Research Project Portfolio

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Exploring Respectful Maternity Care During Pregnancy and Childbirth: A Mothers' and Birthing Persons' Perspective following a UK Hospital Birth

Laura Edwards-Bailey, BSc, MSc, PhD.

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Doctorate in Clinical Psychology

Acknowledgements

Firstly, I would like to thank all the individuals who registered their interest in this study. To the mothers and birthing people that I had the pleasure of interviewing, I will forever be grateful for your bravery and trust in sharing some of your most personal and life-changing experiences with a complete stranger! I hope I have done justice to your stories, including the wonderful experiences that some of you had, whilst also sharing those that we need to learn from and improve for future birthing people. Whenever I was struggling for motivation on my thesis journey, I held your voices in mind to spur me on, so this is for you.

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Portfolio Abstract

Background

Childbirth is a significant life-event; however, approximately 45.5% of global births are experienced as traumatic by mothers/birthing people. To promote positive and empowering births, the World Health Organisation published the model of Intrapartum Care in 2018. Delivery of Respectful Maternity Care (RMC) and establishing Psychologically Safe Environments were proposed. However, understanding of these concepts is limited, calling for further research with birthing people to “describe their vision for respectful care and experiences”.

Literature exploring birthing experiences is often limited to homogeneous samples of white middle-class mothers despite worse birthing outcomes for ethnic minorities and those from lower socioeconomic backgrounds; and focuses specifically on birth rather than the whole pregnancy experience. Considering this alongside recent reports of unsafe care, lacking respect, kindness and compassion in UK maternity services, this study aimed to explore the meaning of RMC and psychological safety amongst a heterogeneous sample of mothers/birthing people.

Method

A qualitative design, using semi-structured interviews was adopted. Individuals who had given birth in a UK hospital since 2018 at 37+ weeks were invited to complete an online screening questionnaire, measuring study eligibility. Birthing experience was rated on a 5-point Likert scale (very positive - very negative), alongside collating demographics (e.g., ethnicity and deprivation). Purposive sampling was applied to select a range of participants based on these factors, addressing existing literature gaps. Fifteen mothers/birthing people were interviewed. Initially, inductive reflexive thematic analysis was conducted, followed by deductive thematic analysis with existing models of RMC guiding a coding framework.

Analysis

Four themes, with three corresponding sub-themes, were constructed inductively: “You can’t feel respected if you don’t feel safe”: Familiarity is key; Respectful control: “That’s exactly what I wanted, but she didn’t ask first”; Overlooked and Unmet Needs: “They just didn’t see me as an individual”; and “Respect has to be earnt, it’s a two-way process”. Companionship from birthing partners and/or midwives enhanced safety due to trust, whilst a lack of attentiveness and availability of staff left individuals feeling uncared for and disrespected. Physical hospital environments were seen as an externalisation of respect for the birthing process, mirroring positive or negative experiences of care. Showing awareness of poorer minority outcomes and exploring psychological well-being demonstrated respect through openness and desire to change. All deductive codes were used, mostly mapping onto inductive themes, with “Effective communication” and “Companion of choice” discovered most frequently.

Discussion

To the best of the author's knowledge, this study is the first to explore RMC and psychological safety throughout pregnancy and birth from a mother’s/birthing person's perspective in a UK hospital setting. Global definitions of RMC do not incorporate nuances and individual needs. Maternity services should acknowledge disparity in birthing outcomes for minority groups, and offer tailored resources to symbolise acceptance, consequently enhancing safety and respect.

Impact on Clinical Psychology

Acknowledging and supporting psychological well-being throughout pregnancy and birth is required. Incorporating this into birth planning and preparation may offer opportunity to increase birth satisfaction, highlighting a potential role for clinical psychology within multi-disciplinary maternity care.

Statement of Contribution

An overview of contributions to the main research study conducted are presented in the table below:

Domain	Contributor
Project design	Laura Edwards-Bailey with supervision from Dr Danielle De Boos, Dr Rachel Sabin-Farrell[a], Dr Dave Dawson, Dr Jenna Brough and Dr Kerry Evans
Ethics application	Laura Edwards-Bailey with supervision from Dr Danielle De Boos
Writing the review of literature	Laura Edwards-Bailey with supervision from Dr Danielle De Boos and Dr Dave Dawson
Recruiting participants	Laura Edwards-Bailey, with support from Dr Jenna Brough via social media advertisement
Data collection	Laura Edwards-Bailey
Transcription	Laura Edwards-Bailey
Data analysis	Laura Edwards-Bailey, with supervision from Dr Danielle De Boos, Dr Dave Dawson, Dr Jenna Brough and Dr Kerry Evans
Write-up	Laura Edwards-Bailey with supervision from Dr Danielle De Boos and Dr Dave Dawson

[a] Original primary researcher supervisor during the design phase of this study, prior to leaving the course staffing team in 2022. Following this, Dr Dave Dawson joined the research team as secondary supervisor, with Dr Danielle De Boos acting as primary supervisor.

Journal Paper

A Qualitative Exploration of Respectful Maternity Care during Pregnancy and Childbirth:
A mothers' and birthing persons' perspective following a UK hospital birth.

Short Title:
Experiences of respectful maternity care in UK hospitals

Authors and Affiliations
Laura Edwards-Bailey[1], PhD;
Danielle De Boos[1+], DClinPsy;
Dave Dawson[2], DClinPsy;
Rachel Sabin-Farrell[1], DClinPsy;
Jenna Brough[2], DClinPsy;
Kerry Evans[3], PhD

[1]University of Nottingham, Wollaton Road, Nottingham, NG8 1BB, Mental Health and Clinical Neurosciences
[2]University of Lincoln, Brayford Way, Lincoln, LN6 7TS, School of Psychology
[3]Queens Medical Centre, Nottingham, NG7 2UH, UK, School of Health Sciences

[+]Corresponding Author
Dr Danielle De Boos
Mental Health and Clinical Neurosciences, University of Nottingham, B09 YANG Fujia Building, Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB, Trent Doctorate of Clinical Psychology
Email: mczdcd@exmail.nottingham.ac.uk

Chosen journal for submission: Women and Birth

Authors guidance:
https://www.elsevier.com/journals/women-and-birth/1871-5192/guide-for-authors

Please note that this journal has format-free submission. To allow for an accurate word count, NLM referencing has been applied (which is used by the journal if accepted), with a maximum of 50 references permitted. APA style has been adopted for all other formatting throughout.

Main text word count: 5000
Note: Confirmation that the 5000-word limit excludes title page, figures, tables, references, statement of significance and the abstract has been sought from the journal.

Abstract

Background

Establishing respect and psychological safety in maternity settings is crucial for reducing mistreatment and negative birthing experiences. Existing definitions of these concepts are broad, lacking consideration of lived experience in specific contexts. Literature regarding birthing experiences is often limited to homogeneous samples of white middle-class mothers despite worse birthing outcomes for ethnic minorities and groups with lower socioeconomic status.

Aims

Explore the meaning and experiences of respectful maternity care (RMC) and psychological safety during pregnancy and birth from a mother's/birthing person's perspective. Influence, if any, of personal characteristics on these concepts were considered.

Methods

A qualitative design, using semi-structured interviews with fifteen birthing people who had experienced a UK hospital birth. Inductive-deductive reflexive thematic analysis was conducted.

Findings

Four themes were constructed: "You can't feel respected if you don't feel safe": Familiarity is key; Respectful control: "That's exactly what I wanted, but she didn't ask first"; Overlooked and Unmet Needs: "They just didn't see me as an individual"; and "Respect has to be earnt, it's a two-way process". Companionship during pregnancy and birth promoted safety through familiarity and trust. Physical hospital environments were seen as externalisations of respect, mirroring positive or negative experiences of care. Acknowledging poorer minority outcomes and psychological well-being symbolised RMC. Deductive codes of "Effective communication" and "Companion of choice" were most common.

Conclusions

Findings extend understanding regarding RMC and psychological safety in a UK context. Greater recognition of psychological well-being and offering tailored resources for differing groups would promote these factors by symbolising acceptance.

Keywords:

Respectful Maternity Care; Childbirth; Pregnancy; Psychological Safety; Birthing People; Mothers

Statement of Significance

Issue

Respectful maternity care (RMC) is a global recommendation to promote positive birthing experiences. International reports suggest that mistreatment of women within maternity healthcare settings remain.

What is already known?

The World Health Organisation advocate RMC in global policies, publishing recent guidelines. Whilst definitions of what constitutes RMC exist, exploration of mothers'/birthing people's experiences and meaning of RMC are lacking.

What this paper adds

This paper provides a clear response to multiple calls for further research to share the vision of mothers'/birthing people's experiences of RMC in a UK hospital setting. Initiatives to promote RMC in practice are suggested.

Introduction

Following childbirth, approximately 4-10% of birthing people develop Post-Traumatic Stress Disorder (PTSD), and an estimated 45.5% of women worldwide experience birth as traumatic [1,2]. The impacts of these negative experiences include reduced maternal health and quality of life; impaired child development; bonding and attachment difficulties with infants; and poorer familial relationships [3-4][1]. In the UK, approximately one-quarter of women report perinatal mental health difficulties [5], costing NHS and social care £1.2 billion annually [6]. Considering this alongside recent reports of unsafe care, lacking compassion and respect for mothers and families in UK maternity hospitals, reforming maternity care is crucial [7][2].

Scholars have identified factors associated with negative birth experiences, including existing maternal mental health difficulties; emergency deliveries and birth complications; and negative interactions and/or poor care from healthcare professionals (HCPs) [8]. Globally, it is recognised that many women "experience disrespectful, abusive or neglectful treatment during childbirth" [9, p.1]. These experiences have been conceptualised as 'obstetric violence', describing intimate examinations without permission; involuntary caesarean-section; induction without medical reasoning; denial of labour companions; and disregard for mother's experiences of disaffirmation (i.e., treating individuals as objects) and limited autonomy [10][3]. However, what constitutes obstetric violence has been criticised as ambiguous, with varying definitions across the literature. Resultantly, the WHO proposed the need for further studies to "better define, measure and understand disrespectful and abusive treatment of women during childbirth, and how it can be prevented" [9, p.1].

Reports of mistreatment during childbirth have been associated with increasing frequency of medicalised births [11]. In 2021, approximately 84% of births globally were assisted by HCPs, growing from previous years [12]. These rising rates are attributed to initiatives aiming to reduce infant and maternal mortality during childbirth, with

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[1] Please see extended introduction (1.1) for further background regarding the impacts of pregnancy and childbirth.

