family size varied from having an exact number of children to only having a rough idea. For example, Emma thought she'd always have more than one child, whereas Gráinne said she always wanted three children. As expected, several participants expressed upset and disappointment over their unmet expectations regarding family size. However, what concerned the participants more was the impact a smaller family or lack of siblings might have on their current child or children. They had

envisioned a certain family dynamic for their existing child or children, making it especially upsetting when those expectations were not met.

For Emma, this manifested as intense guilt. She has a close relationship with her siblings, and so she worries her son will be alone as an adult without other immediate family. On multiple occasions her son has expressed his satisfaction in being an only child, even directly stating he does not want siblings. However, Emma remains concerns for his future, feeling selfish and like a bad mother for not giving him siblings;

> *I think it's only now that my son has grown, he's nine now and I'm kind of thinking, oh God, you know, it would have been nice for him to have a brother. I felt bad, I think because I have three siblings and I'd be lost without them. And I'm thinking, in the years to come, like he has nobody. Like okay, please God he'll have friends and his cousins. But I was worried about him. I felt selfish for him because he has no one when he grows up [laughs through tears].* (Emma)

Ruth and Michael also worried about whether their son was lonely, however, as a couple they never planned to have children, so they were not battling with unmet expectations. Ruth, while having some regrets, ultimately believed that she made the right decision;

> *And he's playing on his own and I'm like, oh if he had a sibling, they could be playing together, or at Christmas I'm like he doesn't get to experience that excitement with a sibling. So in some respects, I'm very much, I do regret it, but in other respects I don't because I would have been having a child for the wrong reasons.* (Ruth)

Those who had more than one child also worried about the impact a smaller family would have on their existing children. Siobhán always envisioned having more than two children and would have loved for her youngest child to experience being an older sibling. Her aspirations for her children has made it more difficult to relinquish the dream of having a larger family;

> *Em and I suppose I would have loved to give Liam a little brother or sister, and Fionn obviously, but with Liam being the youngest now, just to see our family grow and,*

you know, have another child experience the love of our family and all the things we do for the kids. Yeah. It's harder. It's harder for me to let go. (Siobhán)

The gender of the participant's existing children influenced how they coped with their unfulfilled expectations. Maria and Eilish both expressed their disappointment as they would never have a daughter. As previously discussed in section 7.4.1, Maria was particularly devastated by this unfulfilled expectation;

I still wonder what it would have been like to have had a bigger family. You know, what it would have been like to have had a family where it's not just all boys. I suppose again, like there's a bigger loss there for me that it would have been nice to have had a daughter. (Maria)

For Niamh and Aileen, having both a daughter and a son appeared to ease the burden of their decision to limit family size. Simply put, they were not missing out on a potential son or daughter and their expectations for their ideal family had been met;

I think if I hadn't had a girl. I know it's a terrible thing to say and you're not allowed to have these kind of preferences. But if I hadn't had a little girl, it might have been a harder pill to swallow. But I had my lovely boy, I have my lovely girl, and I was like, I couldn't wish for more. (Niamh)

What also became apparent was that the female participants' expectations of themselves was related to their roles as mothers, daughters, and wives. However, these expectations were rarely voiced by the people in their lives, instead they appeared to be implied by the participant's perception of their role and related duties. For example, one participant believed she should have had more children for her husband, even though he never expressed this expectation of her. Instead, it may have been implied by her role as a wife. These implied expectations may be shaped by society's expectations of fertile women to have multiple children.

Orla is disappointed by her own unmet expectations regarding family size. She also feels she has disappointed her partner despite him being completely aligned with the decision to limit family size;

> *And my partner is much more solid than me [on the decision to not have more children], and he's objecting. He says let's enjoy what we have, thank God we have two healthy children, let's not poke the bear. Like, let's not eh...tempt with fate type of thing.* (Orla)

But then later in the conversation she expresses concerns that she is denying her partner the chance of having a son;

> *My partner quite possibly maybe would have wanted a boy because we have two daughters. I quite possibly might have wanted to have, you know, 1 or 2 more children. But I know he will never express these needs because he would be afraid that I might go through the trauma in order to have that child, you know, because I love him.* (Orla)

Maria is also plagued by the feeling she has disappointed her husband's expectations for their family. Maria explains that her husband, Peter, is a good father who is especially fond of the baby stage of parenthood. She also would have loved for him to have a daughter. Although he has never voiced disappointment with her decision to limit family size, Maria senses it is a loss for him;

> *I know he would have liked more children. Peter likes small babies and stuff. Em you know he likes, he liked that, he's good at being a dad but he particularly liked that period when they were small. And he's a big, tall person so he can carry a little tiny person in one hand kind of thing. I know there was a loss there for him, and maybe he's not really spoken about that much to me.* (Maria)

In Peter's interview, he briefly expresses some inclination for a daughter, but he does not dwell on it. He is not impacted by the burden of unfulfilled expectations. Instead, he focuses on Maria's health and the relief her decision has brought him;

So when she [Maria] said she wasn't going to have another child, a big part of me was quite relieved. And like I said, there was another part of me that was like, you know, a little girl would've been nice, will we go again? But no the main thing was let it go. It's done. We're finished now because her health is more important than anything else. . . So I was relieved when she said no more. Em and it very much reflected my opinion, so we were very much together on that one, if that makes any sense. There was no 'oh shucks', or what about a girl? Or any of that kind of stuff. (Peter)

Eilish is the only participant who reported someone in her life that openly expects her to have more children. Eilish's mother is expecting another grandchild, and so Eilish is yet to tell her about her decision and her husband's vasectomy. Eilish feels exceptional pressure from her mother to continue having babies as her mother's fertility was prematurely ended by a hysterectomy. Eilish feels emotionally blackmailed as she is choosing to limit her fertility unlike her mother. Enduring this unfulfilled expectation from her mother has made living with her decision more difficult;

I haven't told my side of the family at all [about the vasectomy]. My mother would be devastated. She would be devastated. She expects me to say I'm pregnant in about a couple of months' time. I know she does, because my sister had said she was done and then her younger fella was like five and she decided to go again. . . And because she [Eilish's mother] had a hysterectomy. I remember her going through that at the time even though I was like 11 when she had a hysterectomy. She was always like, I can't believe now I can't have any more kids . . . myself and my sister get that a huge amount of that from mom, it's not intentional. I genuinely don't think it's intentional. It's that kind of like emotional blackmail where it's kind of like you know, oh you have you have the opportunity to have babies and all this kind of stuff and look how healthy your babies are and aren't they fantastic and all that kind of stuff. I definitely think that some of my kind of response to things has been due to outside kind of influences em. (Eilish)

7.5 Passage Three: ‘Moving Forward, But Not Moving On’

As the participants reflected on their experience, many described reaching a level of acceptance with what had happened and their decision to limit family size. However, acceptance did not imply they had moved past or completely overcome their trauma. Instead, they chose to move forward while acknowledging that their experiences remained deeply ingrained within them. Some participants, mainly their partners, even opted for sterilisation to help them move forward from their experience.

The final passage, ‘Moving Forward, But Not Moving On’ reflects this sentiment among the participants. Individual experiences of this passage are illustrated through three emerging themes 'Reaching Acceptance', 'Lingering Trauma', add 'Making it Permanent'.

7.5.1 Emerging Theme: ‘Reaching Acceptance'

Overtime, many of the participants came to accept what had happened to them and their decision to limit family size. Acceptance did not mean the participants had fully gotten over what had happened to them or that they completely moved on. When the participants spoke about accepting their decision, they expressed neither happiness nor sadness about reaching this state; instead, they conveyed a sense of neutrality. Acceptance was achieved over time and after enduring the difficult emotional challenges described in this chapter. The term 'reaching' was chosen to convey this journey to acceptance.

At the time of the interview, six years had passed since Maria's second son was born. She describes living with a sense of acceptance. This is neither positive nor negative, but simply an acceptance of what has happened, and a recognition that she can no longer change that chapter of her life. She still suffers from waves of grief, and acknowledges she will never completely move on, however she has learned how to move forward;

> *I guess I just came to some form of acceptance that that's the way that it was going to be and...em as I say, it would have been nice to have had a daughter. Em so it's not that I'm comfortable with it, it's more just a sense of acceptance that I don't have the... there's nothing that I can do and there's no point in regretting or being angry or...eh it's okay to be sad about it. But I don't think there's any point in*

regretting anything . . . You never get over grief. It's not something to get over. It's not something that you move around or leave behind or get past or any of those horrible phrases that people use. Grief is something that you just learn to [pause] hold in your heart. It's just a space that's there. And we adapt, I adapt around it. (Maria)

Aisling also reflects on her journey to acceptance. The possibility of becoming pregnant has weighed on her over the years but five years on, she has come to terms with her decision;

Em so yeah, I think I think where I'm at now is a level of gradual acceptance. The longer it goes, the more I'm accepting, accepting it. Em but initially, I think if it had been taken away abruptly completely, just say I got my womb taken out say at the birth, that would have been diff- it would have been not easier. In some ways the decision was gone like and I wasn't there, whereas I always had it in the back of my mind I could have kid, I could have another child. Em and that was kind of a bit distressing, I suppose, in a way you know like, so em I think, you know, the older I get and the longer it goes on, the more I feel a level of acceptance. (Aisling)

One participant was still struggling with accepting that she would not have more children. Siobhán knows she will not have a third child, but the possibility still lingers in her mind. It may be more difficult for Siobhán to embrace acceptance as she is the only participant that was advised against future pregnancies by a doctor;

It's harder. It's harder for me to let go I suppose that sums it up. Em so it's not just as simple as saying, yeah we won't have a third and that's it, door closed, forget about it. For me, it goes on and on, goes on. But I suppose like deep down I know now we're not, you know, I know we're not. . . it'll be a niggle I suppose... maybe always. It will probably always be there as, what if, what if we have a third? It's not in my head every second of every day. Just because you're told you can't. It's just probably...maybe it'll always just be there, a little open door. (Siobhán)

7.5.2 Emerging Theme: ‘Lingering Trauma'

It was evident in all the interviews that trauma remained a constant presence in the participants' lives. While they had moved beyond the most intense and disruptive phase of their traumatic experiences, its effects continued to linger. Many participants had sought counselling, and some had even used medication to manage their symptoms. However, many of the participants acknowledged that they might never fully overcome their trauma, and that there would continue to be days where they were overwhelmed with emotion.

At the time of the interview, it had almost been five years since Orla's traumatic birth experience. When her youngest was a newborn, Orla's trauma manifested itself as physiological symptoms. When she was asked about the birth, she would experience shortness of breath, palpitations, nausea, and shaking. She attended a therapist and worked with them to process her birth trauma. Although it is not as raw as it once was, and she was able to discuss her experience during the interview without experiencing the same symptoms, Orla’s emotional well-being is still negatively affected by her birth. The trauma continues to linger;

> *The birth was hugely traumatic for me. It brought up a lot of physiological symptoms, you know, like I'd have palpitations, shortness of breath. The things- just talking about it. Um, you know, I was randomly asked when we had baby checks, you know, at six months, at one year, at four years whatever. I was asked about her birth and, you know, I could feel myself going eughh. And, and then immediately shaking and the doctors said you should speak to somebody. And I'm in therapy, I have a therapist whom I worked with for years, she knows me and she knows my history and I did work on it. It has been processed. It's not like I just left it and said that never happened. I have worked on it already and it's still pretty- I wouldn't say it's raw or traumatic, I can talk to you about it without being in bits. But em it still affects me, every time I think about.* (Orla)

Similarly, Eilish describes how her traumatic births have affected her emotional well-being. She attended counselling to help cope with her trauma, yet overwhelming emotions from her birth experiences still hits her from time to time. While she tries to rationalise her experience as a way of coping, the trauma remains raw. At the time of the interview, two

years had passed since her last birth. Although this may be a relatively short period of time, she wonders if she will always feel this way;

> *Both of my births and hospital experiences would flash through my mind on a fairly regular basis. And as I've said, I've been to counselling to work through the process a little bit but it's something that I know will probably be with me forever . . . I think what's interesting for me as well is like I can look at it objectively and go you know, there was nothing specifically. You know, if you rate trauma on a scale of 1 to 10, my traumas in terms of medical side of things, probably like one. But mentally for me, the trauma is not it's not a ten like it's not a deadly car accident. But like, it's a, it's a resounding kind of maybe seven that just kind of sits with me. And it's something that. Sometimes I'm just driving along and I'll think about something very specific that happened during the birth process and I will end up like in floods of tears. Like and just then feeling that kind of sense of, Oh my God I can't believe that still feels so raw to me. Like I have done the work, I've done the counselling, I've written it down, I've discussed it through with people. But the actual emotion itself is still hugely raw. I don't know whether time will kind of resolve it.* (Eilish)

After her traumatic PPH experience, Cara immediately started having flashbacks. the days following the birth, she vividly recalled the events surrounding the PPH, obsessively discussing it with her husband. She could not find joy in small milestones, like when her baby turned a week old, instead she felt intense anxiety and panic, constantly recalling how she almost died a week earlier. For six to eight months she replayed the PPH in her head and suffered from nightmares. Eventually she broke the cycle of intrusive thoughts and flashbacks however six years later she admits that she has not fully let go. The memory of the PPH appears to remain lucid in her mind. During the interview, she recounted her experience in great detail, even remembering the exact times of certain events. Cara went on to accidently conceive after she decided not to have more children. At the time of the interview, her youngest daughter was a year old. This recent birth was a positive experience, however the trauma of the PPH continues to linger;

> *Afterwards I remember being like, this time yesterday, this is the time it happened. This is when it happened. And I kept getting flashbacks and everything. And then*

when I was home, the baby was a week old and I wasn't celebrating the baby being a week old, I was panicking saying this time last week I nearly died. . . There was no celebration of her being a week or two weeks or a month. Now I did break the cycle after a while. But no, it was a good- a good six to eight months before I kind of- I will never say I let go, I'll never say let go completely. . . And I won't forget it because I tell you, I know the times, I know the doctors' names, the nurses', the midwives' names. It had such a huge impact on my life . . . It'll be six years in August. But I remember like it was yesterday, honest to God. It was a Tuesday. A Tuesday. I'll never forget as long as I live. (Cara)

Gráinne describes feeling haunted by trauma. The remnants of her birth trauma will appear when she is feeling anxious or overwhelmed by something in her everyday life, reminding her of how she used to feel. As her mental wellbeing has recovered since the birth of her youngest child, she has learned how to cope with the anxiety and trauma when it resurfaces;

I suppose when you talk about trauma it's really affected me emotionally and physically, and it's something that haunts you, you know? I definitely feel haunted. And even sometimes, even if I feel anxious about something, just normal things might be something to do with work or anything. Em I don't want to call it- fear, it kind of hits you, oh this is how I felt before. You kind of have to learn how to cope with it and talk yourself down and say, no this is completely different, this is separate. But you still have the same feelings . . . It's just your body reacting and your brain reacting to something that happened a good few years back. (Gráinne)

7.5.3 Emerging Theme: 'Making it Permanent'

At the time of the interviews, five of the participants had made their decision permanent through sterilisation. Eilish, Aileen, and Gráinne all disclosed that their husbands had vasectomies. Michael also shared that he had a vasectomy. Emma had a gynaecological procedure which meant she would not be able to conceive again. When consenting to this procedure, she had to be sure she was done with childbearing. Not only did sterilisation mean their decisions were now permanent, but it also provided relief by eliminating the

lingering possibility of becoming pregnant again. It offered a way for these participants to move forward with their healing process.

For Eilish, her husband's vasectomy provided a massive sense of relief. What was particularly poignant was that through Eilish's perspective, her husband was sharing the burden of their difficult decision by taking away his fertility. Eilish no longer felt that she was depriving her husband of more children. It also allowed her to reflect on her experiences from a different perspective, as she had previously been hesitant to be too critical of the maternity services, knowing there was always a small possibility that she might need their care again;

> *The process of getting the vasectomy just it, just it's an ending that I don't think that we would have gotten otherwise. And to be honest with you, I've started to look into menopause. But I think I would have felt a different wave of guilt when menopause came around, that I was no longer able to carry the babies, I was no longer able to get pregnant. I was no longer able to give him a baby if he wanted a baby. So for him to take that burden away from me is huge [starts to cry]. It's such a massive relief. And it's ,it's, it's like the end of a book we can just kind of close that. And ehm it's allowed me to, I suppose, reflect on my births in a different way. Because when you're going into a second birth reflecting on your first birth, you can't be too harsh on any part of the system because [pause] you're going to do it again, like you know you're there . . . But I'm so much more relieved. It's like that option's just taken away.* (Eilish)

Six weeks after their third baby was born, Aileen's husband had a vasectomy. As their third baby was unplanned, Aileen was eager to make sure there were no more surprise pregnancies, especially as the third pregnancy and birth had also been a traumatic experience. Like Eilish, Aileen felt a huge amount of relief after the vasectomy, knowing there was no longer a possibility of another traumatic birth experience;

> *After the vasectomy there was a huge amount of relief, I was like thank God that's done with. And we don't have to deal with another surprise or even just the conversation anymore. It's gone. There's no debate, that's just gone. So it was*

absolute relief. And then to know that I didn't have to do it again, such a relief. I don't regret it, I think it was a really good decision. (Aileen)

Emma underwent endometrial ablation for a gynaecological issue six years after the birth of her son. Pregnancy after endometrial ablation is unlikely, Emma was aware of this when consenting to the procedure. Emma describes the duality of feeling both sadness and relief with the reality of becoming infertile. Although it was upsetting, the procedure lifted the guilt she felt about not having another child despite being physically capable of doing so. She could finally let go of the constant back and forth on whether she should have another child, or whether she was wasting her fertility. Making her decision permanent meant freedom from the constant weight of her thoughts about more children;

So the doctor said that you cannot get pregnant again if you get this [endometrial ablation] done, that's it like it's permanent. So that was three years ago. The doctor said to me, are you sure you don't want any more children? And I'm laughing going no I don't want any more kids! . . . It was a little bit sad but at the same time, it just was like, well I can't have them now anyway so the decision is taken away from me you know. I don't have to feel guilty anymore. I can't have them anyway. So in that way, yeah, I think I did I was like, yeah now I don't have to worry about it because I can't have them, so I just have to get on with it. And then you know? It was just final then . . . Because it does wreck your head. When I went back for my six-week postnatal check, the doctor said because of my age I have to think about having another one quickly. It's just constantly in your head because of my age, I have to, I have to think about it. I have to think about it. And you just never stop and you feel...guilty I suppose. (Emma)

During her interview, Maria disclosed that she is perimenopausal, and so the decision to have more children is no longer under her control. Although she did not purposefully seek permanency through a procedure, she describes a similar sense of relief to that of other participants knowing she can no longer become pregnant. Maria still thinks about what it would have been like to have a bigger family and a daughter, her birth trauma still lingers, but she is finding a way to accept what has happened and move forward;

> *And part of me is relieved that I'm perimenopausal or menopausal at this stage. I'm sort of bordering on one end to the other. Em so even the ability to have children now whether I wanted to or not is gone. But I still wonder what it would have been like to have had a bigger family. You know, what it would have been like to have had a family where it's not just all boys. I suppose again, like there's a bigger loss there for me that it would have been nice to have had a daughter. There is a part of me that is sad that that chance is gone. And then there's also a part of me which is [pause] accepting of it.* (Maria)

Michael had a vasectomy shortly after his and Ruth's son was born. Their story differs to the other participants as they had originally never planned to have children. In her interview, Ruth disclosed that earlier in her life she had wanted four children, but this had changed due to a traumatic experience terminating a pregnancy. Although the couple had never originally planned to have children, they both considered whether they should have another child so their son could have a sibling. However, their traumatic experience of pregnancy and the postpartum period, combined with their separation, solidified their decision to not have more children. Michael already began researching the vasectomy procedure during Ruth's pregnancy. He ended up expediting the process so that he was sterilised shortly after the baby was born, making their decision permanent;

> *Em so then kind of when she [Ruth] got back on her feet, we then went, right we're not going through that again. So once Ben is born, I'll go get my operation and get the vasectomy. So I actually have a vasectomy done. I had looked into it while she was pregnant. And then after the pregnancy and the birth, we were like, definitely, we're not going again. I'll fast track it and I got it done then. I think if Ruth had had a better pregnancy and postpartum experience, we probably might have gone and had a second child.* (Michael)

7.6 Constitutive Pattern: 'Acting on Self-Preservation'.

A constitutive pattern represents a common meaningful experience shared by the participants (Dibley *et al*., 2019). The decision to not have more children was ultimately an act of self-preservation, forming the constitutive pattern: 'Acting on Self-Preservation'. This constitutive pattern links the three passages and eight emerging themes together and

reveals the meaning of limiting family size as a result of a traumatic birth experience. Self-preservation can be defined as: "preservation of oneself from destruction or harm", or "a natural or instinctive tendency to act so as to preserve one's own existence" (Merriam-Webster, n.d.). In the school of psychology, the self-preservation instinct is "the fundamental tendency of humans and nonhuman animals to behave so as to avoid injury and maximize chances of survival (e.g., by fleeing from dangerous situations or predators)" (APA, n.d.).

As explored through the emerging themes (‘Instinctive Knowing', ‘Eliminating Risk’, and ‘Preventing Mental Anguish’) from passage one, 'Confronting a Difficult Decision', the participants' decision to limit family size was often driven by an instinctual need to protect themselves, whether it was physically, emotionally, or psychologically. For the participants, another pregnancy or birth could pose a potential threat, placing them in situations they perceive as dangerous to their physical or mental well-being. Thus, the decision to limit family size as a result of birth trauma reflects the participants' inclination towards self-preservation.

Although the decision to limit family size was a way for participants to protect themselves, it was incredibly difficult and emotionally tumultuous for the participants. This was explored in passage two 'Bearing the Burden in the Aftermath' through the emerging themes 'Navigating Emotional Turmoil' and 'Enduring Unfulfilled Expectations'. In the aftermath of their decision, many of the participants had to confront deep feelings of loss, sadness and guilt, making their decision a source of inner conflict and distress. Despite the emotional hardship, the strong desire to protect themselves and prioritise their wellbeing ultimately outweighed the pain of the decision. The strong instinct for self-preservation meant that they were willing to endure the emotional challenges that came with their choice.

Part of the participants' lived experience involved coming to terms with their decision, whether it was through a process that led to acceptance or more permanent means. This was explored in the third passage, 'Moving Forward, But Not Moving On’ through the emerging themes 'Reaching Acceptance', and 'Making it Permanent'. This process of learning to live with their decision is a key aspect of the pattern 'Acting on Self-

Preservation.' For the participants, self-preservation meant not only making the difficult choice to limit their family size but also finding ways to live with that choice and move forward in their lives. Engaging in counselling, solidifying their decision through permanent measures, or simply the passage of time, all contributed to moving forward. While the trauma of their experiences never completely disappeared, as described through the emerging theme 'Lingering Trauma', these efforts allowed them to cope, accept, and find a sense of peace with what had happened. Through these actions, they prioritised their emotional and psychological well-being, demonstrating a resilient commitment to self-preservation.

7.7 Conclusion

In conclusion, this chapter has presented the findings of the research study, which aims to develop an in-depth understanding of the lived experience of limiting family size to less than desired as a result of birth-related trauma. This chapter sought to present these findings in a manner that authentically represents the participants' lived experiences and resonates with the reader. The findings are presented through passages, emerging themes, and a constitutive pattern. By using passages as a narrative device, the chapter illustrated the three phases of the participants' journeys; from the initial decision to limit their family size, through to the time of their interviews. Through iterative analysis of the transcripts, common meanings in the participants' lived experiences were identified and interpreted as emerging themes (Diekelmann, 1992). The deeper meaning of the lived experience was expressed through the constitutive pattern, which revealed the underlying connections and relationships among the emerging themes (Diekelmann, 1992). This chapter has thus aimed to not only capture the essence of their lived experiences but also to interpret the deeper significance of their stories, offering insights into the complex realities of making such a life-changing decision. The following chapter is concerned with the discussion of these findings.

Chapter 8: Discussion

8.1 Introduction

This chapter discusses some of the findings that resulted from the iterative analysis of the participants' lived experiences of limiting family size after birth-related trauma. Section 8.2 will provide a narrative overview of the findings. Section 8.3 discussed the sample demographics and related issues. In section 8.4, the factors that contributed to the participants traumatic birth experiences are discussed and compared with previous literature, followed by a discussion on how these factors can be differentiated and addressed. Section 8.5 focuses on the key findings from the participant's decision making process, comparing and contrasting them to the literature previously discussed in Chapter 3. Section 8.6 and 9.7 opens up a broader discussion on issues within the Irish maternity services that impacted on the participants decision-making, suggesting recommendations to reflect the findings of the study. The chapter concludes with a discussion of meaning that emerged from the participants' lived experiences; fortitude and grief.