[2] Please see extended introduction (1.7) for further background relating to reforming UK maternity care.

[3] Please see extended introduction (1.3) for further exploration of obstetric violence.

frequency of medicalised births in high-income countries surpassing those in low and middle-income countries [13][4]. The WHO has sought to promote initiatives ensuring childbirth remains a respectful and empowering experience, including the Intrapartum Care Model (ICM) for positive childbirth [14]. One key recommendation refers to 'respectful maternity care (RMC)', summarised as: "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth"[14, p.3][5]. From a social and behavioural theoretical stance, respect is viewed as a form of communicating concern for the well-being of others. When individuals feel respected, psychological processes such as personal well-being and self-esteem increase [15], which are key factors in enhancing patient care within other healthcare settings (e.g., cancer services) [16]. Whilst the importance of 'respect' is consistently highlighted in maternity literature, and healthcare broadly, various definitions and interpretations exist[6].

Individuals at greater risk of experiencing mistreatment and poorer pregnancy and birthing outcomes have been identified. In 2021, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) published statistics highlighting women from black ethnic minority groups were four times more likely, and Asian women twice as likely, to die during pregnancy and childbirth compared to white mothers. Additionally, mortality among pregnant women doubled in highly deprived areas compared to the most affluent [17]. Despite these identified at-risk groups, there is a surprising trend of homogeneity within the literature exploring birthing experiences, notably amongst white middle-class women [18][7]. Therefore, greater consideration of the meaning of RMC across diverse samples of mothers/birthing people is required, offering potential to reduce negative birthing experiences [19].

Given the drive to increase RMC within maternity settings, barriers and facilitators to implementation are documented from an HCP perspective. A recent systematic review

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[4] Please see extended introduction (1.2) for further background on the medicalisation of birth

[5] Please see extended introduction (1.4) for further exploration of WHO (2018) model and RMC

[6] Please see extended introduction (1.5) for further exploration of psychological theories of respect

[7] Please see extended introduction (1.7.3) for further background on research identifying at-risk groups.

found that delivering RMC was more challenging when senior HCPs failed to model RMC, attributed to biases towards women and those with cultural beliefs that challenged ‘westernised medicine’, as well as high levels of fatigue and burnout amongst maternity staff globally [20]. However, a patient perspective regarding barriers and facilitators to RMC in a UK context has not been considered, despite revealing target areas of change in other healthcare populations (e.g., chronic illness) [21].

Alongside RMC, the WHO recommends establishing psychologically safe environments (PSEs) within maternity settings [11]. PSEs encourage employees to voice concerns and share feedback openly, promoting collaboration within teams. Benefits of increased psychological safety in healthcare include higher quality of patient care, increased job satisfaction for HCPs, and clearer communication between HCPs and patients across settings (e.g., cancer care) [22]. However, understanding what constitutes PSEs specifically in maternity care is lacking, requiring further exploration [13][8].

Across the evidence-base, respect is considered nuanced and multifaceted, requiring in-depth exploration within specific settings and communities [23]. Resultantly, in 2020 further research with mothers and families “describing their vision for respectful care and experiences, as well as offering suggestions for increasing respectful care in facilities” was called for [24, p.2]. In summary, existing literature highlights several gaps where a mother’s/birthing person’s perspective is needed to aid understanding of: 1) what constitutes RMC in a UK context throughout pregnancy and childbirth; 2) how individual characteristics may influence the meaning of RMC by including diverse samples; and 3) factors enhancing or preventing implementation of RMC. Whilst global, but broad, RMC definitions exist, understanding application to UK settings is warranted given differing healthcare structures between UK vs global settings [11]. This study aims to address these gaps by sharing the views of mothers’/birthing people regarding RMC [24][9].

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[8] Please see extended introduction (1.6) for further background on psychologically safe environments.

[9] Please see extended introduction (1.8) for further exploration of the study rationale.

Aims

1. Gain a greater understanding of the meaning and experiences of RMC during pregnancy and childbirth from the perspectives of mothers'/birthing people following a UK hospital birth using an in-depth qualitative approach.

Secondary Aims

2. Explore the influence, if any, of key demographics on mothers'/birthing persons' experiences of RMC during pregnancy and childbirth.
3. Explore mothers'/birthing persons' views on factors influencing PSEs in maternity care during pregnancy and birth.
4. Understand barriers and facilitators in implementing and promoting RMC throughout pregnancy and birth from a mothers'/birthing persons' perspective.

Method

Design[10]

This study adopted a retrospective qualitative approach, utilising semi-structured interviews. Ethical approval was granted by the University of Nottingham Ethics Committee (ref-3006)[11].

Recruitment and Participants

Mothers/birthing people who had given birth in a UK hospital since 2018 (year of the WHO ICM publication [14]) at 37+ weeks were invited to register interest in undertaking a one-to-one interview. Completion of an online screening questionnaire, measuring study eligibility[12] and collating informed consent was required. Individuals rated their birthing experience on a 5-point Likert scale (i.e., very positive - very negative),

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[10] Please see extended methods (2.1) for further exploration of study design.

[11] Please see extended methods (2.2) for further details regarding ethical considerations.

[12] Please see extended methods (2.3.2) for further details on eligibility criteria.

alongside demographics (e.g., ethnicity and deprivation). Postcodes were used to calculate an index of multiple deprivation (IMD), ranked 1 (most deprived) to 10 (least deprived) [25]. A purposive sampling approach was adopted to select a range of interview participants based on birthing experience; ethnicity; and IMD, addressing existing literature gaps and study aims[13].

The Trent Doctorate in Clinical Psychology (DClinPsy) Service User Carer Advisory Panel (SUCAP) were consulted regarding study materials[14]. Study adverts were shared on social media platforms (e.g., Instagram, X and Facebook) and with organisations supporting mothers/birthing people, particularly from minority backgrounds. Individuals seeking psychological support for birth-related trauma, and/or had experienced loss of an infant, were excluded[15].

Data Collection[16]

Fifteen semi-structured interviews were conducted in English by LEB between May-September 2023. Individuals were contacted on a rolling basis, with recruitment and interviews occurring simultaneously. Birthing people were offered face-to-face, video or telephone interviews. All opted for video via Microsoft Teams and were audio recorded. LEB had no existing relationship with participants.

The interview schedule was designed based on existing RMC definitions [14] and literature gaps (see Table 1)[17]. A pilot interview was conducted with a SUCAP member who had experienced childbirth, with feedback adopted accordingly. On average, interviews lasted 61 minutes (range 58-113 minutes), with final interview numbers determined by data adequacy, indicated by limited development of new codes during data analysis [26][18].

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[13] Please see extended methods (2.4) for further details on recruitment and sampling.

[14] Please see extended methods (2.7) for further details on patient and public involvement.

[15] Please see extended methods (2.3.2) for further details on eligibility criteria.

[16] Please see extended methods (2.5) for further information regarding data collection.

[17] Please see extended methods (2.5.2) for further information regarding semi-structured interview schedules.

[18] Please see extended methods (2.3.1) for further exploration of sample size.

Table 1

Semi-structured Interview Topics and Prompts

Topic/Question	**Prompts**
Exploration of most recent experience of a UK hospital birth.	Time since birth; type of birth; UK region.
Birth expectations.	How did experience compare to expectations (if relevant, compare to previous birth/pregnancy).
Did you feel respected by maternity services/HCPs during pregnancy/childbirth?	Explore interpretation and meaning of respect; what made you feel/not feel respected?
Did you feel safe during pregnancy/childbirth when attending maternity services/hospitals and with HCPs?	Interpretation and meaning of psychological safety; what made you feel/not feel psychologically safe?
Factors increasing RMC/psychological safety during pregnancy and childbirth. *(if not covered in above)*	What can services/HCPs do to facilitate this.
Decision-making during pregnancy/childbirth.	Autonomy; informed consent; understanding of information; benefits/risks explained?
Presence of birthing partners/companion during pregnancy/birth?	General reflections on experience; response/treatment towards partners from HCPs/services.
Harmful or abusive care during pregnancy/childbirth.	*If applicable* - What about this felt harmful/abusive; anything that would have helped promote safety/respect?

Data Analysis[19]

Data were transcribed verbatim and analysed using inductive-deductive reflexive thematic analysis (TA)[26]. Aligning with study aims, TA allowed similarities and differences across accounts, and with existing RMC definitions, to be identified[20]. Inductive analysis was carried out first to minimise the influence of existing RMC definitions, following the six stages of TA (Table 2) [27][21]. A critical realist epistemological position was adopted, recognising individual experiences alongside the wider context in which they occurred [28][22]. Following this, a deductive approach was taken, utilising a codebook including thirteen components of RMC described in the WHO ICM [14] and a recent scoping review operationalising RMC at an HCP-level [23][23] (Figure 1). The Standards for Reporting Qualitative Research were consulted throughout[24].

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[19] Please see extended methods (2.6) for further information regarding data analysis.

[20] Please see extended methods (2.6.1) for exploration of selecting TA.

[21] Please see extended methods (2.6.2) for further details on inductive TA the present study.

[22] Please see extended methods (2.1.2) for further exploration of epistemological position.

[23] Please see extended methods (2.6.3) for further information regarding deductive TA.

[24] Please see extended methods (2.6.4) for further exploration of establishing methodological quality.