8.2 The Lived Experience of Limiting Family Size after Birth Trauma

This is the first study to conduct an in-depth qualitative exploration and interpretation of the decision to limit family size to less than desired, as a result of traumatic birth experiences. The participant's descriptions of their lived experiences were summarised in Chapter 6. These traumatic experiences were characterised by severe illness in pregnancy, inadequate social support, obstetric interventions, obstetric emergencies, mental health challenges, and disrespectful or neglectful treatment from maternity care providers. One of the participants, Siobhán, had a cardiac arrest several weeks after the birth of her second baby. The participants' testimonies highlighted the deeply personal nature of traumatic birth experiences, revealing how each individual has a unique threshold for what they perceive as traumatic. This reflects Beck's (2004) suggestion that traumatic childbirth is "in the eye of the beholder" (p. 28), which emphasises the subjective nature of traumatic birth experiences. This is especially pertinent in cases where maternity care providers may view the woman's experience as a routine delivery or a typical hospital birth.

The findings that resulted from the iterative interpretive analysis of the participants' interview transcripts were presented in Chapter 7. The findings revealed that the

participants' decision to limit their family size, due to traumatic birth experiences, initiated an emotionally challenging journey that was characterised by self-preservation. In section 7.3, how and why the participant's came to their decision is explored through passage one 'Confronting a Difficult Decision', and the emerging themes ‘Instinctive Knowing' (section 7.3.1), ‘Eliminating Risk’ (section 7.3.2), and 'Preventing Mental Anguish’ (section 7.3.3). For many of the participants, their decision was instinctual, prompted by traumatic experiences that occurred during pregnancy, labour and birth, or in the postnatal period. To ensure physical and psychological safety, eliminating the risk of a reoccurring traumatic experience meant making a decision to not have more children. The participants believed that another pregnancy and birth would likely cause further trauma and suffering. For others, the long-term negative impact their traumatic experience had on their mental health motivated their decision. These participants feared their mental wellbeing was too vulnerable to withstand another pregnancy or birth, especially if they were at risk of experiencing more trauma.

The participants acknowledged that their decision was ultimately in the best interest of their own and their families' well-being, yet it still had emotionally devasting consequences. This is explored in section 7.4, 'Bearing the Burden in the Aftermath'. For some of the participants, the lack of perceived autonomy over their decision was particularly difficult to grapple with. They felt their traumatic experiences had forced them into a position that required the decision to avoid future pregnancy. Siobhán was the only participant who was advised against future pregnancies by her doctor. Although she logically understood why she could not have another child, it did not make the negative emotional consequences any easier to withstand.

In processing the aftermath of their decision to limit family size, the participants encountered an array of challenging emotions, this was described in the emerging theme, ‘Navigating Emotional Turmoil’ (section 7.4.1). Participants described feeling angry at their care providers who had contributed to their birth trauma through their disrespectful and dehumanising actions. Others described their reactions to seeing other pregnant women or small babies, and how it caused them to experience a wave of jealousy or despair. Grief was experienced by several of the participants as they felt a deeply personal loss, whether it was the loss of their ideal birth, or the loss of a child and family unit they would never have.

In section 7.4.2, 'Enduring Unfulfilled Expectations', how the participants grappled with their unfulfilled expectations is explored. Feelings of loss were also intertwined with the weight of unmet expectations. As one would expect, their unfulfilled expectations related to the number or gender of children they wanted. Interestingly, some participants were more troubled by how their decision affected their current child or children rather than themselves. They had envisioned an ideal family structure for their child, and when they were unable to fulfil this, they felt deeply saddened with some even expressing feelings of guilt. This sentiment was especially strong among participants with only one child. What was unexpected was that the participants felt they had no met expectations that were expected of them through their role as a mother or wife. This was true even when the women's partners supported their decision to not have more children, and had no expressed disappointment with not having more children. Biology and social constructs mean that women have been primarily seen as mothers (Kennedy, 2002). Therefore there are biological and social expectations for women, especially married women, to have multiple children. In Ireland, the role of the mother has been institutionalised in the Constitution, meaning the status of the family largely hinges on the mother (Kennedy, 2004). One could speculate that the cultural expectations of Irish mothers to have multiple children impacted on their perceptions of failing expectations.

The final passage, 'Moving Forward, But Not Moving On' (section 7.5), describes how the participants lived with their experience and decision at the time of the interview. Many of the participants came to a level of acceptance for what had happened, a neutral disposition that was neither positive nor negative ('Reaching Acceptance', section 7.5.1). What remained was a 'Lingering Trauma', a feeling that their traumatic experiences would always be with them. For some this sentiment was stronger, and intense negative emotions relating to their traumatic experiences would emerge from time to time. The final emerging theme is 'Making it Permanent' (section 7.5.3). It detailed how a portion of the participants made their decision permanent through sterilisation. Permanency offered relief from the burden of potentially having another child, it resulted in freedom from the constant thoughts about more children.

When seen as a whole, the meaning of the passages and emerging themes revealed itself through the constitutive pattern: 'Acting on Self-Preservation'. Meaning, the decision to

not have more children was ultimately an act of self-preservation. Self-preservation can have negative connotations as it may be viewed as a selfish or thoughtless action. However, in the context of these findings, it is a positive attribute, as it shows how the participants persevered through their challenging experiences.

8.3 Sample Demographics

The study sample consisted of 15 women and 4 men. Among the women, ages ranged from 30 to 49, with the majority (n=10) in the 40–49 age group and five in the 30–39 range. Fourteen women were married or partnered, and one was separated. In terms of parity, three women had one child, 9 women had two children, and three women had three children. Most identified as White Irish (n=12), with one participant of Southeast Asian background and two of White European background.

Among the four male participants, one was aged 30–39, two were 40–49, and one was 50–59. Two had one child and two had two children. All men identified as White Irish; three were married and one was separated.

Although formal data on education or employment status was not collected, many participants described occupations that typically require third-level qualifications, suggesting a generally high level of education. Overall the sample was relatively homogenous; participants were predominantly older, White Irish, and in committed relationships.

In terms of time since first delivery, participants' first children were born between 5 and 11 years prior to data collection. The youngest child of any participant was 6 months old, this was Carmen's third baby who was unplanned after making the decision to not have more children.

The relatively older age of the sample may reflect the nature of the research topic, as the passage of time may have allowed participants to come to terms with their birth experiences or view their reproductive decisions as more permanent. This is also consistent with national trends, as the average age of first-time mothers in Ireland is 31.5 years (CSO, 2022).

8.4 The Multifaceted Nature of Birth Trauma

The participants' narratives expanded existing knowledge on the factors that contribute to birth-related trauma. All but two participants described how multiple interconnected factors compounded together to make their birth, or events connected to their birth, a traumatic experience. Many of the birth experiences described in this study echoed findings from previous research linking traumatic or negative births with the decision to limit family size. The following section will summarise and compare findings from this study with findings from previous research linking traumatic or negative births with the decision to limit family size.

In this study, obstetric intervention featured prominently in women's experiences, this included induction of labour (IOL), emergency and elective caesarean sections (EMCS/ELCS), forceps and ventouse instrumental vaginal deliveries (IVD), and complications like postpartum haemorrhage (PPH) and HELLP syndrome. Several studies also found obstetric interventions significantly impacted experiences negatively, including IVD (Hildingsson et al., 2013; Jolly et al., 1999; Porter et al., 2006), CS (Jolly et al., 1999; Porter et al., 2006), episiotomy and perineal trauma (Aksu & Serçekuş, 2023; Hofberg & Brockington, 2000), frequent vaginal examinations (Aksu & Serçekuş, 2023; Allen, 1998), and oxytocin induction (Aksu & Serçekuş, 2023). Severe pain during labour, birth, CS, and postnatal recovery was reported by participants in this study and previous bodies of research (Aksu & Serçekuş, 2023; Allen, 1998; Dennis, 2015). Pregnancy-related conditions like hyperemesis gravidarum and symphysis pubis dysfunction were reported in this study. These were not reported in the previous studies however their definition of traumatic birth may not have included antenatal contributors.

Non-physical elements were equally significant for the participants, such as interactions with care providers, challenges with mental health, and social factors. Negative interactions with maternity care providers included insufficient support, mistreatment, dehumanising care, pressure to consent to procedures, and lack of consent for interventions. Social factors also contributed, including lack of social support, controlling partner behaviour, and difficult transitions to motherhood. These aspects of care and social factors were less extensively examined in previous studies connecting traumatic or negative births with the decision to limit family size. While postnatal depression was identified as a significant factor in the

decision to limit family size by Porter *et al*. (2006), participants in this study reported a wider spectrum of mental health challenges including antenatal anxiety and depression, postnatal anxiety and depression, intrusive thoughts, childbirth-related PTSD, and suicidal ideation. Negative interactions with maternity care providers, mental health challenges, and social factors are well-documented in the broader literature on birth trauma (Andersen *et al*., 2012; Ayers *et al.*, 2016; Beck, 2004b).

There were participants in this study who reported more specific traumatic experiences such as preterm birth, baby loss due to fatal fetal abnormalities, EMCS due to breech birth, and a cardiac arrest during the postpartum period. Carmen experienced two subsequent traumatic births as her first baby was born preterm, and her second tragically passed away due to a fatal fetal abnormality. Chen et al. (2022) interviewed women whose experience of preterm birth was so traumatic it led them to avoid future pregnancies. The broader birth trauma literature also reports that both preterm birth and having a baby admitted to the neonatal intensive care unit can contribute to experiences of birth trauma (Andersen *et al.*, 2012; Beck *et al.*, 2013). Leah had a painful EMCS for breech presentation hours after a failed external cephalic version, this experience was deeply traumatic for her and influenced her decision to not have another child. In Lightfoot's (2017) study using secondary data from online forums, commenters shared that the trauma of an undiagnosed breech birth led them to decide against having more children. Siobhán's traumatic experience arose from a cardiac arrest at 11 weeks postpartum. Beck (2004b) also found that cardiac arrest contributed to experiences of birth trauma in their study.

Overall, this research provides a comprehensive, socially-contextualised understanding of birth trauma. It enhances existing research that connects traumatic or negative birth experiences with limiting family size decisions, while also expanding the broader birth trauma literature.

8.4.1 Modifiable and Non-Modifiable Contributors to Birth Trauma

Engaging with the participants' narratives revealed that the factors contributing to their traumatic birth experiences could be differentiated into two distinct categories; modifiable and non-modifiable factors. Modifiable factors are those that can be influenced or altered

through changes in service provisions and care practices. Non-modifiable factors are those that seem beyond the control of healthcare providers. Recognising the differences between contributing factors provides a valuable foundation for making meaningful recommendations and mitigating future trauma.

The non-modifiable factors identified in the participants' narratives are those that stem from pregnancy-related conditions or interpersonal and social issues. Pregnancy-related conditions such as hyperemesis gravidarum and symphysis pubis dysfunction were reported by several participants. These complications are physically and emotionally draining for those impacted, healthcare professionals can aid women in managing these conditions, however, they are difficult or impossible to prevent. Severe or life-threatening conditions such as HELLP syndrome can be deeply traumatising due to the critical risks they pose. Other non-modifiable factors include preterm birth or the diagnosis of congenital abnormalities, both of which can introduce unforeseen challenges and increase the emotional burden on women and their families Additionally, unexpected medical events such as cardiac arrest, without any pre-existing risk factors, is a significant non-modifiable factor that can lead to traumatic outcomes. Finally, a lack of social support emerged as a significant factor in women's experiences of birth-related trauma. For some, relationship issues, including controlling or unsupportive partners, added a layer of difficulty during an already challenging time. Although these factors can be avoided or altered, they are not under the influence of healthcare providers.

The participants' narratives highlighted a number of modifiable factors that can significantly influence the experience of birth-related trauma and, importantly, can be addressed by healthcare providers and service provision. Among the most impactful factors were interactions with care providers**.** Negative encounters, including insufficient support**,** mistreatment, and dehumanising care, were frequently described by participants as contributing to their trauma. Another critical modifiable factor is the prevalence of seemingly unnecessary interventions**.** Many of the participants directly linked their birth trauma to their experience of interventions such as induction of labour, EMCS, or IVD. These interventions can be medically necessary and may be considered non-modifiable at times, however the participants often questioned the medical legitimacy of the interventions they received and whether they were necessary. The participants often agreed to one

intervention that triggered a cascade of intervention, resulting in a traumatic birth experience.

While non-modifiable factors stem from pregnancy-related conditions, unforeseen events, or social circumstances, modifiable factors are those that can be addressed through improved care delivery, communication, and support to reduce the potential for trauma.

8.5 Limiting Family Size after Birth Trauma: Key Insights

'Acting on Self-Preservation' emerged as the constitutive pattern, representing a common meaningful experience shared by the participants (Dibley *et al*., 2019). This reflects a shared sentiment across participants' narratives, the decision not to have more children emerged as a form of protection. For many, this response felt instinctive, influenced by trauma rather than choice, leaving them with a sense of diminished autonomy over their reproductive decision-making. This insight offers a unique contribution to the understanding of reproductive decision-making after birth-related trauma.

The findings also revealed more specific influences that shaped the participants' decision-making process. While self-preservation represents a common meaningful experience shared by the participants, the participants' decision-making was influenced by their desire to eliminate the risk of another traumatic experience or protect their mental health, or a combination of both. These findings were explored in passage one 'Confronting a Difficult Decision' (section 7.3) through the emerging themes 'Eliminating Risk' (section 7.3.2), and 'Preventing Mental Anguish' (section 7.3.3). The following sections will explore these key findings while comparing and contrasting them to previous literature in this area.

8.5.1 Eliminating the Risk of Reoccurring Trauma

'Eliminating Risk' explored how the participants wished to reduce the risk of another traumatic birth experience to zero. By not becoming pregnant again, they were specifically avoiding experiencing another emergency or elective CS, a PPH, severe pain, or further mistreatment and traumatising care. Similar findings were documented in just two studies that had reported some link between birth trauma and the decision to limit family size. Lightfoot (2017) and Taghizadeh *et al*. (2013) both reported incidences of women who

decided to forgo future pregnancy to reduce their risk of further birth trauma. What was more commonly reported were changes in birth plans to reduce the risk of reoccurring trauma. Rather than restricting family size, participants in these studies modified their birth plans to avoid specific delivery methods or locations connected to their previous traumatic experiences. Altered birth plans included opting for an ELCS (Bryanton *et al.,* 2022; McGrath & Ray-Burruel, 2009; Ryding, 1993), planning a homebirth including HBAC (Jackson *et al.,* 2020; Keedle *et al.,* 2015), or planning to freebirth (Jackson *et al.,* 2020).

For women who have previously experienced a traumatic birth, planning and altering birth plans is a way to ensure a different experience, and to protect themselves from another traumatic birth experience (Greenfield *et al.,* 2019). However the participants in this study did not trust that changes in birth plans could guarantee them a positive birth experience, especially as their future birth options were limited to hospital-based birth, a model of care that had already proven traumatising. Furthermore those who had experienced traumatising factors that can be categorised as non-modifiable, such as a major PPH or severe hyperemesis gravidarum, were aware of the high likelihood of recurrence in future pregnancies. The perceived risk of being re-traumatised was too great. With limited alternatives available, the only way participants felt they could guarantee emotional safety was by eliminating the possibility of further trauma entirely. For these participants, this meant choosing not to have more children, even when this decision did not align with their deeper desires.

A key finding of this research lies in the contrast between eliminating and minimising the risk of reoccurring birth trauma. This distinction underscores the primary difference between women who do not have more children and those who modify their future birth plans following a traumatic birth experience. This finding reveals the diverse ways in which trauma shapes reproductive decision-making and the importance of perceived safety in guiding those choices.

8.5.2 Preventing Mental Anguish and Protecting Emotional Wellbeing

'Preventing Mental Anguish' explores the impact that participants' mental health had on their decision to not have another child. Their traumatic birth experiences had such a

severe long-term negative impact on their mental health and emotional wellbeing, such as postnatal depression, postnatal anxiety, and suicidal ideation. These participants feared their mental wellbeing was too vulnerable to withstand another pregnancy or birth, especially if they were at risk of experiencing more trauma.

Similar findings were reported in only one other study that had identified a link between birth trauma and the decision to limit family size. In Porter *et al.*'s (2006) study of 82 women, 61 of the participants only had one child, many of which reported an inability to overcome negative birth experiences due to insufficient mental resilience or maternal feeling. More commonly reported in the wider literature was women's pursuit of care options that fostered a sense of psychological safety for future births. Traumatic birth experiences left women feeling that their physical and psychological sense of safety had been compromised (Feeley & Thomson, 2016; Hollander *et al.*, 2015; Jackson *et al.*, 2020; Rigg *et al.*, 2017; Sassine *et al.*, 2021). In response, some women sought alternative birth settings, such as homebirth and freebirth, as these options offered a renewed sense of safety that had been previously undermined during their hospital-based births (Feeley & Thomson, 2016; Hollander *et al.*, 2015; Jackson *et al.*, 2020; Rigg *et al.*, 2017; Sassine *et al.*, 2021). By planning for a birth experience that aligned with their emotional needs, women sought to protect their mental wellbeing and guard against further psychological distress.

At the time when the majority of the participants in this study gave birth, formal birth reflection services were not yet established and so they received little to no follow-up care to address their experiences. A current online review indicates that such services are available in only 6 of Ireland's 19 maternity units, with one of these currently suspended due to staffing shortages. Although this service is limited, it is an option for those who have recently had a baby and wish to discuss their birth with an experienced practitioner familiar with birth-related trauma and the maternity services. However, as was the case for the participants in this study, this service was not available at the time of their births, and they are now beyond the typical timeframe to avail of this service.

Access to specialised services within the maternity system that address previous birth trauma is typically limited to women who are currently pregnant, thereby restricting support for those who may be uncertain or hesitant about pursuing another pregnancy.

Women with the financial means may access private counselling; however, this support exists outside the maternity care system and lacks integration with the multidisciplinary team, potentially limiting its effectiveness in fostering a sense of safety during future births. There appears to be a significant gap in the care provision for those who have experienced a previous traumatic birth. What could help women who are unsure whether future pregnancy is safe for them is a dedicated trauma-informed service, that is integrated within the maternity services, and that women can access prior to future pregnancies. Such a service could offer multidisciplinary input and collaborative care planning to support emotional safety in subsequent births.

8.6 Restricted Maternity Care Pathways and Implications for Future Births

Previous research on future reproductive decisions after birth-related trauma reveals that women often change their birth plans and opt for alternatives models of care. Changes in birth plans are motivated by a search for supportive care, as well as a way of reclaiming safety and control after a birth trauma. As previously discussed, the participants in this study limited their family size as a way to eliminate the risk of reoccurring trauma and preventing mental anguish. Many of participants reported that their traumatic birth experiences were either caused or exacerbated by the medicalised model of care they gave birth in. The participants were acutely aware they had limited care options for the future, not only due to the general limitations of care in Irish maternity services but also due to their obstetric risk factors such as previous PPH or CS. In this section, findings from previous literature on future reproductive decision-making after birth-related trauma will be compared to the Irish maternity services.

In Ireland, the maternity system has been characterised as being 'predominantly hospital-based and consultant-led' (Begley *et al*., 2009, p. 1). As a result, this medicalised maternity care system has diminished women's choices (O'Brien *et al.*, 2017). For example, choice is often reduced to whether women want to have public or private care within a maternity hospital (Begley *et al*., 2009). Published in 2016, the National Maternity Strategy acknowledges this lack of choice, recommending strategies for developing models of care that reflects the best available evidence to ensure all pregnant woman have appropriate and informed choices (DOH, 2016). Within the strategy, women's birth options are also dependent on what obstetric risk category they are assigned to, for example, women who

wish to have a homebirth must be considered 'Normal Risk' (DOH, 2016, p.86). Risk in childbirth is associated with age, parity, social class, obstetric history, previous stillbirth, neonatal death, abortion, CS, coexisting disease, hypertension, and diabetes (Kennedy, 2002). By these criteria, all of the women in the study are considered to be obstetrically high risk thus limiting their maternity care options even further.

As explored in Chapter 3, women who had previous traumatic deliveries made plans to have an ELCS, VBAC, homebirth with an RM or UBW, and freebirth. CS is an accessible birth option for women in Ireland, accounting for 36.6% of all births in first-time and subsequent mothers (AIMS Ireland, 2024). If women wish to have an ELCS due to a previous traumatic birth experiences, that is an option that should be supported and offered to them. However, it is not radical to suggest that women should not feel obliged to have a major procedure like a CS when there are no other options available to them. This is especially true for women who have been previously traumatised by their CS experience. In Ireland, the only options available to women who have had a previous CS are ELCS or VBAC. Three out of four women, with a history of one CS, successfully achieve a VBAC according to the HSE website (HSE, n.d.). A woman's likelihood of a successful VBAC decreases if she has never had a vaginal delivery, labour is induced, the previous CS was due to labour not progressing, and if her body-mass index is over 30 (HSE, n.d.). If a woman's previous birth trauma involved a CS, she may feel hesitant to attempt a VBAC, as it could result in an EMCS, another potentially traumatic experience.

The literature also identified homebirth as a birth plan made by women who have experienced a traumatic birth. Jackson *et al.* (2020) reported that women in their study chose homebirth as their previous traumatic hospital births was so life-changing, that they did not want to return to the source of this trauma. Homebirth services in Ireland are limited as they are not available nationwide, and are accessible to a very specific group of women who are deemed obstetrically low risk (Gregory *et al.*, 2023). Some argue that Ireland applies unusually strict criteria for assessing obstetric risk for homebirths when compared to other countries (Gregory *et al.*, 2023; O'Boyle, 2014). Between 2018-2020, homebirth accounted for 0.275% of overall births in Ireland (San Lázaro Campillo *et al.*, 2022). As homebirth is a restricted service, women giving birth in Ireland may not even

consider it as an option. Furthermore, as previously stated, the women in this study are considered to be obstetrically high risk and would not be able to avail of this service.

This study highlights the need to broaden maternity care options in Ireland to better support women who have experienced birth-related trauma. Expanding access to diverse models of care, such as midwifery-led units and homebirth services, may help foster a greater sense of safety, autonomy, and trust in future pregnancies. However, it is also important to recognise that some women, due to non-modifiable obstetric risk factors, may remain ineligible for certain alternative care pathways. For these women, trauma-informed, compassionate care within existing hospital-based services remains essential to ensuring positive and emotionally safe birth experiences.

8.7 Moving Towards Psychologically Safe Maternity Care

A key finding from this research is the participants distrust that they will not become retraumatised during future births. Their traumatic birth experiences gave them an inherent mistrust of mainstream Irish maternity care. Due to systemic limitations within the maternity care system and their own obstetric risk profiles, participants often found themselves with no viable alternative but to give birth in a hospital setting once again, something they were unwilling to do. The following section explores how maternity care in Ireland can be improved to ensure it is more emotionally and psychologically safe for those with a history of birth trauma.

It is well documented that the care women receive during labour and birth can contribute to how they will experience their birth (Beck, 2004a; Murphy & Strong, 2018; Nicholls & Ayers, 2007; Peeler *et al.*, 2018; Thomson & Downe, 2008). Unsupportive, dismissive, and disrespectful care is frequently described by women who have had traumatic birth experiences (Feeley & Thomson, 2016; Greenfield *et al.*, 2019; Rigg *et al.*, 2017; Rigg *et al.*, 2020; Sassine *et al.*, 2021). Several participants in this study felt that the care they received either caused or intensified their experience of birth trauma. Their descriptions of their interactions with midwives and doctors detailed care that was mechanical, and lacked empathy. They used words like undermined, dismissed, bullied, dehumanised, and controlled to describe how their care-givers made them feel. Participants also felt they were pressured into interventions, which often led to a cascade of intervention that only further

compounded their trauma. These participants were determined never to be subjected to such traumatising care again, and so they decided to not have more children. Ultimately they did not trust the maternity care system not to re-traumatise them.

The risk of traumatisation in maternity care is relatively high as it involves intrusive procedures, and prolonged periods of time where a person is vulnerable and dependent on a caregiver (Sperlich *et al*., 2017). One strategy for making maternity services safer and supportive for those who have experienced trauma is the implementation of trauma-informed care. Broadly speaking, trauma-informed care is an approach to care-giving that acknowledges a person's history of trauma, the presence of trauma symptoms, and acknowledges the role trauma has played in their lives (Seng & Taylor, 2015). What is not immediately apparent from this definition is that trauma-informed care is not just about the interactions between a clinician and client, it also encompasses the service delivery context as a key factor in facilitating trauma-informed care (Seng & Taylor, 2015). Multiple authors have recommended the implementation and integration of trauma-informed care principles into the maternity services and maternal mental health services (Ayers *et al*., 2024; Benton *et al.,* 2024; Seng & Taylor, 2015; Sperlich *et al*., 2017). Implementing trauma-informed care in midwifery can help mitigate the effects of maltreatment, various adverse childhood experiences, and the consequences of traumatic stress on childbearing outcomes (Sperlich *et* al., 2017). An international mapping exercise of policies for screening for traumatic birth identified that only The Netherlands, out of eighteen countries, had an established national policy on screening, treatment, and prevention of traumatic birth (Thomson *et al.*, 2021). Ireland currently has no guidelines for trauma-informed care in the maternity services. The National Maternity Strategy states that additional support will be available for women who have experienced traumatic birth or the loss of a baby (DOH, 2016), they do not make any recommendations for the creation or implementation of trauma-informed care guidelines.