Table 2

Overview of TA Approach applied, utilising Braun and Clarke's (2006) Six Stages of TA[25] *[31]*

Stage	**Description**
Data familiarisation	Following conduction of interviews, LEB transcribed audio-recordings. Any identifiable data was removed to maintain anonymity (e.g., hospital names). On completion, recordings were listened to alongside transcripts to check accuracy. Transcripts were then read on several occasions and stored using NVivo 14 software. Critically engaging with the data is recommended to enhance familiarity [26]. This was achieved by aiming to recognise meaning within data accounts, with LEB utilising prompts such as "what did this interaction represent and mean for this individual, and how have they made sense of this experience?". Throughout this stage, LEB noted initial observations and impressions in a reflective diary, which developed closeness to the data. Reflexivity was also considered by querying any biases or alternative ways in which the data could be interpreted, drawing on research supervision[26].
Initial data coding	Sentence-by-sentence coding, at the semantic and latent level, was completed for each transcript by LEB using NVivo 14. Codes aimed to provide meaningful labels to sections of data, ensuring enough data was coded to prevent loss of context, retaining the participants voice as much as possible. Further, the annotations NVivo function was used to note any further impressions that had not been noted in stage one, including patterns, as well as nuances and differences between participant experiences. For each segment highlighted, consideration of existing codes occurred, with LEB concluding whether a new code was required. To promote analyst triangulation, coding was reviewed on a random selection of transcripts (n=2) by DDB, and research meetings with all

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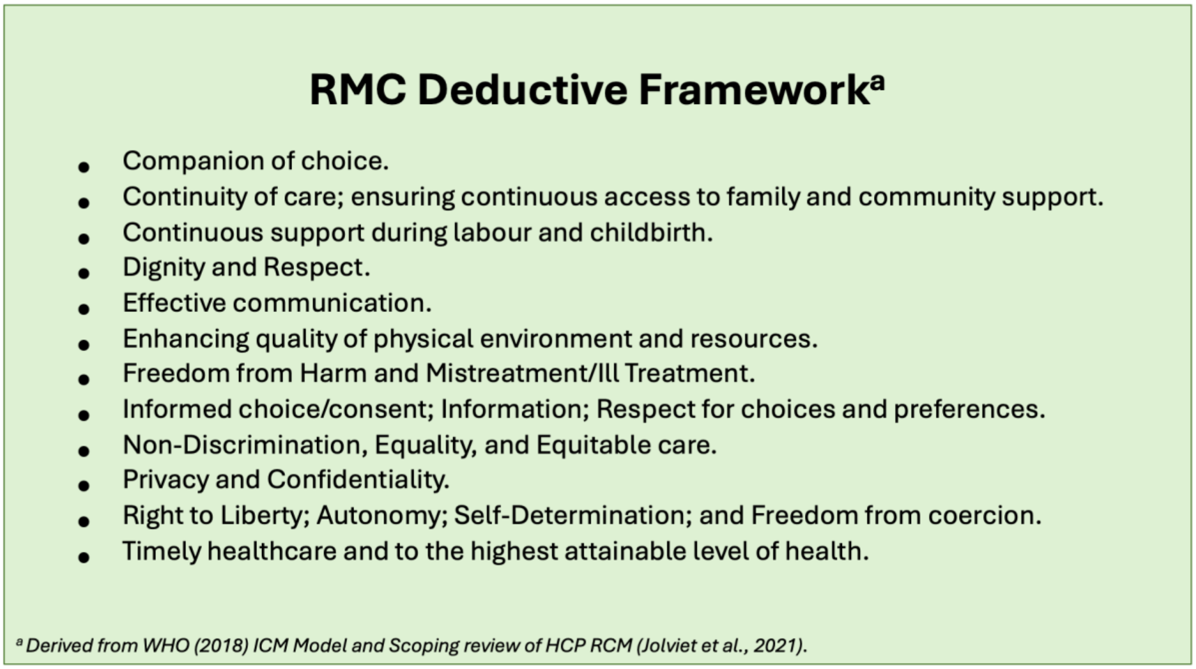
[25] Please see extended methods (2.6.2) for further details on inductive TA.

[26] Please see extended critical reflections (5.3) for further details on reflections following interviews.

	authors were held to discuss any interpretative differences. This led to some codes being combined and new codes developing, forming a richer collection of codes.
Generation of initial themes	Once all transcripts were coded, LEB organised codes based on the largest number of references (i.e., most common) on NVivo. Each code and the corresponding data items were reviewed, and codes with similar meanings and patterns were collated. At this point, candidate themes were constructed in Microsoft Word, with a thematic map to facilitate this process. When codes did not fit, a “miscellaneous” node was generated in NVivo to ensure these were not lost and could be considered in later stages when determining final themes.
Theme development	A team meeting with all researchers was held to consider candidate theme ideas. Potential overlap between themes was discussed. Following this, LEB returned to the data and re-read the transcripts to assure that themes accurately reflected participant reflections. A second thematic map was developed at this stage to aid theme organisation.
Refining, defining, and naming themes	Using the thematic map developed in the previous stage, LEB continued to refine themes until sufficient demarcation between themes and sub-themes was established. When narrowing down themes, LEB aimed to ensure the meaning of participants' experiences were reflected, alongside identification of patterns across the dataset. Themes were then assigned names, intending to provide concise and clear representations of what each theme incorporated. This often included participant quotes, with the researcher aiming to remain as close to the data and participant voices as possible.
Writing up	Finally, findings were written up theme by theme. Participant pseudonyms were generated to maintain anonymity. Quotes representing each theme were selected to evidence the researchers’ interpretations. Further, this ensures readers have the opportunity to consider whether the data item and the researcher interpretations align. Quotes were elicited based on guidelines [29], with an equal balance between interpretation and data extracts recommended. In line with the study aims and capacity of this paper, data that was unrelated to respect or psychological safety during pregnancy and/or birth has not been incorporated.

Figure 1

Respectful Maternity Care Deductive Framework Applied



RMC Deductive Framework[a]

- Companion of choice.
- Continuity of care; ensuring continuous access to family and community support.
- Continuous support during labour and childbirth.
- Dignity and Respect.
- Effective communication.
- Enhancing quality of physical environment and resources.
- Freedom from Harm and Mistreatment/Ill Treatment.
- Informed choice/consent; Information; Respect for choices and preferences.
- Non-Discrimination, Equality, and Equitable care.
- Privacy and Confidentiality.
- Right to Liberty; Autonomy; Self-Determination; and Freedom from coercion.
- Timely healthcare and to the highest attainable level of health.

[a] *Derived from WHO (2018) ICM Model and Scoping review of HCP RCM (Jolviet et al., 2021).*

Reflexivity

Reflexivity promotes rigour in qualitative research by acknowledging the researchers' position[27]. LEB maintained a reflective diary throughout, promoting transparency and recognition of analytical biases, alongside opportunity to consider the interview context, aligning with the CR epistemological position [30][28]. LEB is currently undertaking, and DDB, DD and JB have completed, a doctorate in clinical psychology, all holding interest in the interaction between physical and psychological well-being. DDB, RSF, JB and KE had personal birthing experiences, DD had experience as a birthing partner, whilst LEB had no direct or indirect birthing experience. JB works in perinatal services and as a

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[27] Please see extended methods (2.1.3 and 2.6.4) for exploration regarding establishing methodological quality and reflexivity.

[28] Please see extended methods (2.1.2) for further exploration of the researcher's epistemological position.

doula. KE is a trained midwife and clinical researcher. All authors had qualitative and quantitative expertise, identified as White-British, with experiences of working in the NHS.

Results[29]

Participants mean age at most recent birth was 31.5 years (range 25 - 39). Most identified as primiparous (66.7%, n=10) white British (73.3%, n=11) birthing people who gave birth in England (86.7%, n=13); were married or in domestic partnerships (93.3%, n=14); and had vaginal (un/assisted) delivery (73.3%, n=11). Birthing experience ranged from very positive to very negative. Table 3 presents further demographic and contextual information.

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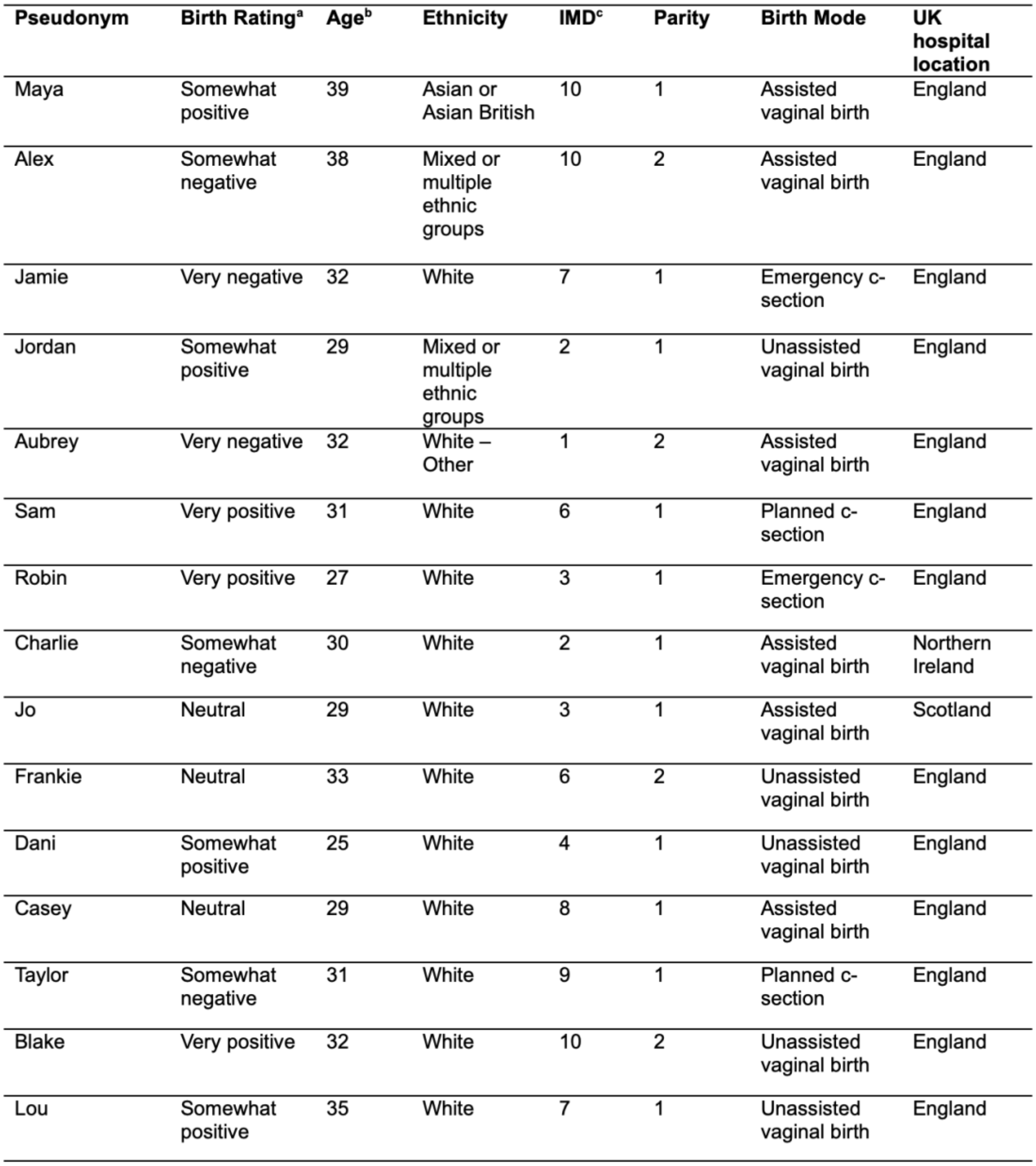
[29] Please see extended paper (section 3) for further exploration and details of results.