Sperlich *et al.* (2017) state there are *4 R's* that are essential to make care trauma-informed; 'realising the impact of trauma, recognising its signs and symptoms, responding by integrating knowledge into practice (and policies and procedures), and resisting re-traumatisation' (p. 664–665). Benton *et al.*, (2024) make recommendations for the integration of trauma-informed approaches in maternal mental health care within the

context of perinatal trauma and loss. Their recommendations include; screening for trauma, access to specialist care, clear communication that is sensitive to trauma, consistency and continuity of care, offering individualised care and recognising diversity, collaboration between women, families, and services, care provider training to enhance skills and knowledge, as well as supervision and peer support for care providers' wellbeing (Benton *et al.*, 2024).

The introduction of trauma-informed care within the maternity services is essential for creating a safer and more supportive environment for individuals who have experienced previous birth trauma. It is especially crucial for individuals who have been traumatised by the system and have concerns about the prospect of becoming pregnant again. Ensuring maternity care is psychologically and emotionally safe should be a priority.

8.8 Emerging Meaning from the Lived Experiences

Hermeneutic phenomenology, as a qualitative methodology, seeks to uncover meaning embedded within lived experiences, with the aim of deepening our understanding of what it means to be human (Crist & Tanner, 2003). Through a process of interpretive analysis, meaning is not simply discovered but emerges through engagement with the narratives, shaped by the researcher's own context and understanding. Importantly, meaning is never fixed or final, interpretation is an iterative and ongoing process. Within this study, two central meanings emerged from the participants' accounts; fortitude, reflecting the strength and resilience of the participants, and grief, capturing the profound and pervasive sense of loss woven throughout their experiences.

8.8.1. Fortitude in the Lived Experiences

All of the participants exhibited remarkable strength. Fortitude emerged as a central meaning within the lived experiences, as their narratives revealed the depth of their inner strength, not only in enduring the trauma of their births, but also in facing the equally challenging process of making life-altering decisions in its aftermath.

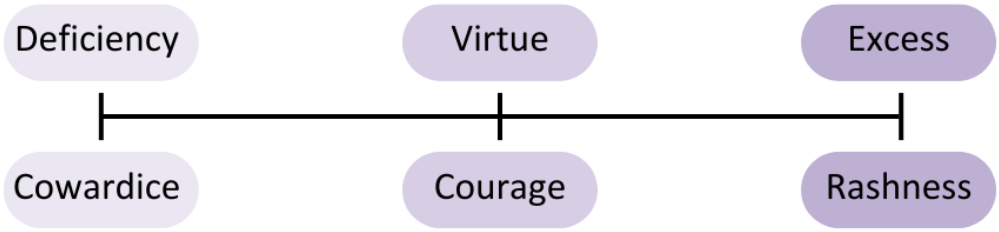
The Cardinal Virtues are four fundamental virtues found in Western philosophy (Hursthouse & Pettigrove, 2023) and Christian theology (Austin, 2012) that serve as the foundation for

moral behaviour. They have been a central feature of ethical discourse since the ancient Greeks, notably with Plato and Aristotle (Hursthouse & Pettigrove, 2023). The four virtues are temperance, justice, prudence (practical wisdom), and courage or fortitude (Austin, 2012). The virtues are excellences of character that human beings do not naturally possess, instead they are developed and cultivated through acting well. Hursthouse & Pettigrove (2023) describe a virtue as;

> *an excellent trait of character. It is a disposition, well entrenched in its possessor – something that, as we say, goes all the way down, unlike a habit such as being a tea-drinker – to notice, expect, value, feel, desire, choose, act, and react in certain characteristic ways* (para. 7).

The most historically influential account of the virtues was provided by Aristotle, who advanced the notion of the mean; every virtue is a mean between a deficiency and an excess (Vella, 2008). For example, rashness is the excess of fortitude or courage, while cowardice is the deficiency. A courageous person is not entirely confident or devoid of fear; instead, they demonstrate the right balance of confidence and fear appropriate to the situation (Vella, 2008). This is the mean between cowardice and rashness (Vella, 2008), and what human beings should aspire to attain.

Figure 3: Visual Representation of the Mean for the Virtue of Courage.



While Aristotle's principle of the mean is applied to all the virtues, it is not a one-size-fits-all approach as the principle, instead it must be adapted to the differing situation and needs of each specific individual (Kraut, 2022). For instance, some people are naturally more

cautious or risk averse, while others are more daring and risk-taking, but virtue involves purposefully breaking bad habits and replacing them with good ones. For each, finding the mean involves the use of the primary virtue of prudence (practical wisdom) to ascertain whether they are deficient or excessive (Austin, 2012).

Fortitude shows itself in the lived experience of limiting family size after birth trauma. The participants were faced with a difficult dilemma after their traumatic birth experiences; they could choose to potentially retraumatise themselves through another birth, or they could decide to protect themselves from further harm and not have another child. Fortitude is a kind of firmness of mind in the face of threats and dangers, it is cultivated through what is referred to in virtue ethics as *acting-well*. One acquires a virtue through developing the habit of acting-well. The participants' descriptions of their experience of limiting family size reveal how their decision caused them intense emotional turmoil. However, in the face of such pain, they remained steadfast with their original decision, there-by demonstrating the virtue of fortitude.

8.8.2 Grief in the Lived Experiences

Grief was experienced by several participants in response to the loss of the child they would never have. By making the decision to have less children than they originally desired and planned for, they reported significant feelings of loss and grief. Grief is a normal multifaceted response to loss (Casarett *et al*., 2001), and can be described as the anguish one experiences after a siginificant loss, usually the death of a loved one (APA, n.d.). However the participants did not experience what society would consider a *normal loss* as they had not lost a pregnancy or an actual child. Ambiguous loss can be described as loss without closure, occurring when a significant element is absent, in turn disrupting mourning rituals and preventing typical coping behaviours (Boss, 2006). Perinatal loss is often characterised as ambiguous loss as it involves the simultaneous physical absence and psychological presence of the fetus or infant (Boss, 2004). Ambiguous loss can contribute to disenfranchised grief, which is grief that is not openly acknowledged, socially validated, or publicly mourned (Doka, 1989). It can occur when a loss is minimised, stigmatised, or unrecognised by society, leaving bereaved individuals without adequate support or validation (Doka, 1989).

The loss of a child that one has planned for and pictured in their head is experienced as an ambiguous loss. This loss can be challenging to process as it lacks the physical presence of a person that is conventionally associated with loss and bereavement. The participants' peers, as well as wider society, may have trouble understanding and acknowledging this type of loss. Feelings of grief may be further stigmatised especially when parents already have living children and are still physically able to carry a pregnancy. This sentiment was echoed by some participants, who seldom shared their feelings of loss with others. When they did, conversations often shifted toward expressing gratitude for the child or children they already had, instead of acknowledging their grief and loss.

Just like birth trauma, grief is a deeply personal and multi-faceted experience. Aisling did not feel grief for the loss of potential future children, instead Aisling grieved the loss of the positive birth experience she had envisioned for herself. Tsakmakis *et al.* (2023) refers to this as 'birth grief' (p. 370), where a woman grieves for the birth she had envisioned and prepared for, but was unable to achieve for various reasons. Aisling had prepared for a holistic, intervention-free, water birth, however she ended up having an EMCS after experiencing a cascade of intervention.

Maria recognised that she began grieving for the daughter she would never have after learning that her baby was a boy during her second pregnancy. Her first ELCS experience had been so traumatic, now in her second pregnancy and facing a second ELCS, she doubted her mental health could handle the prospect of a third ELCS in the future. Therefore she started to grieve for her dream daughter as she anticipating that her second son would be her last child. The concept of anticipatory grief was first introduced by Lindemann (1944), it refers to when individuals are confronted with the expectation that they will encounter a significant loss, and so they begin the grieving process in anticipation of said loss (Fulton *et a*l., 1996). Anticipatory grief can manifest as tearfulness, sadness, guilt, anxiety, depression, irritability, and anger (Irish Hospice Foundation, n.d.). Intense grief can manifest itself through suicidal ideation. During Maria's second pregnancy she struggled with suicidal ideation. It is beyond the scope of this research to speculate the underlying causes of this, however intense grief can manifest itself through suicidal ideation (APA, n.d.).

Over time, the participants learned to accept their experiences and their circumstances of their decision to limit their family size. Reaching acceptance did not imply that they had completely overcome their trauma or moved on entirely, instead it meant they had found a way to move forward from their suffering. Acceptance after a loss is explored in grief literature. Kübler-Ross, (1997) proposed a model that outlines five stages of grief that individuals experience when experiencing a loss. These five stages are denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1997). These stages should not be thought as resolute or a rigid process, as individuals may not experience them in the same manner or sequence, or may not experience all of them at all (Kübler-Ross, 1997).

8.9 Strengths and Limitations

This study makes a unique and valuable contribution to the existing body of knowledge by shedding light on reproductive decision-making following birth-related trauma. It is the first piece of qualitative research to focus on the decision to limit family size after birth-related trauma. Another strength of this study is the centring of participants' voices. As a result it provides in-depth insights into how trauma can shape future reproductive choices. It moves beyond surface-level descriptions to explore the complex interplay of emotional, psychological, and systemic factors that influence such decisions. Furthermore, the findings carry clear and practical implications for midwifery practice. By highlighting specific areas where care can either exacerbate trauma or support healing, this study offers valuable guidance for improving the quality of care. As such, it has direct relevance for clinical education and professional development, advocating for more trauma-informed, empathetic, and responsive maternity care.

There are limitations to every study no matter how well they are conducted (Polit & Beck, 2017). In this study, the participant sample was relatively homogenous, consisting primarily of older, married, white Irish working professionals. There were three participants who were not Irish, two originated from Europe and one from South Asian. Furthermore, the experiences of younger women, particularly those under the age of 30, were not captured. A homogenous sample limits research by restricting the diversity of perspectives and experiences represented in the findings. When participants primarily share similar demographic backgrounds, such as ethnicity, marital status, and socioeconomic status, the research may not fully capture the range of experiences and interpretations that could arise

from individuals with different backgrounds. Furthermore, only four men participated in the study, and while their insights provide invaluable in-sights, the male perspective in the overall findings is limited. To address this limitation, future research should aim to recruit from a broader and more diverse pool of participants. Expanding recruitment beyond an existing longitudinal study and utilising social media platforms could help access individuals from varied backgrounds and experiences.

A criticism of hermeneutic phenomenology is that the findings are not generalisable. It is recognised in the tradition of hermeneutic phenomenology that experiences are highly subjective and vary from person to person. Therefore the specific descriptive findings from any study utilising this methodology may not be directly applicable to a larger population. The goal is that findings resonate with readers, and allow them to gain a deeper understanding of the lived experience.

Researcher bias is also a concern in hermeneutic phenomenological research as interpretation of data can be influenced by the researcher's pre-understandings and their own lived experiences. Researchers who use this methodology recognise that interpretations of the same data can vary, and that no interpretation is necessarily correct or incorrect. However it is imperative for researchers to try understand their biases and analyse them before data collection and interpretation. To minimise the risk of researcher bias, I examined my pre-understandings through a pre-supposition interview. Furthermore, I kept a reflexive journal throughout the research process.

8.10 Conclusion

This chapter has discussed the key findings that emerged from the interpretive analysis of participants' lived experiences of limiting family size following birth-related trauma. It began with a narrative overview of the findings and a discussion of the sample demographics, before examining the complex and often compounding factors that contributed to the participants' experiences of trauma. These factors were then differentiated into modifiable and non-modifiable elements to support meaningful recommendations for care. The discussion then focused on the participants' decision-making processes, revealing the deep emotional reasoning behind their decisions and comparing these with existing literature. Broader systemic issues within Irish maternity care

were also considered, highlighting how limited options and insufficient psychological safety influenced participants' reproductive choices. The chapter concluded by reflecting on the deeper meanings of the lived experiences, particularly the emerging meaning of fortitude and grief. The chapter concluded with a discussion on the strengths and limitations of the study. The following chapter presents the conclusion of this thesis.

Chapter 9: Conclusion

9.1 Introduction

This final chapter concludes the study and reflects on its overall contribution. It begins by summarising the key findings and contribution to knowledge, offering a synthesis of how the research advanced understanding of reproductive decision-making following birth-related trauma. This is followed by a set of recommendations that have been based on the findings of this study. Recommendations for future research, service provision, as well as midwives and maternity care providers have been outlined. The chapter also presents a dissemination plan, detailing how the findings will be shared among clinicians, academics, and the participants. Finally, the chapter concludes with a personal reflection on the research journey, acknowledging the insights gained and the ongoing relevance of this work for maternity care practice and future scholarship.

9.2 Key Findings and Contribution to Knowledge

This study offers important new insights into how birth-related trauma influences reproductive decision-making, specifically the decision to limit family size. 'Acting on Self-Preservation' emerged as the constitutive pattern, representing a common meaningful experience shared by the participants (Dibley *et al.*, 2019). This reflects a shared sentiment across participants' narratives, the decision not to have more children emerged as a form of protection. For many, this response felt instinctive, influenced by trauma rather than choice, leaving them with a sense of diminished autonomy over their reproductive decision-making. This insight offers a unique contribution to the understanding of reproductive decision-making after birth-related trauma.

A central finding is the distinction between minimising versus eliminating the risk of a subsequent traumatic birth. This distinction proved pivotal in decision-making, while participants in other studies some considered altering future care plans to reduce risk, the participants in this study felt that only by completely eliminating the possibility of another birth could they feel emotionally and physically safe.

Another key finding is the deep sense of mistrust some participants developed toward the maternity services following their traumatic experiences. This mistrust was not only rooted

in specific clinical events, but also in the emotional and interpersonal aspects of care. Participants described feeling psychologically and physically unsafe within a system that had previously failed them, and this shaped their views on future pregnancies and care options. The study also identified both modifiable and non-modifiable contributors to birth trauma. While certain factors, such as pregnancy-related health conditions, are beyond the control of healthcare professionals, many others are systemic or relational in nature. These include poor communication, lack of informed consent, and emotionally neglectful or dehumanising care. Recognising this distinction provides healthcare professionals with clear areas where change is both necessary and possible in order to prevent avoidable trauma.

In terms of its contribution to knowledge, this is the first known qualitative study to specifically explore the connection between birth trauma and the decision to limit family size. It fills a significant gap in the literature by foregrounding the voices of those who have made this decision in the aftermath of traumatic birth experiences. Through in-depth, interpretive engagement with participants' narratives, the study offers a nuanced and emotionally resonant understanding of how trauma reverberates beyond the birth event itself, shaping long-term reproductive choices. By asking participants to reflect on and articulate these experiences, this research provides a foundation for both scholarly and clinical efforts to improve post-trauma support and to foster safer, more responsive maternity care.

9.3 Recommendations

Hermeneutic phenomenology does not aim to generalise or problem solve (Dibley *et al*., 2020; Smythe *et al*., 2008). Instead, the researcher provides their interpretation of a participant's experience, which may stimulate reflection in the reader and encourage a dialogue of understanding (Smythe, 2011; Smythe *et al.,* 2008). Although the ultimate purpose of this research is not to provide resolutions, some recommendations can be made from the findings.

9.3.1 Recommendations for Further Research

This study has revealed that there is cohort of women in Ireland who have suffered from birth-related trauma and altered their future reproductive decisions as a result. As a qualitative piece of research, this study offers an in-depth understanding of parents' lived experiences of limiting family size to less than desired after experiencing birth-related trauma. First, I recommend a longitudinal quantitative study that examines the relationship between traumatic birth experiences and future reproductive decisions in Ireland. This type of research can provide data on how birth trauma impacts women's choices regarding family planning over time. This type of quantitative data would provide measures that could aid in the planning of service provision. Building on the findings of this study, as well as incorporating Public and Patient Involvement (PPI), a quantitative study could be undertaken to design and evaluate an intervention aimed at supporting women who have experienced birth-related trauma and wish to have another child but feel hesitant. The goal of this future research would be to develop an evidence-based intervention that helps parents achieve their desired family size following the impact of traumatic birth experiences.

9.3.2 Recommendations for Service Provision

The findings of this study reveal that, due to their traumatic birth experiences, some participants did not feel emotionally or physically safe to have another baby within the existing Irish maternity care system. Arising from these findings is the recommendation that maternity services should adopt trauma-informed principles to ensure care is delivered in a way that recognises the impact of trauma, fosters safety and trust, and empowers women. Training on trauma-informed principles of care should be embedded at all levels, from undergraduate education to ongoing professional development.

9.3.3 Recommendations for Midwives and Maternity Care Providers

The participants' narratives revealed how the actions and behaviours of maternity care professionals can have a devasting impact on women's experiences of birth. Midwives and other maternity care providers play a pivotal role in reducing trauma by focusing on modifiable factors such as communication, informed consent, as well as respectful and supportive care. Practitioners should prioritise reflective practice, seek regular feedback

from service users, and engage in continuous professional development aimed at fostering trauma-informed, compassionate care.

9.4 Dissemination

To ensure that the findings of this study reach the widest and most relevant audiences, a dissemination strategy will be employed. Given the interdisciplinary nature of this research, it is important to publish and present findings across a range of academic and professional domains.

The findings will be submitted to peer-reviewed journals that cater to midwifery, maternity care, and broader health and social sciences audiences. Priority will be given to journals that are widely read by clinicians, researchers, and policy makers. These include: *Birth, Women and Birth, Qualitative Health Research*, *Social Science & Medicine*, and *Journal of Advanced Nursing.* By targeting both discipline specific and multidisciplinary journals, the research can reach healthcare providers, mental health professionals, and decision-makers involved in maternity care.

To engage with scholars and practitioners, findings will be presented at relevant conferences. A presentation will be submitted to methodological conferences that focus on phenomenological research, such as those hosted by the British Society of Phenomenology, to explore and discuss the hermeneutic phenomenological approach used in the study. Presentations will also be submitted to maternity and midwifery-focused conferences, including THEConf at Trinity College Dublin, Nursing and Midwifery Annual Research Conference at University College Cork, and International Labour and Birth Conference hosted by the University of Central Lancashire. These presentations will allow for discussion with peers, refinement of ideas through feedback, and broader knowledge translation.

In keeping with the ethical commitment to participants, a plain-language summary of the findings will be shared directly with them. A visually engaging PDF document will be designed to include a plain-language overview of key findings, infographics and data visualisations, and summarised insights and implications for care.

9.5 Final Reflections

As discussed throughout this thesis, reflective practice is central to hermeneutic phenomenological research to aid interpretation and understanding. The following section offers my concluding reflections on the research process as well as personal insights and meaningful moments that have remained with me throughout the journey.

As a result of conducting this study, I have a renewed appreciation for qualitative research and its contribution to knowledge generation. While qualitative research sometimes receives less recognition within the wider research community, its unique strengths deserve acknowledgment. Although these observations are by no means new or unique within methodological discourse, they merit reiteration in light of my research experience. Qualitative approaches amplify individual voices, this is particularly crucial in maternity care research, where centring women's and service users' voices should be paramount. The methodology provides essential contextual understanding that quantitative data alone cannot capture, illuminating the complexity of lived experience. Perhaps most significant for birth trauma research, qualitative research honours subjective experiences and interpretations. This became strikingly apparent throughout my study, where participants' definitions of birth trauma varied considerably. Had I conducted a quantitative study, I would have likely failed to capture the full spectrum of traumatic birth experiences, as standardised measures cannot accommodate the same degree of subjective interpretation. Qualitative methodologies offer irreplaceable insights, particularly when investigating deeply personal phenomena like birth trauma.

Conducting the interviews was a profoundly meaningful part of the research process, surpassing my initial expectations of data collection. Each interview proved to be a compelling encounter that deepened my understanding of the phenomenon. Each participant shared their experience with incredible depth, honestly, and clarity. I was frequently struck by the clarity and composure with which participants articulated their traumatic experiences. I often found myself being able to vividly visualise the moments they described. Throughout data analysis and interpretation, I could vividly recall the tone and cadence of each participant’s voice, reinforcing the emotional and experiential weight of their words. Certain phrases or descriptions left a lasting impression and stayed with me throughout the rest of the research process. I often thought about Gráinne description of

the delivery room resembling a war zone after a postpartum haemorrhage, a scene I could easily picture as a result of my own midwifery experience. Cara's words also had a profound impact on me, as she bled after the birth of her second baby, she believed that she was dying and that she would never see her eldest daughter again. Even six years after the event, the emotion in her voice was unmistakable, carrying the weight of her trauma into the interview.

All the participants demonstrated remarkable strength. The ability and willingness to recount traumatising experiences to a complete stranger reflects the participant's courage and resilience. Birth trauma research largely depends on the participation of those impacted. Their voices can contribute to both the advancement of knowledge, as well as changes in practice and service provision. As a researcher and midwife I am so grateful for this cohort's participation and willingness to share.

Conducting this study also prompted reflection on midwifery, both the profession as a whole and my own personal practice. At the outset of this study, I was not naïve to the fact that some midwives engage in behaviours that are harmful to the women in their care. I had witnessed instances of poor practice firsthand, heard many troubling accounts, and engaged with existing literature on the subject. Prior to commencing data collection, I anticipated that negative experiences with healthcare providers, including midwives, would feature prominently in participants' narratives. Yet, despite this awareness, I was still profoundly affected by feelings of shame and embarrassment as participants recounted these experiences. Listening to them, I became acutely aware that I was a representative of the profession. I wondered whether participants might question if I condoned or had engaged in such behaviours. This was further intensified by the fact that I work in the same hospital some of the participants attended. There was a real possibility that they were speaking about my midwifery colleagues. I found myself trying to make sense of why a fellow midwife might act in a way that so obviously causes harm, are these behaviours and attitudes influenced by the stress and burnout caused by institutional faults and resource issues. I reflected on my own practice, especially during times of heightened stress, and questioning whether I had ever inadvertently contributed to such harm. Nonetheless, I believe that these challenges do not excuse poor behaviour. Midwives who consistently

treat women in harmful or disrespectful ways must engage in serious self-reflection and consider whether they are suited to be a midwife.

What I had not anticipated, were the positive accounts of midwives that some participants shared. Amid their traumatic experiences, there were moments when a midwife offered the right words or provided a level of support that left a lasting impression. These moments stood out to participants as instances in which they felt genuinely cared for. In some cases, the impact was so profound that participants recalled the midwife by name. This contrast in experiences highlighted the significance of consistent compassionate and supportive care, and the lasting difference it can make in a woman's experience.

To conclude, I reflect on the way in which this research has directly informed my midwifery practice. The greatest influence has been a renewed attentiveness to seemingly minor details that can meaningfully shape a woman's experience. I will use an example to illustrate this point. Recently, I cared for a woman in the delivery suite who had been induced following a prolonged prelabour rupture of membranes. Despite trying various methods of induction over many hours, her body was not ready for labour. Although she had hoped to avoid surgical intervention, she had an emergency caesarean section and a postpartum haemorrhage over one litre. In the recovery room, she appeared upset and withdrawn, almost detached from the experience. I found myself thinking of the participants in my study. Many had described how, when birth deviated from their expectations, the care they received in those moments profoundly shaped their perception of the experience. I was particularly reminded of Aisling, whose birth story bore striking similarities to this woman's. What stood out in Aisling's account was the significance she placed on breastfeeding, as it was the only element of her birth plan that remained intact. The woman I was caring for also expressed a desire to breastfeed. Although I was expected back in the delivery suite, I made the conscious decision to stay with her a little longer and support her in initiating breastfeeding. When her baby struggled to latch, I assisted her in hand expressing colostrum, showing her partner how he can assist her with the next feed. A few days later, I visited her on the postnatal ward. Though she was still coming to terms with her birth experience, she expressed her gratitude for the breastfeeding support, telling me how much it had meant to her. This act may seem small, and it alone could not transform how she felt about the birth overall, but it mattered to her. I share this story as a reminder of the

lasting impact that small, thoughtful gestures can have. As midwives, we have the opportunity to make people feel genuinely cared for, simply by listening and responding to what they need from us in that moment.

9.6 Conclusion

This research has illuminated the far-reaching and deeply personal impact of birth trauma on women's wellbeing and future reproductive decisions. The findings revealed that the participants' decision to limit their family size initiated an emotionally challenging journey that was characterised by self-preservation. This decision was an instinctive response to experiences that left women feeling vulnerable, disempowered, and unsafe. For some, the prospect of another pregnancy evoked profound fear, particularly when previous care lacked emotional support or autonomy. Central to the participants' narratives was the urgent need for maternity care that not only prevents avoidable trauma, but actively fosters a sense of safety, choice, and respect.

The findings of this study strongly support the need for systemic change. This includes addressing modifiable factors within maternity services, such as provider attitudes, models of care, and communication practices, as well as implementing trauma-informed approaches that validate women's experiences and restore trust. Women who have experienced birth trauma require care that recognises both the emotional and physical dimensions of safety. If the maternity system is to truly serve all women and birthing people, it must create the conditions in which those who have been traumatised can once again feel safe to imagine and pursue further childbearing, should they choose to do so.