Table 3

Participant Demographics and Characteristics



Pseudonym	Birth Rating[a]	Age[b]	Ethnicity	IMD[c]	Parity	Birth Mode	UK hospital location
Maya	Somewhat positive	39	Asian or Asian British	10	1	Assisted vaginal birth	England
Alex	Somewhat negative	38	Mixed or multiple ethnic groups	10	2	Assisted vaginal birth	England
Jamie	Very negative	32	White	7	1	Emergency c-section	England
Jordan	Somewhat positive	29	Mixed or multiple ethnic groups	2	1	Unassisted vaginal birth	England
Aubrey	Very negative	32	White – Other	1	2	Assisted vaginal birth	England
Sam	Very positive	31	White	6	1	Planned c-section	England
Robin	Very positive	27	White	3	1	Emergency c-section	England
Charlie	Somewhat negative	30	White	2	1	Assisted vaginal birth	Northern Ireland
Jo	Neutral	29	White	3	1	Assisted vaginal birth	Scotland
Frankie	Neutral	33	White	6	2	Unassisted vaginal birth	England
Dani	Somewhat positive	25	White	4	1	Unassisted vaginal birth	England
Casey	Neutral	29	White	8	1	Assisted vaginal birth	England
Taylor	Somewhat negative	31	White	9	1	Planned c-section	England
Blake	Very positive	32	White	10	2	Unassisted vaginal birth	England
Lou	Somewhat positive	35	White	7	1	Unassisted vaginal birth	England

[a] Individuals were asked to rate their birthing experience on a 5-point Likert scale (i.e., very positive - very negative).

[b] Indicates age at most recent childbirth.

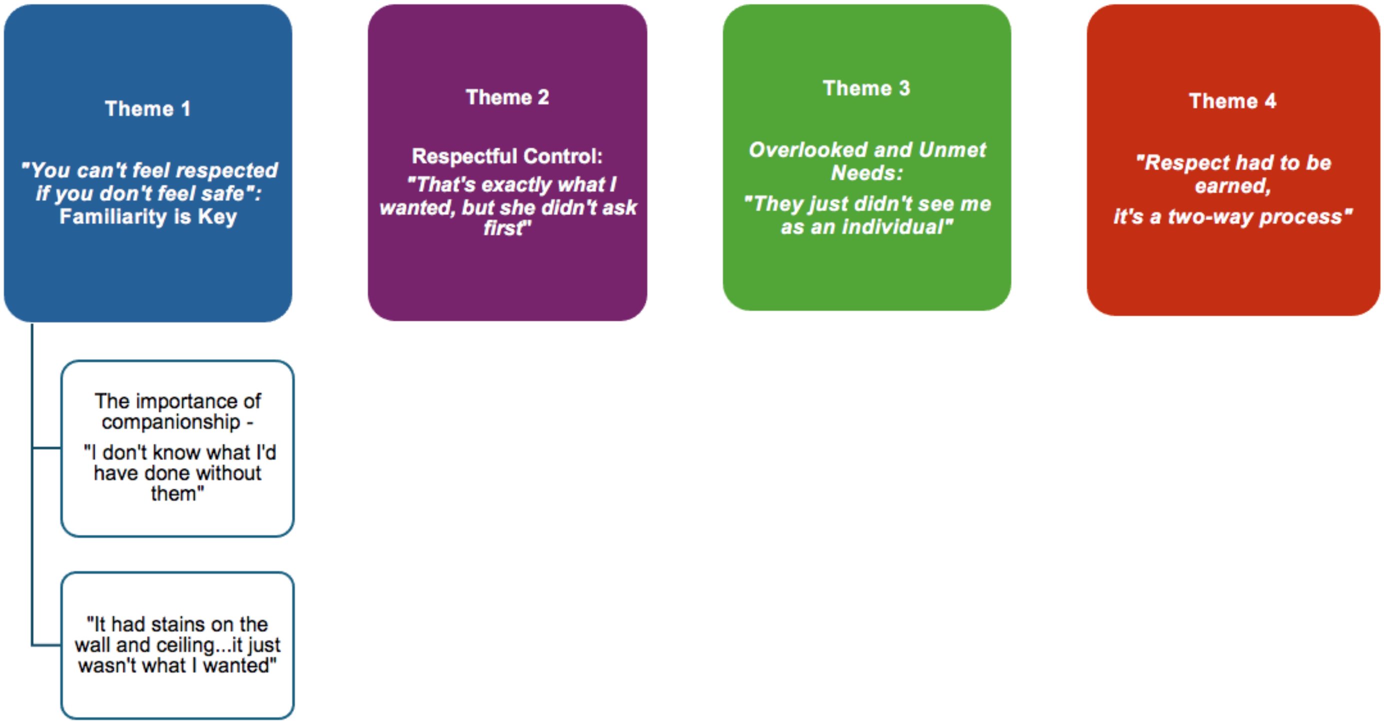
[c] IMD = Index of Multiple Deprivation was calculated using participant postcodes, with 1 = most deprived and 10 = least deprived. Separate IMD calculators for each UK region are available and were applied as appropriate.

Inductive Analysis

Four themes, with two corresponding subthemes, were constructed inductively (Figure 2). Across accounts, an overarching theme of “one size doesn’t fit all” was apparent, with respect and safety relating to HCPs acknowledging individual needs. The impact of communication on establishing RMC was evident and is explored throughout.

Figure 2

Inductively Constructed Themes and Subthemes from Interviews with Birthing People



Theme 1: "You can't feel respected if you don't feel safe": Familiarity is key[30]

Theme 1, presented across two subthemes, explores reflections from birthing people regarding the relationship between feeling psychologically safe, and how this impacted respectful care.

The importance of companionship - ***"I don't know what I'd have done without them".*** Companionship during pregnancy and childbirth was "crucial" in promoting safety due to feeling "a whole other level of vulnerability". Dani, who gave birth before COVID, noted she would have felt "unsafe" without her partner due to "not knowing anyone". Similarly, when partners were not present or HCPs were slow to respond, birthing people felt "isolated", "scared", and "alone", and subsequently unsafe and disrespected as they believed "no one cared":

> I've just been through this massive, traumatic experience, hadn't slept all night, and then they tell me, your partner has to leave now….how could I feel respected when they clearly didn't care that he was what I needed most in that moment? (Alex).

Maya and Sam, both NHS doctors, attributed different meanings to being left alone by staff. They did not appear to feel unsafe due to understanding staffing pressures, with a sense of reassurance that HCPs would be there when "they really needed someone for something important", which they related to medical needs (e.g., pain relief).

A "lack of flexibility" during COVID-19 to accommodate partners represented limited regard for birthing peoples' needs, which many experienced as "disrespectful". Whilst recognising COVID-19 as "challenging" for HCPs, simple adjustments would have significantly reduced their distress. This was crucial for Aubrey during her first pregnancy in a foreign country:

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[30] Please see extended results (3.1.1) for expansion on theme one findings.

> I had to go alone for my 20-week scan, which was quite scary. It was a new country and my first pregnancy…I did ask could I FaceTime my partner, but they didn't want me to.

With few exceptions, positive relationships with midwives promoted safety. Jamie felt “scared” when her midwife was not on shift, “bursting into tears” when she arrived the next morning: “I was so happy to see someone that I knew”*.* When familiar midwives were unavailable, individuals lacked trust in other HCPs “because I’d never met them”. Initiatives such as “meet the midwife” established familiarity and safety prior to labour:

> It's where you go and meet all the midwives….so whenever you go into Labour, you have met that person before…it showed they cared about me feeling comfortable, I’d say that’s respectful. (Blake).

Interestingly, Maya, who identified as Asian, reflected that whilst having medical knowledge promoted safety, it was important that her husband was a “predominantly white male” for ensuring her wishes were executed, indicating mistrust without him present:

> …even though he knows nothing medical, he’s good at saying (Maya) would want this, and like advocating for me, especially when I was a bit out of it. So I knew I’d always be safe, even if they didn’t respect my wishes.

Companionship during pregnancy and birth promoted safety through familiarity and trust in partners and/or HCPs. When HCPs were attentive and present, this demonstrated respectful care.

Subtheme: ***“It had stains on the wall and the ceiling….it just wasn’t what I wanted”***. Several birthing people described the physical environment as an “externalisation” of respect from HCPs/hospitals, “mirroring” the care received:

> The hospital where I gave birth have clearly made so much effort, they've got a really lovely labour ward and the birthing rooms are calm….they were just so supportive…the calmness of the environment came through in the staff too, like showed they really cared and respected the birth process. (Frankie).

On the other hand, “unpleasant” physical environments left birthing people feeling “unsafe” and ”uncared” for, representing a lack of priority for their “life-changing experience”. Charlie shared their disappointment when moving from a birthing suite to labour ward, indicating a sense of loss:

> The new room was really small, it had stains on the wall and ceiling, like when I was looking up, I was just like this is not what I wanted. It was dark, but like a grim dark, rather than a cosy dark. The contrast was just unbelievable, one minute I had a gorgeous room and attentive midwives, the next I was in a gloomy room with staff who clearly didn’t respect me.

Several individuals were told there was “no space” when arriving at hospital following their waters breaking, resulting in them standing in corridors during labour, or being placed in “a tiny little room with no windows”, causing distress and a desire to leave: “I just felt so uncared for and wanted to be at home where I knew I’d be safe” (Aubrey). Interestingly, several related lack of safety resulting from the physical environment as negatively impacting birth progression:

> I was like, I'm not progressing because you’ve got me in the middle of a room with all the lights on, you've got 20 people walking in and out…I'm not in a situation where I'm relaxed enough for my body to let go and say, come on, let's do this. (Alex).

Birthing people felt safe when the physical environment was calm, well-resourced, and attuned to individual needs, externally representing respect for the birthing experience.

Theme 2: Respectful control: "That's exactly what I wanted, but she didn't ask first"[31]

Participants explored factors enhancing their sense of control, which promoted respect. Involvement in decision-making was demonstrated by HCPs asking, "how would you like this to go?", preventing births feeling "medicalised" as "I was still making the decisions". Maintaining control was crucial when births differed from expectations:

> And although things did go differently to what I envisaged and wanted, it was still within my remit of my choice….I felt like I was always choosing what I and baby needed at that time. (Robin).

In contrast, when hospitals felt "authoritative", individuals lacked control, having to "ask permission" regarding their preferences. When "dismissed" birthing people felt "unheard", impacting birth progression due to loosing bodily control:

> In labour you don't want to have to be arguing, crying, shouting at a consultant to please, just listen to you. I mean that's horrendous. And it was like I'd lost my body at that point, we just weren't in sync and everything just stopped progressing. (Taylor).

When HCPs did not ask permission regarding procedures, or offer a space for the birthing persons voice in decision-making, some related this to hospital contexts "normalising assault", heightened by "power imbalances within clinical settings that are even more medicalised":

> It's just become normalised…I think the fact that when you do that job so much you have to disconnect and you can't always have pleasantries, but this is my body. You wouldn't come up to me in the street and grab my arm without asking because that would be assault. (Robin).

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[31] Please see extended results (3.1.2) for expansion on theme two findings.

Several individuals associated a lack of “individualised and respectful care” to personal characteristics. Due to fearing how care would be impacted based on socioeconomic background, Aubrey indicated reluctance to challenge HCPs:

> It often felt like I needed to comply in some way in order to get a little bit of what I wanted rather than just, I don't know, I think when you’re working-class you just expect that people won’t listen to you or value your opinion.

Interestingly, some individuals spoke about decisions being made that aligned with their wishes, but because “they (HCP) didn’t ask first”, the birthing person lacked control and consequently did not feel respected. When options were limited due to medical needs, respect meant offering all available options, and prioritising time and space to hear the mothers/birthing person’s voice.

Theme 3: Overlooked and Unmet Needs: “They just didn’t see me as an individual”[32]

Feeling respected was associated with acceptance, desiring HCPs to acknowledge individual difference and circumstances, thereby meeting personal needs. When enacted, birthing people felt “comfortable” and “validated”, which they relayed as examples of respectful care:

> It's just meeting me where I'm at, demonstrating you understand….she (midwife) was saying based on all the hundreds of births and babies I've delivered blah blah….but he looked at the situation and treated me as an individual, so I trusted him. (Lou).

Showing awareness of poorer outcomes for minorities was related to respect, demonstrating an openness, desire to change, and valuing individual circumstances. When this was not addressed by HCPs, and/or individuals had to raise these concerns

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[32] Please see extended results (3.1.3) for expansion on theme three findings.

themselves, most ethnic minority birthing people felt this was “disrespectful”. Resultantly, the need for “greater diversity” within the workforce and tailored resources were suggested, offering opportunity to acknowledge and validating differing needs, promoting RMC:

> If you have stuff tailored to people’s different communities, I think that would make a massive difference. And like stats and stuff…I think that would have a massive impact on making people feel respected, like acknowledging that we see you, we understand your experience….maybe the leaflets they give they could tailor to different people’s needs. (Jordan).

However, several participants expressed caution, noting whilst differences exist due to personal characteristics, care should not be delivered as a “tick box exercise” purely on that basis:

> It wasn't nuanced. I was told because you've got some Caribbean in your background, you have to have this gestational diabetes test, whereas I was like.…I want you to look at me as an individual. Look at the other factors, and let's talk about it in that respected way, instead of going, you are this, therefore this. (Alex).

Mental well-being was mostly overlooked during pregnancy, which was disrespectful as “all areas of my health weren’t considered” (Jo). Consequently, individuals felt “scared” and “reluctant” to share difficult thoughts and feelings they experienced during pregnancy because HCPs would be “dismissive” as they “didn’t see me as an individual” (Lou). To address this, exploration of mental well-being during pregnancy would help “open-up” conversations, requiring a preventative approach to promote respect and “prevent unnecessary trauma”: “…it’s a shame you have to experience such horrific trauma to be treated with enough respect that the topic of mental health is actually approached”. Robin shared this viewpoint after a positive experience with perinatal services during pregnancy but felt this proactive approach which acknowledged her “individual psychological needs” should be offered to all birthing people.

Theme 4: “Respect has to be earned, it’s a two-way process”[33]

Some individuals viewed respect as transactional, noting to be treated with respect, you must show HCPs respect. This included recognising and acknowledging difficult situations both birthing people and HCPs may face during labour, with openness to diversion from birth plans and managing expectations:

> I was just chilled, like not everything will go to plan, but that isn’t their fault. So just acknowledging it was hard for them too I think helped…I think they showed me more respect after that, like recognised it was difficult for me too as it wasn’t what I hoped for. (Casey).

Some individuals felt they respected HCPs by being “passive” and “calm”, but this was not reciprocated. Consequently, birthing people considered alternative approaches for future, including “being more assertive”. Several suggested why HCPs may not reciprocate respect, noting “demands of the role” with HCPs showing signs of “burnout” and “yawning on multiple occasions”. However, Aubrey noted that continuing to work in this “state” puts patients’ psychological well-being at risk: “I think it's important, especially midwives, if they are burnt out in their job, they shouldn't be there because it's something that can ruin a life…it can give you birth traumas, it's really bad.”

Reciprocal respect also applied to HCPs and birthing partners. Here, respect was linked to partners “being heard”, adapting information and explanations for their needs. When mothers/birthing people had medical backgrounds, this appeared particularly important:

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[33] Please see extended results (3.1.4) for expansion on theme four findings.

> It was making sure both of us understood, because they could have very easily just spoke to me, especially with my profession, but they did talk to (partner) and checked he understood what was going to happen. (Sam).

A couple of birthing people described partners being “cared for” by HCPs, such as offering coffee and blankets, representing respect for their “partnership”. However, when partners were left in “limbo” and “didn’t have a clue what was happening”, birthing people felt this indirectly showed a lack of respect for them both due to birthing partners not being seen considered “equally important” in the birthing process. Therefore, acknowledging birthing persons, partners, and HCPs experiences appeared crucial for establishing RMC.

Deductive Analysis

When applying the deductive framework, all codes were used across participant accounts, with most mapping onto inductive themes. Separating RMC deductive domains was often difficult, with overlap evident across the data. For example, distinguishing ‘Autonomy’ from ‘Informed choice’ and ‘Respecting choices and preferences’. The most common deductive codes were ‘Effective Communication’ and ‘Companion of Choice’, mapping inductive themes one and two[34].

Discussion[35]

This study aimed to explore the meaning of RMC from the perspective of mothers/birthing people who had experienced a UK hospital birth since publication of the WHO ICM [14]. Secondary aims of identifying factors enhancing or preventing implementation of RMC, understanding how demographics influenced meanings of RMC, and how maternity services can create PSE, were addressed. In doing so, a response to multiple calls for RMC research is provided, with inclusion of birthing people

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[34] Please see extended results (3.2) for further exploration of deductive findings.

[35] [35] Please see extended paper (section 4) for extended discussion.

from multiple ethnic and socioeconomic backgrounds building on existing literature [18]. Findings highlighted respect as a nuanced and complex phenomenon, influenced by personal characteristics and experiences. Aligning with existing RMC literature [12,14, 33], importance of companionship, autonomy and choice were highlighted. Familiarity with maternity HCPs promoted psychological safety, and the physical hospital environment was perceived as an external representation of respect for the birthing experience, mirroring care received.

Findings suggest birthing people feel safe and respected when involved in decision-making, aligning with RMC recommendations within the WHO ICM [14] due to greater birth satisfaction when individuals feel in control [31]. Maternity services have aimed to address this is by developing birth plans, documenting preferences regarding: mode of delivery; medical intervention; place of birth (e.g., home vs hospital); partner/family presence; labour position; and skin-to-skin contact [32]. However, absence of psychological factors has been critiqued [33], with the WHO noting these should be prioritised alongside physical health [14]. This study extends understanding of how this relates to RMC, with minimal regard for mental health during pregnancy and birth experienced as disrespectful due to lacking care for all domains of the birthing person's well-being. Consequently, this prevented disclosure of psychological difficulties due to fear of dismissal.

Respect has been defined as "recognition of the unconditional value of patients as persons" [34, p.692]. This aligns with birthing people's views that RMC meant being accepted as an individual by HCPs. Ethnic minority patients report reluctance to voice personal beliefs and preferences, fearing criticism from HCPs [35]. Further, individuals from lower socioeconomic backgrounds express dissatisfaction with HCP communication [36]. Research with HCPs highlights the significance of implicit biases on patient-HCP interactions, demonstrating more positive attitudes towards white patients compared to ethnic minorities [37]. The current study offers a unique perspective on how these factors were experienced by birthing people in hospital settings, with concerns and individual needs often overlooked, particularly for ethnic minorities. Further, some individuals felt a need to comply with HCPs, fearing their opinion would not be valued based on their socioeconomic background, offering further insight regarding higher rates of mistreatment amongst these groups.

Another element of RMC is continuity of care, with improved perinatal outcomes documented when the same midwife is present throughout pregnancy and labour [38, 39][36]. Whilst this was important to birthing people, our findings offer a nuanced perspective regarding how this related to respect and psychological safety. Familiarity through companionship promoted trust and meaningful relationships with HCPs, which also influences midwives' fulfilment in their job roles [40]. This may be understood by previous research exploring birth and maternal attachment, suggesting presence of an attachment figure during birth provides a secure base, increasing birth satisfaction [41][37].

Bidirectional communication, in which patients and HCPs demonstrate active listening and clear communication, enhances shared understanding and quality of care [42]. Birthing people in the current study viewed respect as a two-way process. This echoes findings amongst midwives who described reciprocal relationships, in which birthing people showed understanding of their needs, as promoting mutual respect between themselves and patients [43]. When achieved, midwives were more likely to meet their own well-being needs whilst fulfilling their job role [40]. However, our findings uniquely highlighted that respectful relationships between birthing partners and HCPs was equally important for establishing RMC[38].

Recognition of physical environments on patient well-being has grown over the 21st century [44] influencing 'healing environments'. This describes settings in which staff and patient interactions result in good health outcomes due to desirable physical surroundings. For example, natural lighting, as well as calming colours and sounds in hospital environments. Financial benefits are also documented due to shorter hospital stays, thus reducing patient stress [44]. The impact of physical environments and patient safety in maternity care has recently been noted, recommending greater visibility of nursing stations for patients [45]. This study advances understanding of why this is

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[36] Please see extended discussion (4.1) for further exploration of person-centred care.

[37] Please see extended discussion (4.3) for further exploration of theoretical understanding of respect.