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Appendix 1

Search Strategy

Web of Science Core Collection

(limits= English only)
(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*)
AND
(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour)
AND
(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting")
AND
(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **NEAR/3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **NEAR/3** spacing) OR terminat* OR abort* OR steril*)

Maternity & Infant Care

(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*).AB,TI
AND
(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour).AB,TI
AND
(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting").AB,TI
AND
(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **ADJ3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **ADJ3** spacing) OR terminat* OR abort* OR steril*).AB,TI

Embase

(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*):AB,TI OR ('family decision making'/exp) OR ('shared decision making'/exp)
AND
(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour):AB,TI OR 'childbirth'/exp OR 'labor'/exp OR 'pregnancy'/exp OR 'puerperium'/exp OR 'prematurity'/exp
AND
(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting"):AB,TI OR 'psychotrauma'/exp OR 'posttraumatic stress disorder'/exp OR 'mental stress'/exp OR 'fear of childbirth'/exp OR 'prematurity'/exp
AND
(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **NEAR/3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **NEAR/3** spacing) OR terminat* OR abort* OR steril*):AB,TI OR 'childlessness'/exp OR 'birth control'/exp OR 'contraception'/exp OR 'induced abortion'/exp OR 'fertility'/exp OR 'infertility'/exp OR 'cesarean section'/exp OR 'reproductive sterilization'/exp

Cinahl

(limits= exclude Medline, English only)
TI(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR AB(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR (MH "Decision Making+")
AND
TI(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR AB(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR (MH "Childbirth+") OR (MH "Labor+") OR (MH "Pregnancy+") OR (MH "Postnatal Period")
AND
TI(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR AB(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR (MH "Psychological Trauma+") OR (MH "Stress, Psychological") OR (MH "Stress Disorders, Post-Traumatic")
TI(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR AB(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR (MH "Childlessness") OR (MH "Family Planning") OR (MH "Birth Intervals") OR (MH "Fertility") OR (MH "Infertility") OR (MH "Contraception+") OR (MH "Cesarean Section+") OR (MH "Abortion, Induced") OR (MH "Sterilization, Sexual+")

Medline

(limits= English only)
TI(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR AB(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR (MH "Decision Making+')
AND
TI(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR AB(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR (MH "Parturition") OR (MH "Labor, Obstetric") OR (MH "Pregnancy")
AND
TI(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR AB(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR (MH "Psychological Trauma+") OR (MH "Stress Disorders, Post-Traumatic)
AND
TI(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR AB(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR (MH "Abortion, Induced") OR (MH "Sterilization, Reproductive+") OR (MH "Fertility") OR (MH "Infertility") OR (MH "Contraception+") OR (MH "Cesarean Section")

PsycINFO

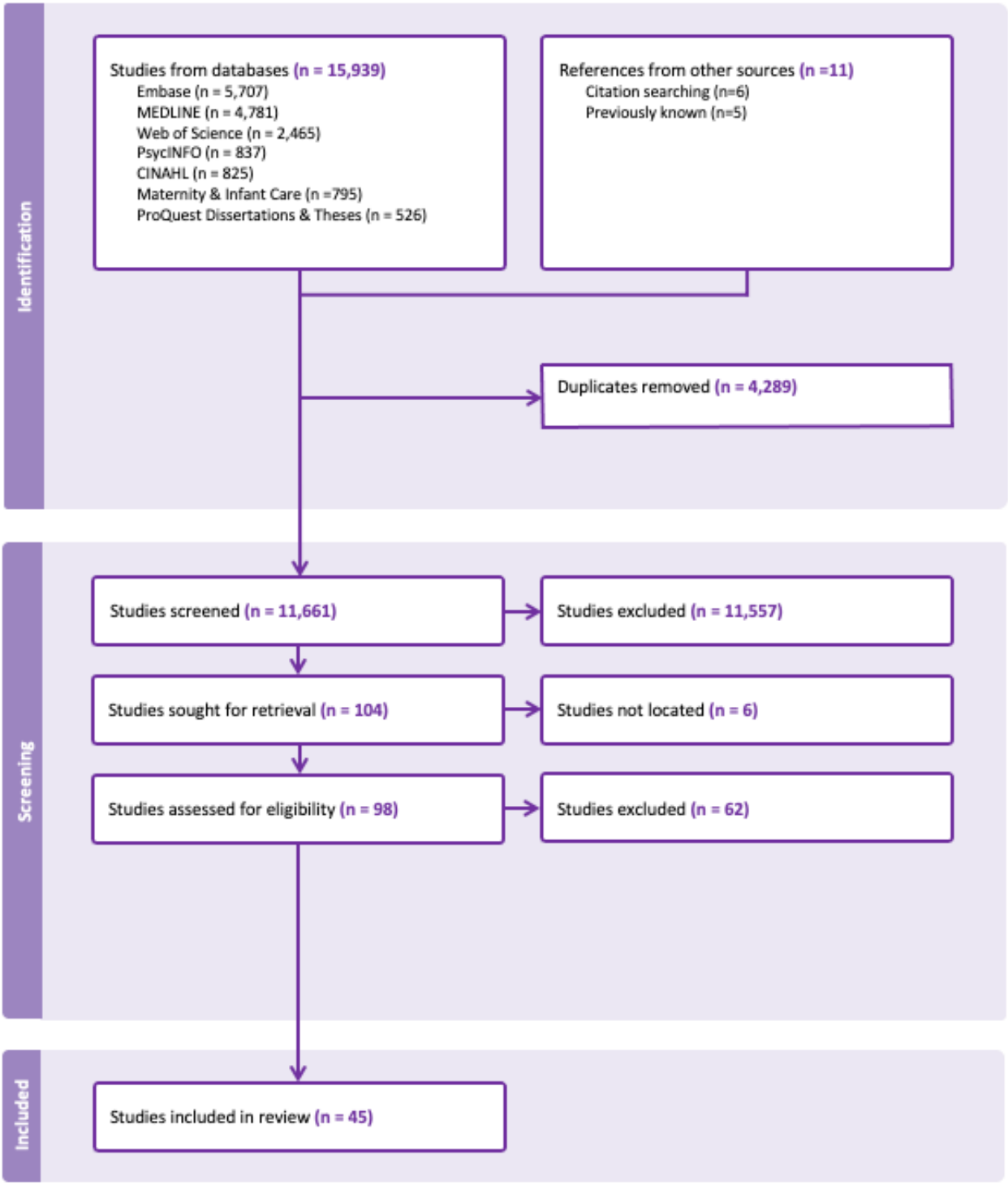
(limits= English only)
TI(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR AB(consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*) OR (DE "Decision Making") OR (DE "Choice Behavior")
AND
TI(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR AB(Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour) OR (DE "Birth") OR (DE "Labor (Childbirth)") OR (DE "Perinatal Period") OR (DE "Pregnancy") OR ("Postnatal Period") OR (DE "Premature Birth")
TI(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR AB(premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting") OR (DE "Trauma") OR (DE "Posttraumatic Stress") OR (DE "Posttraumatic Stress Disorder") OR (DE "Psychological Stress")
AND
TI(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR AB(((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) **N3** (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* **N3** spacing) OR terminat* OR abort* OR steril*) OR (DE "Childlessness") OR (DE "Family Planning") OR (DE "Birth Control") OR (DE "Fertility" OR DE "Infertility") OR (DE "Caesarean Birth") OR (DE "Induced Abortion") OR (DE "Sterilization (Sex)")

Proquest

(limits English only, PhD only, anywhere but full text)
noft((consensus OR consent* OR choice* OR choos* OR chose OR decision* OR decid* OR disput*)) AND noft((Birth* OR childbirth* OR pregnan* OR postnatal OR "post natal" OR postpartum OR "post partum" OR antenatal OR "ante natal" OR prenatal OR "pre natal" OR parturition OR labor OR labour)) AND noft((premature* OR trauma* OR psychotrauma* OR posttrauma* OR PTSD OR intrusive OR anxiety OR stress OR fear* OR helpless* OR terror* OR negativ* OR depress* OR tokophobi* OR tocophobi* OR "life changing" OR "life threaten*" OR "long lasting")) AND noft((((next OR finish* OR complet* OR plan* OR defer* OR delay* OR postpon* OR future OR subsequent OR intention* OR avoid*) NEAR/3 (childbear* OR pregnan* OR birth* OR childbirth* OR caesarean OR cesarean OR reproduc* OR family OR contracepti* OR fertility OR infertility)) OR (child* NEAR/3 spacing) OR terminat* OR abort* OR steril*))

Appendix 2

PRISMA diagram



Appendix 3

Recruitment Email

Dear MAMMI study participants,

I hope you and your family are very well.

My name is Sofia O'Byrne, I am a midwife and second year PhD student at the School of Nursing and Midwifery in Trinity College Dublin. As part of my doctoral research thesis, I am researching the experience of limiting family size as a result of traumatic birth.

Some existing research shows that there may be a connection between people having less children than they wanted because of a traumatic birth experience. A traumatic birth experience may refer to anything that happened during pregnancy, childbirth or the postpartum period, that caused distressing emotions and reactions, and any negative outcomes on a person's health or life. My research aims to ask what this experience is like for people (women with and/or without partners) and what it is like to make the decision to have less children than you would like.

One of the questions in the most recent MAMMI study survey you were asked if there is anything you wish to tell us about trying to become pregnant, choosing not to become pregnant or any subsequent pregnancies and/or births in the years since you had your first baby. I would really like to talk to you and your partner, together or separately, if you feel your experience of pregnancy, birth or postpartum influenced your future plans to have less children. Women are also more than welcome to participate by themselves.

If you would like to receive more information about the study, please contact me at [email address].

I look forward to hearing from you,

Thank you,

Sofia O'Byrne.

Appendix 4

Letter of Invitation

Dear [name],

I would first like to thank you for letting me share some information about my research study with you. You and your partner are being invited to participate in a research study titled 'The lived experience of limiting family size as a result of a traumatic childbirth'. I understand this can be a hard topic to talk about so I am very grateful for your time.

Some research shows that there may be a connection between people having less children than they wanted because of traumatic birth. My research study aims to ask what this experience is like for people and what it is like to make the decision to have less children than you would like.

This research is being carried out as part of my doctoral research at Trinity College Dublin. The research is being supervised by Prof Joan Lalor who is based in the School of Nursing and Midwifery in Trinity College Dublin, and Prof Soo Downe who is based in the School of Community Health and Midwifery in the University of Central Lancashire.

You are being invited to take part as you have identified that your birth experience influenced your future plans to have less children. You have given your consent to the MAMMI study for us to send you further information on this study. This research study is only recruiting participants from the MAMMI study and is otherwise not connected to it. I am inviting both you and your partner to take part but you can take part by yourself as well.

Before you or your partner decide if you would like to take part, please read the participant information leaflet. Taking part is completely up to you. If you or your partner would like to participate in the study, please fill out the consent forms. You are also welcome to participate alone. As you have taken part in the MAMMI study, you are probably familiar with these kind of documents.

Don’t feel rushed or under pressure to make a quick decision. You may wish to discuss it with you family, friends or a trusted healthcare professional. If you have any questions, please email me at [email address].

Best wishes,

Sofia O'Byrne

Appendix 5

Participant Information Leaflet

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

The lived experience of limiting family size as a result of traumatic childbirth.

Participant Information Leaflet.

You and your partner are being invited to take part in a research study that is being done as part of a doctoral research thesis led by Ms Sofia O'Byrne at TCD School of Nursing and Midwifery. The research is being supervised by Prof Joan Lalor (Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin) and Prof Soo Downe (Professor of Midwifery, School of Community Health and Midwifery, University of Central Lancashire). Trinity College Dublin is the only data controller for this research study.

This study is aiming to understand how a traumatic birth experience influences a person's decision to have less children than they originally wanted. A traumatic birth experience may refer to anything that happened during pregnancy, childbirth or the postpartum period, that caused distressing emotions and reactions, and any negative outcomes on a person's health or life. This study is only recruiting participants from the MAMMI study and is otherwise not part of the MAMMI study.

Before you or your partner decide whether or not you wish to take part, **please read this information leaflet carefully**. You and your partner should clearly understand what taking part in this study involves and the risks and benefits to you, this way you can make a decision that is right for you. If you would like to participate and your partner does not want to, you are still welcome to take part.

Don’t feel rushed or under pressure to make a quick decision. You may wish to discuss it with you family, friends or a trusted healthcare professional. If you have any questions, please contact Sofia O'Byrne by emailing obyrnes1@tcd.ie

Why is this study being done?

One-third of women are estimated to view their childbirth experience as traumatic. We are doing this study to understand how a traumatic childbirth experience might influence a person's decision to have less children. We are interested in interviewing parents who have experienced childbirth as traumatic, and decided to have less children than desired or were once considering having less children than desired. This means that if you eventually decided to have more children since your traumatic experience you can still take part.

This study will ask you

- Your original plans to have a family
- Your experience of childbirth
- How did your experience of childbirth affect the decision to have less children?
- How is this experience affecting your life?

Why have I been invited to take part?

You are being invited to take part as you have identified that your birth experience influenced your future plans to have less children. You have given your consent to the MAMMI study for us to send you further information on this study.

We are also inviting your partner to take part in the study as we are interested how the birth may have impacted them and their desire for more children. If your partner does not want to take part, you can still take participate in the research.