[38] Please see extended discussion (4.2) for further exploration of factors relating to psychological safety.

critical for RMC, with birthing people expressing a desire for attentiveness and companionship from HCPs. Further, the physical environment was perceived as an externalisation of respect for the birthing process. Interestingly, greater quality of care and commitment to work have been reported by nurses working in refurbished settings, compared to colleagues who remained in an old facility [46]. Therefore, alongside patient safety, enhancing physical environments may also promote job satisfaction and retention of staff, offering potential to address wider systemic issues (e.g., poor staffing) identified as barriers to RMC in this study.

Implications for Practice and Future Directions[39]

Early detection of prenatal mental health difficulties improves maternal and child outcomes by increasing access to timely support [47]. Given birthing people identified lack of acknowledgement for their mental well-being during pregnancy and birth as disrespectful, and increased risk of developing poor mental health up to two years post-birth [5][40], exploration of factors relating to maternal well-being within birth plans may be beneficial[41]. Evidence suggests adhering to a greater number of birth plan requests significantly increases sense of control [48]; a key factor in establishing RMC in this study. As mode of birth and availability of resources (e.g., birthing pools) can be unpredictable in UK hospitals [49], identifying preferences relating to well-being (e.g., strategies and techniques to be used) may offer factors that are more adaptable and achievable during labour and birth. Similarly, to promote RMC and safety for ethnic minorities and those from lower socioeconomic backgrounds, participants proposed tailored resources and diversifying the midwifery workforce[42].

Staff presence and trusting relationships with caregivers/partners were crucial to RMC and psychological safety[39]. Whilst fulfilling, continuity of care challenges midwives

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[39] Please see extended discussion (4.6 and 4.8) for further exploration of implications for practice and future directions.

[40] Please see extended discussion (4.5) for further exploration of the role of clinical psychology in maternity care.

[41] Please see extended discussion (4.2) for further exploration of psychological safety.

[42] Please see extended discussion (4.4) for further exploration of RMC in a UK context.

work-life balance. Potential strategies to overcome this were discovered in this study, including opportunities during pregnancy to meet other midwives and HCPs working in the maternity service in which they planned to give birth. Further, given the importance of birthing partners, understanding how safety and respect may be impacted for individuals with limited familial/social support is needed[43]. Finally, identifying strategies for incorporating therapeutic healing environments into maternity care is warranted. Given the association of RMC and safety with meeting individual needs through acknowledgement of psychological well-being, as well as cultural and social factors, adopting a biopsychosocial health model [50] in maternity care may be beneficial[42].

Limitations[44]

The presented study had several limitations. Given differing care pathways, individuals who gave birth at: <37 weeks (i.e., premature); <18 years; and/or at home were excluded, and therefore findings cannot be generalised to these groups. Interviews focused on pregnancy and birthing experiences since 2018, during which COVID-19 had significant impacts on NHS care, and findings may be less representative of standard practice. However, reflections during this period offer valuable lessons for future practice. Accessibility for minority groups may have been limited by the requirement to speak English.

Conclusions

RMC is nuanced, multifaceted and individual. Findings highlight multiple areas that are key in promoting RMC and psychological safety throughout pregnancy and childbirth, aligning with a biopsychosocial health model. Recognition of psychological well-being, physical environments, and social and cultural differences are crucial[45].

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[43] Please see extended discussion (4.3) for further exploration of theoretical understanding of respect.

[44] Please see extended discussion (4.7) for further exploration of study limitations.

[45] Please see extended discussion (4.5 and 4.6) for further exploration of implications for practice and clinical psychology.

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Extended Paper

1. Extended Background

1.1 The Impact of Pregnancy and Childbirth

Negative birthing experiences are reported in up to 60% of birthing people, and are a strong predictor for the development of birth trauma or Post-Traumatic Stress Disorder (PTSD) during the post-natal period (i.e., following childbirth) (Ayers et al., 2016; Dekel et al., 2017). Birth trauma describes symptoms of PTSD that directly relate to an individual's birthing experience (e.g., flashbacks, nightmares, and avoidance), with the experience of birth only recognised as a potential cause of PTSD in 2014 (Svanberg, 2019). These negative and/or traumatic births are associated with poorer mental health (e.g., higher rates of anxiety and depression), with quality of care from healthcare professionals identified as the most significant factor impacting an individual's perception of their birthing experience (Coo et al., 2023). Further, a systematic review found that lacking a sense of control during birth also influenced birth satisfaction (Hosseinin Tabaghdehi et al., 2020). However, whilst helpful to identify risk factors through quantitative methods, there is a lack of understanding regarding the nuances and meanings behind these processes (e.g., why lack of control contributes to negative births), and how existing expectations of birth and control may be influential.

Interestingly, perception of birthing experience has been evidenced to alter with time, suggesting individuals are more likely to report positive experiences immediately post-birth compared to reflections collated at a later date (Conde et al., 2008; Maimburg et al., 2016). However, other findings report the contrary, and one longitudinal cohort study reported no difference between two-months post-birth and follow-up one year later (Waldenstrom, 2003). Whilst discrepancies exist, there is an agreement across the literature that a period of time is required post-birth to allow birthing people to make sense and process their experiences. Resultantly, when researching experiences of birth, it is recommended to accommodate this with a delay between partaking in studies and the time of the individuals most recent birthing experience (Sawyer et al., 2013; Waldenstrom, 2004).

1.1.1 Perinatal Mental Health

Perinatal mental health is deemed a major public health issue by the WHO, with approximately one in five women globally experiencing mental health difficulties during this period (WHO, 2014, 2022a). Higher estimates are reported in the UK, rising to an estimated one in four women (Howard et al., 2018). Anxiety and depression are most prevalent during this period, and the risk for developing mental health difficulties, either for the first time or recurrent, is particularly high within the first few weeks following birth Schmeid et al., 2016). Additionally, having an infant admitted to neonatal care following birth further heightens this risk (Gong et al., 2023). These difficulties within the perinatal period are reflected in suicide risk for this group, with suicide reported as the leading cause of death amongst mothers/birthing people post-birth (covering 6 weeks to 12 months following childbirth). Birth trauma, complications during pregnancy and birth, as well as poor infant health have been found to increase the risk of suicide during this period (Bright et al., 2022). Therefore, initiatives to reduce negative birthing experiences and promote perinatal mental health are critical (Knight et al., 2017).

Given the additional changes and adjustments during this time (e.g., physical, hormonal, emotional, and financial), perinatal mental health has significant impacts on the birthing person and their offspring. Greater difficulties in emotional, behavioural, cognitive, and attentional domains have been reported amongst school-aged children (Kingston & Tough, 2014), with longitudinal research highlighting that these difficulties do not diminish during adolescence (O'Donnell et al., 2014). Studies have also considered later life impacts specifically in UK populations, with higher rates of conduct disorders, being arrested by police, and committing violent acts reported amongst adolescents of mothers who experienced antenatal depression (Hay et al., 2010). Further, antenatal depression has also been identified as an independent risk factor for offspring depression in adulthood (Pearson et al., 2013). Alongside this, perinatal mental health has significant economic costs, particularly in health and social care, approximated at £75,728 in healthcare per birthing person, and £34,840 per person in the social care sector (Bauer & Knapp, 2016). In response, a £290 million investment in specialist perinatal mental health services was enforced by the UK government (Gov

UK, 2016), and improvement to services continues to be key on the NHS agenda (see below - section 1.7.2).

1.2 The Medicalisation of Birth

Medicalised births are distinct from natural births, with pregnancy and childbirth acknowledged as treatable conditions, as opposed to naturally-occurring processes (Bergeron, 2007; Munro et al., 2009). Application of medical technology during pregnancy and childbirth has continued to grow in recent years, with medical intervention during birth considered to be normal practice in Western society (Johanson et al., 2002). However, this has not always been the case, with most births occurring at home before the 20th century. During this time, labour support was provided by females in the family and local communities, as well as midwives, with hospital births considered unusual (Donnison, 2023). Further, men only became involved with childbirth when complications arose, utilising on-hand instruments to aid delivery prior to the development of forceps. Resultantly, many mothers and infants died during birth due to the risks associated with such interventions (Johanson et al., 2002). As the medical sciences developed, the use of forceps, caesarean section, and analgesia during labour grew in popularity, with infant and maternal mortality reducing as a result (Loudon, 2000), influencing perceptions of hospital birth as one of safety and high-quality care.

Since the turn of this century, high-income countries have encouraged births within healthcare settings, with rates increasing as a result (Oladapo et al., 2018). The rationale for hospital-based births is the close proximity to medical resources and intervention should this be required, meaning this can be achieved in a timely manner. Considering this specifically in a UK setting, a continued reduction in spontaneous births alongside increased medical intervention have been observed in the last ten years (NHS Digital, 2021). Most healthy birthing people will experience at least one form of clinical procedure during labour and childbirth, such as induction, caesarean sections, or episiotomy (i.e., the procedure by which the area between the vagina and anus are cut during childbirth to widen the opening for infant delivery) (Coulm et al., 2012; Euro-peristat, 2022). Using medical interventions that do not align with a birthing person's wishes or needs can limit their power and capability during birth, negatively impacting their birthing experience (Renfrew et al., 2014).

One potential explanation for the increased use of medical procedures during the intrapartum period is the recent surge in numbers of legal proceedings regarding medical negligence, with a 9.5% increase in 2022-23 alone, costing £2.7bn (Dyer, 2023). The development of medical technology and practice in recent times has been argued as driving these complaints, with altered public perceptions of healthcare in which the majority of deaths are viewed as avoidable. However, the ability of legal professions to determine whether a death was preventable or not is of debate. Consequently, Johanson et al. (2002) propose that doctors and healthcare professionals may adopt ‘defensive practice’ as a means of self-protection, with almost all legal cases (99%) attributed to a lack or delay of medical intervention. If a healthcare professional encounters a situation in which they advise a lack of obstetric intervention and then something goes wrong, the chances of that individual and those within their healthcare team developing defensive practice is likely to increase (Turrentine et al., 1999). As cases of unnecessary intervention are uncommon in legal cases, healthcare professionals may be more inclined to utilise interventions as opposed to withholding.

1.2.1 Midwives and Medicalisation

Following the increase in the medicalisation of birth, scholars have considered how midwives' roles and approaches to care may have altered as a result. One observational study in which interactions between midwives and birthing people/families were considered during the antenatal and postnatal period, concluded that a mechanical and medicalised perception of childbirth was evident throughout (Olsson et al., 2000). More recently, interviews with midwives in Slovenia revealed that whilst they aim to achieve person-centred care, they are constrained by systemic and organisational factors (e.g., staffing issues and increasing models of bureaucracy), limiting their autonomy to deliver the patient-led care that they strive for (Prosen & Krajnc, 2019). In the UK, similar views have been expressed, with high rates of learned helplessness and guilt amongst midwives which they attributed to a constant threat of being blamed (Kirkham, 1999).

1.2.2 Birth Plans

Due to the importance of control and quality of care on an individual's birthing experience, and increases in the medicalisation of birth, birth plans were introduced in the 1980s. Promotion of autonomy amongst birthing people regarding their preferences and choices during labour (DeBaets, 2017) were targeted, whilst enhancing communication between healthcare professionals and informed decision-making (Divall et al., 2017; Simkin, 2007). When adhered to, birth plans have positively impacted these domains (Bell et al., 2022; Mei et al., 2016), however, when birth plans have been deviated from, satisfaction with birth and level of control reduces (Afshar et al., 2015). This has led to debate regarding the utility of birth plans, and also been considered to influence birthing expectations, with individuals feeling disappointed when their birth has differed from what they have planned. Questions regarding whether birth is something that can be planned given the unpredictability within these circumstances have been raised in response (Divall et al., 2017). However, other reports highlight that birth plans may promote realistic expectations of birth which positively impacts birth satisfaction, indicating that the way in which they are devised and communicated with the birthing person is likely to be influential (Bell et al., 2022). Interestingly from a healthcare professional perspective, birth plans may increase stress for staff when hospital policy or resources do not allow them to carry out the wishes of the birthing person (Welsh & Symon, 2014).

1.3 Obstetric Violence and Gender

Whilst birthing within healthcare facilities is accepted as a proactive approach to preventing maternal and infant mortality, experiences of labour and birth in medical settings has not always equated to high-quality care (WHO, 2018). Reports of disrespectful practice, in which individuals experience mistreatment, including use of intervention without consent, have been documented worldwide (Bohren, 2014, 2015; Chadwick et al., 2014). More recently, this is being understood as experiences of “obstetric violence”, which describes “Gender-based experiences of mistreatment during pregnancy and childbirth, including, but not limited to, violations of the rights to informed consent and bodily autonomy, leading to both physical and emotional harms" (Kukura, 2018, p.726). Martinez-Galiano et al. (2021) conducted a cross-sectional observational study of 899 individuals who had given birth in the last year. Findings revealed that two-thirds (n=606) of women reported experiences of obstetric violence across verbal, physical, and psycho-affective domains. Higher rates of obstetric violence were observed amongst those who: participated in maternity education initiatives; had birth plans but felt these were not respected; required emergency caesarean sections; or when infants required admission to intensive care. When skin-to-skin was offered at the earliest possibility post-birth, and birth plans were respected, these factors were protective in reducing the likelihood of individuals experiencing obstetric violence.

Risk of experiencing obstetric violence has also been explored in the context of language used towards birthing people (von Benzon et al., 2024). Reports of patronising terms from healthcare professionals towards birthing people - referred to as the "good girl" phenomenon in feminist healthcare literature - reduces autonomy by encouraging birthing people to "do the right thing" so they are viewed as a "good" patient (Sointu, 2017; von Benzon et al., 2024). These studies highlight the various ways in which mistreatment and disrespect may be experienced during pregnancy and childbirth.

Similarly to RMC, gender has been recognised by the WHO as a key factor that impacts one's experience and access to appropriate healthcare, including how the individual is treated. Acknowledgement of increased barriers for women are noted, particularly relating to higher incidence of harmful and violent practice on a global scale due to gender inequality. Practicing non-discriminatory care and language is key for addressing these inequalities, with a sustainable development goal to "achieve gender equality and empower all women and girls" (United Nations, 2023, p.22).

1.4 WHO model of Intrapartum Care for a Positive Childbirth Experience

In response to the shift towards medicalised births, the WHO has developed good practice guidelines, promoting a standardised approach to intrapartum care. The intrapartum period refers to the experience of pregnancy during labour, ending when the infant and placenta are delivered (Oladapo et al., 2018). The model defines a positive childbirth as “one that fulfils or exceeds a woman’s prior personal and sociocultural beliefs and expectations” (WHO, 2018, p.1), in addition to establishing a clinically and psychologically safe environment in which a healthy infant is delivered. Continuous support should also be provided, at both a practical and emotional level, from birthing partners and healthcare professionals. Staff should demonstrate compassion and kindness, ensuring every opportunity for a sense of achievement and control over decision-making is made, regardless of whether medical intervention is desired or recommended on a medical basis.

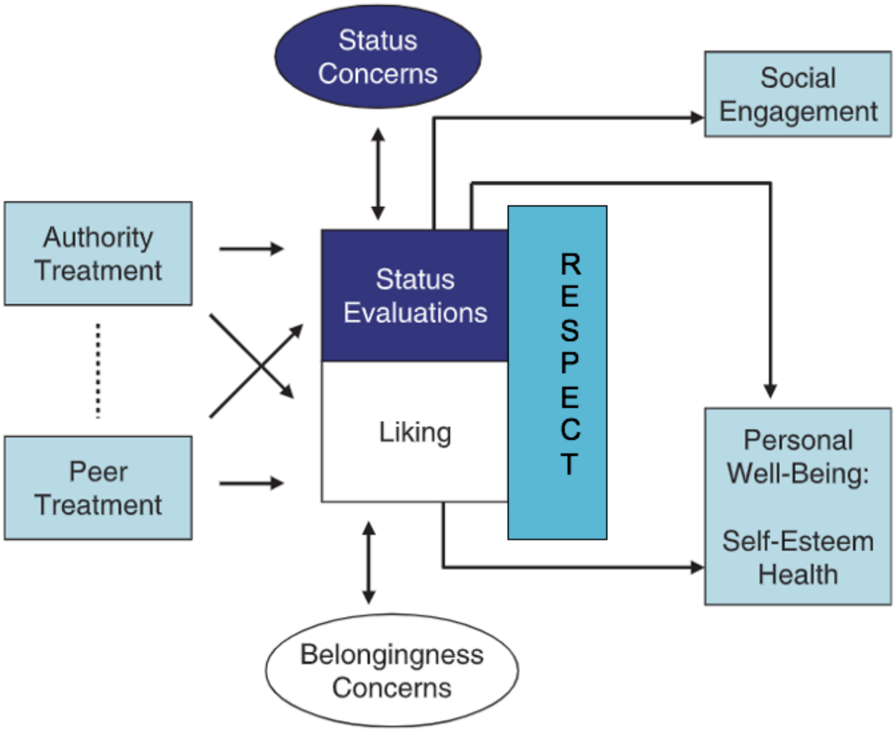
The model surmises a series of key recommendations for a positive birthing experience, which is broken down into stages of labour, as well an overarching category of ‘care throughout labour and birth’ which features four key areas of care: respectful maternity care (RMC); effective communication; presence of a companion; and continuity of care (Appendix A). Here, recommendations for RMC suggest that care should be designed to retain the “dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support” (WHO, 2018, p.19) of all women. In particular, the importance of respectful family-oriented care through acknowledgement of the desires and needs of women during birth is suggested. This echoes research with healthcare professionals which has summarised respectful and dignified care as: treating people as “human”; listening and allowing patients to feel heard; good teamwork; attentiveness; maintaining privacy; acknowledging culture; and reducing power dynamics between healthcare professionals themselves and with patients (Bagnasco et al., 2020; Jolivet et al., 2021). Respect of one’s values and choice are essential elements of labour and birth; however these are not regularly implemented, particularly during the first and second phases of labour (WHO, 2018).

1.5 The Psychology of Respect

When drawing on psychological literature, particularly behavioural and social theories, respect is discussed in the context of groups, representing power, status, and a means of expressing concern for the well-being of others (Huo & Binning, 2008). In a group setting, one may view the feeling of respect as an indicator of how they are perceived and evaluated by others, with groups ranging from a small group of individuals to wider communities. Resultantly, research has considered how respect may impact both group and personal process, including one’s physical and mental well-being, influencing the development of a dual-pathway model of respect (Lind & Tyler, 1988) (see Figure 1). The model brings together an individual's desire for meaningful social interactions, alongside one’s observations of the strength of their relationship with group members. Therefore, respect is considered to incorporate two key social motivators - a desire for belonging, and a drive for status in which the individual is considered a valuable contributor to the success and existence of the group (Lind & Tyler, 1988). Subsequently, two pathways are proposed entitled ‘status evaluations’ and ‘liking’. It is through these domains that when respect is shown towards an individual, or is not present, one’s behaviour and outlook is influenced, which further impacts the prosperity of the group (i.e., social engagement) and the individual’s well-being (i.e., self-esteem and health) (Huo & Binning, 2008).

Figure 1

Dual-Pathway Model of Respect (Lind & Tyler, 1988)



From a humanistic perspective, respect has been related to unconditional positive regard (UPR), which is described as accepting an individual regardless of their personal views, emotions, or behaviours (Rogers, 1957). The notion of UPR has unsurprisingly been deemed as a key process in person-centred care, and is often applied to a therapeutic context, in which the therapist should strive to demonstrate UPR to all clients. Both respect and UPR are used interchangeably in the literature and considered crucial for promoting the mental well-being of others (Bhanji, 2013). This shares considerable overlap with the way in which respect is discussed from a psychoanalytical and psychodynamic perspective, with the notion of 'unconditional respect' from the therapist to the client as imperative to developing the therapeutic relationship and trust (Baum-Baicker & Sisti, 2012). Further, the importance of respecting the client's autonomy and dignity are also noted (Fisher & Oransky, 2008). However, whilst respect is referred to and discussed extensively within psychological literature, similarly to the medical field, definitions are broad, with surprisingly little regard for the individual's experiences and interpretation of this phenomenon (Langdon, 2007).

More recently, respect has also been considered within the neuropsychology literature. In this context, respect is regarded as a sense of appreciation and fondness, acting as a positive social emotion (Arshad et al., 2023). Based on developmental studies, respect has been associated with theory of mind and prefrontal cortex development, with older children demonstrating behaviours indicative of respecting ownership (Sareen, 2014; Kanngiesser et al., 2020: Koski et al., 2015; Watanabe et al., 2015).