We are inviting anyone who believes their birth was traumatic. You do not have to be diagnosed with post-traumatic stress disorder (PTSD) or another trauma-related condition to participate.

We are looking for 15 women, with or without their partner, to take part in individual interviews that are an 1-2 hours long.

How do I take part?

Participation in the study is completely **up to you**. There are no consequences if you do not wish to take part. If you are interested in participating, please read the rest of this leaflet and complete the **consent form.** We ask that you return the consent from in the post (return postage and envelope has been attached) or email it to obyrnes1@tcd.ie. If your partner wants to take part, you must complete separate consent forms.

If we do not hear back from you after two weeks of sending the study information, Sofia O'Byrne will email or phone you to ask whether you would like to participate or not. It is completely fine if you need more time to make this decision.

What if I change my mind?

Participation is completely voluntary/up to you and you can stop taking part in the study at any stage you wish. You do not have to give a reason for changing your mind. To stop taking part, you can email Sofia O'Byrne (obyrnes1@tcd.ie).

Please note that you cannot withdraw your data after the study results have been published or anonymised.

How will the study be carried out?

We are organising interviews between October 2022 and March 2023. Once you have retuned the consent form or emailed that you would like to take part, the researcher will work with you to find a time and date that suits your schedule.

We would like to do in-person interviews in your own home or at a location of convenience for you. Please note the topics discussed may be sensitive and hard for you to talk about, a private location that you feel comfortable to openly talk about your experience is ideal.

As the Covid-19 pandemic continues, we might not be able to do in-person interviews. We then ask that your interview happens online over Zoom video call.

If you feel more comfortable with an online interview, you can choose to be interviewed over Zoom video call even if there are no restrictions stopping in-person gatherings.

With your consent, we would like to make an audio recording of the interview using a digital recorder. If the interview occurs over Zoom, we will only record the audio. These recordings will then be transcribed into writing so the researcher can analyse the interview.

The interviews will be 1-2 hours long. We can take breaks and pause the digital recording. If you become upset and overwhelmed, we can pause or completely stop the interview at any time. You do not have to finish the interview and can choose to leave at any time.

If your partner wishes to participate, you can decide together to be interviewed at the same time or separately.

The researcher will analyse all the interview transcripts and record the results in their PhD thesis. They will also submit the results for publication and present them at conferences.

Confidentiality and Anonymity.

You cannot remain anonymous to the lead researcher during the study as the lead researcher requires your personal information to schedule an interview, and interviews are face-to-face. However, the research supervisors will not know who you are.

All your information will be treated confidentially unless there is a risk to harm to an individual that requires a report to the relevant authorities.

Once your interview is transcribed, any identifiable information (for example, names and places) will be changed to hide your identity. The anonymised interview transcripts (coded transcripts) will be shared with the research supervisors. The lead researcher will keep a key code that will link you to your coded transcript, this is being done so that if you would like a copy of your transcript you get the correct one. The key code will be stored separately to your personal information and coded transcript, deleted after seven years. Your identify will be anonymous in any reports, publications and presentations of the study. Interview quotes may be used in publications, reports and presentations on this research but all identifiable information will be changed.

Are there any benefits to taking part in this research?

There are no direct benefits to you. You might benefit from having an opportunity to share your experience of birth trauma and its impact on your life. You may also benefit from knowing that your experience helps build the area of birth trauma research, and that it could help future research, services and supports.

Are there any risks to me or others if I take part?

As the focus of this study is birth trauma, the main risk is that you become upset or distressed by taking part. You do not have to complete the study and can stop taking part at any point, including during the interview.

You will be asked to talk about your experience of childbirth and how it impacts your life. This may lead to upset or reliving your experience. During the interview, we can take as many breaks as you like or stop at any time.

If you become upset during the study, it may be helpful to talk to family, friends or a trusted healthcare professional. Unfortunately this study is not funded and we cannot provide follow-up counselling services. With your consent, we can make a referral to your GP for extra support.

You can find a list of support services on the AIMS Ireland web page for birth trauma at www.aimsireland.ie/birth-trauma. AIMS Ireland also run a Birth Healing Peer Support Group,

it is a safe space to share stories and provide peer support, if you are interested you can email support@aimsireland.com. This group is not linked to TCD or this research in anyway.

The Birth Trauma Association is a UK based charity that supports women who suffer birth trauma. They have a list of helpful resources for parents on their webpage which can be found at www.birthtraumaassociation.org.uk.

What information (data) about me will be used as part of this study?

The MAMMI study and MAMMI five-year follow-up has previously collected information about your pregnancy/pregnancies, your birth(s) and socioeconomic background. This information will be shared with the lead researcher with your permission to put together background information about you.

We will also need personal information such as names and contact details so that we can get your explicit consent and organise your interview. This information will be stored securely and will only be accessed by the lead researcher (Sofia O'Byrne).

We will collect information about how you experienced your birth, your plans for a family before and after your birth, and how birth trauma has influenced your decision to have less children. This information will be anonymised before it is shared with the research supervisors or published so no one will know you took part. Information gathered in this study is not linked to the MAMMI study and will not be shared with the MAMMI study.

Your medical records are not needed, this study is not connected to any hospital or healthcare institution.

What will happen to my data?

The information you provide in the interviews will be used to study how traumatic childbirth influences the decision to have less children.

The audio recordings will be transcribed and destroyed. The transcripts of the interviews will be coded which means any information that could lead to you will be changed. The transcripts will be kept on a safe storage cloud that is password protected. The original transcripts with information that can lead to you will be destroyed. Each transcript will then be given a code that can be linked to you, the code key will be stored safely. The coded transcripts will be stored safely for seven years after the study results are published, and then destroyed.

Your name and contact information will be stored in a password protected format in a safe cloud. It will be destroyed seven years after data collection and is not linked with the MAMMI study. It will not be used again unless you have consented to be contacted for future research that requires ethical approval.

If you post your consent form back, it will be scanned and saved to a safe storage cloud that is password protected. The paper copy of the consent form will then be shredded. If you email

your consent form back, it will be saved to a safe storage cloud that is password protected. The consent forms will be deleted after seven years.

Your audio recording, transcript and consent form will not be stored together so that your information cannot be linked together by the research team.

Who will access and use my personal data as part of this study?

Sofia O'Byrne will have access to your personal information such as your name and contact details. She will also interview you and have access to your consent form, audio recording, original transcript and anonymised transcript.

Prof Joan Lalor and Prof Soo Downe will only be able to see the coded transcripts.

With your permission, coded transcripts with all personal identifiable information removed may be shared with other academic research institutions for the purpose of birth trauma research.

Will my personal data be kept confidential? How will my data be kept safe?

Your privacy is important to us. We take many steps to make sure that we protect your confidentiality and keep your data and information safe. Here are some examples of how we do this:

- All identifiable information will be changed in transcripts, reports, publications and presentations.
- Use the TCD OneDrive cloud to safely store your personal data, code key, interview audio and transcripts.
- Data protection training has been carried out by Sofia O'Byrne and the research supervisors.
- A Data Protection Impact Assessment has been carried out and reviewed by the TCD Data Protection Office, the research supervisors and the Research Ethics Committee and the risk to your privacy is considered low.

However, if something did go wrong we will report it to the TCD Data Protection Officer and the Research Ethics Committee.

If you have a data protection complaint, you can contact us by emailing obyrnes1@tcd.ie and/or the TCD Data Protection Office by emailing dataprotection@tcd.ie

What are my rights?

This research study is in the public interest, and relies on Article 6.1 (e):; and Article 9. 2 (j) of the GDPR as its lawful basis for use the information you provide. We also ask for your explicit consent, as an extra measure to protect your autonomy, as this is health research.

You are entitled to the following rights in relation to your personal data:

- The right to access to your data and receive a copy of it. A hard copy of your interview transcript will be provided to you within one month of your request. You may amend your transcript or make comments on it.
- The right to have inaccurate information about you corrected or deleted.
- The right to be forgotten as long as results have not been published or anonymised. Your personal information and transcript will be destroyed upon request.
- The right to restrict or object to processing of your data. The right to restrict processing is limited after your personal data has been removed from your transcript.
- The right to receive your data in a portable format and to have it transferred to another data controller.

Has this study been approved by a research ethics committee?

Yes, this study has been approved by the TCD Faculty of Health Sciences Research Ethics Committee. Approval was granted on 27th August 2021.

Who is organising and funding this study?

This research study is being done as part of a doctoral research thesis led by Ms Sofia O'Byrne at TCD School of Nursing and Midwifery. The research is being supervised by Prof Joan Lalor (Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin) and Prof Soo Downe (Professor of Midwifery, School of Community Health and Midwifery, University of Central Lancashire).

This study is not funded. There are no conflicts of interest.

Is there any payment for taking part?

No, we are not paying participants to take part in the study.

Will my personal data be used in future studies?

No, your personal data will not be used in future studies.

Will I be contacted again?

If you would like to take part in this research study, please sign the **consent form** that came with this leaflet. If your partner would also like to take part, they need to sign a separate consent form. Please keep one copy of each consent form for your own records, and return one copy of each signed consent form to the researcher in the envelope provided or email it back.

The lead researcher will contact you to organise a time and date for the interview. The consent form will ask you is it ok to contact you after the interview to check the information we have is right.

The consent form will also ask if you would like to be contacted in the future to participate in future research relating to birth trauma (which will have Research Ethics Committee approval).

Appendix 6

Consent Form

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

The lived experience of limiting family size as a result of traumatic childbirth.

Researcher Contact- Sofia O'Byrne Email: obyrnes1@tcd.ie

Consent Form

There are four sections in this form. Each section has a statement and asks you to tick the box if you agree. **Please ask any questions you may have when reading each of the statements.** **Thank you for participating.**	
General	**Tick box**
I confirm I have read the information leaflet for this research study and I understand the contents.	
I know how to contact the researcher if I need to.	
I have had the opportunity to ask questions and they have been answered to my satisfaction.	
I understand that taking part in this study is entirely up to me, and if I decide that I do not want to take part, I can stop taking part at any time without giving a reason.	
I understand that I will not be paid for taking part in this study.	
I agree to take part in this research study having been fully informed of the risks, benefits and alternatives which are written in the information leaflet which I have been provided with.	
I agree to being contacted by the researcher by phone or email as part of this research study.	
Data Use and Storage	**Tick box**
I understand that all information I share will be treated confidentially unless there is risk of harm to an individual which requires a report to the relevant authorities.	
I agree to my interview being audio-recorded and transcribed. I understand that any identifiable information will be changed and anonymised on the transcripts.	
I understand that in any publications, reports or presentations on this research that my identity will remain anonymous. I understand that extracts from my interview may be quoted with all identifiable information changed.	

I understand that personal information about me will be protected in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act (Health Research Regulations) 2018.	
I understand that I have the right to withdraw my data as long as they have not been published or anonymised.	
I understand that I can request a copy of my transcript and make amendments or comments if I wish.	
I understand that my personal details will be destroyed when this study is completed unless I have agreed to be contacted to participate in potential future research (below in 'Future Contact').	
Future Contact	**Tick Box** **(optional)**
I consent to being contacted by the researcher in order to clarify information provided as part of the research study.	
I consent to my contact details being stored after the study has been completed and to being contacted in the future regarding participation in research relating to the topics covered by this research which will have Research Ethics Committee approval.	

Please PRINT your details in BLOCK CAPITALS.

Name: .....

Address:.....

.....

Phone Number: .....

Email:.....

Signature: ..... **Date:** .....

Please keep one copy of the consent form for your own records.

Researcher's Signature..... **Date:**.....

Appendix 7

Distress Protocol

Participant becomes visibility distressed or verbalise distress.	→	Interviewer pauses the interview, asks participant would they like to take a break and pause the audio recording. Interview continues if participant feels able to carry on.
Participant's distress continues or worsens.	→	Interviewer asks would they like to terminate the interview. Interview asks would they like to contact a friend or family member for support. Interviewer to remain with participant until they feel better.
Follow-up with participant's consent.	→	Contact them later that day to ensure they are no longer distressed. Provide contact details for birth trauma peer support group.

Appendix 8

Ethical Approval Letter

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Sofia O'Byrne
School of Nursing & Midwifery
Trinity College Dublin
24 D'Olier Street
Dublin 2
Ireland

27th August 2021

Ref: 210610
Title of Study: The lived experience of limiting family size as a result of traumatic childbirth.

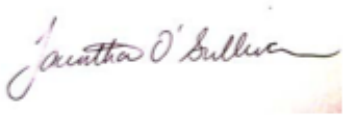
Dear Sofia,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in June 2021. We are pleased to inform you that the above project has ethical approval to proceed.

This study has been ethically approved. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement'

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,



Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee

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