1.6 Psychologically Safe Environments

The concept of psychologically safe environments often features within business and management literature (e.g., Newman et al., 2017). Psychologically safe environments are described as settings in which individuals are able to share their thoughts and feelings without fearing judgement from others, thereby sharing similarities with the concept of UPR explored earlier (see above – section 1.5). Positive impacts of psychologically safe environments are reported across a magnitude of disciplines and settings. For example, in educational contexts, greater academic performance has been associated with psychological safety (Soares & Lopes, 2020). In healthcare settings, psychological safety was initially explored by Edmondson (1999), in which the importance of healthcare professionals being able to take risks without apprehension regarding how others would perceive them was noted. More recently, psychologically safe environments are evidenced to allow healthcare professionals to voice concerns, query decisions and clinical practice, as well as receiving constructive feedback on their own patient care, which is crucial for development and delivery of high-quality care (Hardie et al., 2022). Unsurprisingly, the need to build psychologically safe environments within maternity settings is a featured recommendation across policies relating to RMC and positive birthing experiences (e.g., the Intrapartum Care Model), including the need for greater exploration of factors that promote psychologically safe environments in maternity care (Oladapo et al., 2018). This highlights the change in viewpoint that the concept of safety during birth is purely one related to physical health and reducing maternal and infant mortality, and instead safety is enhanced by promoting respect in the context of autonomy, choice, involvement in decision-making, and if desired, companionship during birth (Downe et al., 2018; Martínez-Galiano et al., 2021).

1.7 Reforming Maternity Care - A UK Perspective

1.7.1 NICE Guidelines for Labour Induction

Recent draft changes to the National Institute for Health and Care Excellence (NICE) guidelines for labour induction propose that ‘high risk’ individual should be routinely induced at 39 weeks (NICE, 2021). However, ‘high risk’ indicators (e.g., ethnicity, body mass index (BMI) and age) has caused controversy, with criticism from the Royal College of Midwives (RCM) due to lacking regard for individual circumstances and joint decision-making (Brigante & Harley-Lam, 2021). Given the domains of RMC explored above (see section 1.4), it is argued that purely basing induction on characteristics such as ethnicity would prevent person-centred care. Further, given that individuals from BAME backgrounds are already marginalised within society and have poorer experiences of healthcare, it was proposed that this would further ostracise this group (Brigante & Harley-Lam, 2021). Recognition of the importance of seeing birthing people as individuals was advocated. Additionally, the draft guidelines further proposed that should these ‘high risk’ individuals refuse induction, healthcare professionals in maternity settings should provide the opportunity for the individual to ‘revise their options weekly’, raising further concerns regarding how this may encourage coercion. Given the existing evidence regarding birthing people feeling pressured into inductions, the need for personalised discussion on all birthing options was highlighted (Brigante & Harley-Lam, 2021). However, it has been recognised that these guidelines were introduced due to increased risk of stillbirth amongst those recognised as ‘high risk’, and therefore greater monitoring and support is likely to be beneficial (NICE, 2021).

1.7.2 NHS Long-Term Plan

The NHS long-term plan (NHS UK, 2019), devised in conjunction with healthcare professionals, service users and families, summarises the need for changes within the NHS due to advancements in medicine and society. Maternity and neonatal services are a feature, with the plan stating a desire to develop and enhance maternity care over the next ten years. Whilst recognising the continued drop in adverse pregnancy and neonatal outcomes (e.g., stillbirths), the ongoing disparity and higher risk of maternal and infant death for Black, Asian and Minority Ethnic (BAME) groups and those from the poorest backgrounds (Draper et al., 2020), are noted.

One element discussed in the context of reforming maternity services is continuity of care, including peri and post-natal periods. Those able to access this continuity are 16% less likely to experience infant mortality; 19% less likely to miscarry prior to 24 weeks; and 24% less likely to have a premature birth (Sandall et al., 2016). Recognition of focusing these initiatives on those with poorer outcomes (i.e., BAME and individuals residing in areas of greater deprivation) is given, particularly due to significant improvement in birthing outcomes (e.g., higher rates of spontaneous births and enhanced neonatal outcomes) when continuity of carer is established for these populations (Homer et al., 2017). In 2019, continuity of carer was offered to 20% of birthing people, with the plan aiming to implement this for most individuals by 2021.

Improvement in perinatal mental health care is also acknowledged in the long-term plan (NHS UK, 2019). Given the economic impact on the NHS and social care sectors, the plan discusses implementing initiatives to aid access to high-quality mental health care for birthing people, partners, and children. Several methods for addressing this are: 1) expanding perinatal services to cover up to 24 months post-birth (previously only commissioning up to 12-months); 2) increasing access to evidence-based psychological therapies for families, not just birthing people; 3) support provisions for partners/fathers with mental health difficulties post-birth; and 4) developing technology and digital means of support for maternal mental health.

1.7.3 UK Maternity Care - Independent Reviews and Confidential Inquiries

Following concerns raised regarding the quality and safety of care delivered in Shrewsbury and Telford Hospital NHS trust, the UK Secretary of State for Health and Social Care requested an independent review of their maternity services back in 2017. Donna Ockenden, a midwife in the NHS and community activist, led on this investigation. Consultations with birthing people and their families regarding their experiences, many of whom had experienced neonatal deaths as a result of poor care, and the experiences of healthcare professionals in this service, were considered. The final report highlighted significant areas of concern, with a magnitude of evidence that indicated opportunities to improve care had been missed. A lack of raising to appropriate senior members of staff regarding clinical decision-making was evident, alongside poor leadership in which concerns were disregarded despite escalation from healthcare professionals; and minimal collaboration between staff, and with other medical specialities/services. From a patient perspective, many families documented a lack of kindness and compassion from healthcare professionals, which may influence injuries amongst mothers and babies (Ockenden, 2022). These findings share similarities with other maternity investigations carried out by Bill Kirkup (2015a, 2015b) at Morecambe Bay hospital, and more recently regarding failures of safe care in East Kent maternity hospital (Kirkup, 2022). Recommendations are clear, including the need to address issues with safe staffing levels including the poor retention of midwives, as well as adequate training, recognition of the experiences and voice of service users, and finally an environment in which individuals can learn from their individual practice and the experiences of others (Norman et al., 2022).

Since these investigations, further concerns regarding care in other NHS maternity services have been raised, and therefore the recommendations stated are targeted at all services caring for women/birthing people and their families during this significant period of their lives. Professionals in the midwifery field have recognised that many of these reports could be taken from any maternity services in the UK, sharing disappointment and concern regarding the current state of maternity care in the UK (Logan & Kelly, 2021). Donna Ockenden is now leading a similar investigation regarding maternity services in Nottingham, including 1700 individuals who have given birth in

Nottingham University Hospitals NHS Trust, making this the largest UK enquiry across all healthcare settings to date (Lacobucci, 2023). Scholars have recognised that considering a range of experiences may provide an opportunity to re-build maternity and perinatal care, aligning with the values of patients, families, and healthcare professionals (Norman et al., 2022).

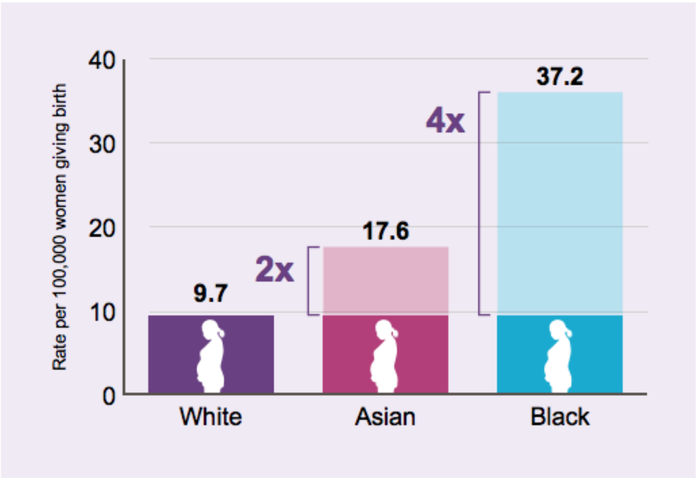
In addition to the above investigations, the Maternal, Newborn and Infant Clinical Outcome Review Programme have been funded to produce annual reports regarding infant and maternal death across the UK, aiming to improve maternity care through crucial investigations. These publications, known as MBRACCE-UK (Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries across the UK) in conjunction with the University of Oxford, have repeatedly identified disparity in birthing outcomes for minority groups, particularly based on ethnicity and socioeconomic deprivation (Knight et al., 2023) (see Figure 2). Similarly to the Ockenden (2022) and Kirkup (2015a, 2015b, 2022) findings, these investigations highlight the need for improvement of maternity services in the UK.

Figure 2

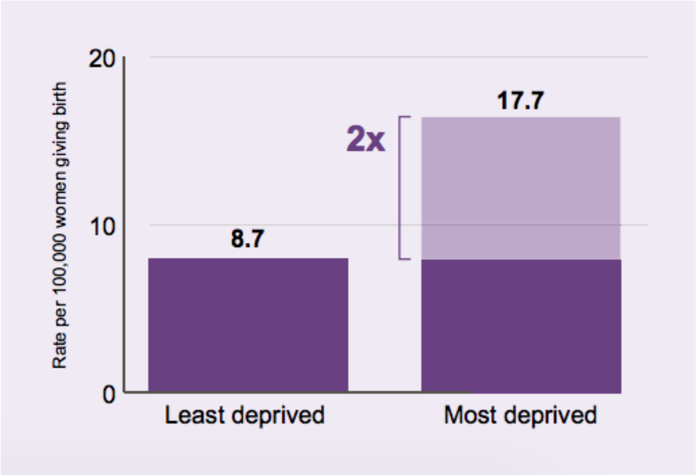
Inequalities in Maternity Mortality and Areas of Deprivation (taken from Knight et al. (2023))

Inequalities in maternal mortality

Ethnic group



Living in more deprived areas



Given the above, the NHS have published a plan for improving maternity and neonatal services in the next three years (NHS England, 2023). Based on accounts and concerns raised in the Ockenden (2022) and Kirkup (2015a, 2015b, 2022) reports, the importance of providing women and families with a voice and honouring their thoughts and opinions for change with compassion, is considered key to providing safer care. Several core strategies proposed in this recent NHS publication include: providing all birthing people with personalised care plans; the publication of equity and equality plans to minimise inequality; provide funding for the involvement of patients in producing policies and strategies; develop strategies to address the retention issues observed in maternity care; and finally, a promise from NHS England to ensure all maternity healthcare professionals are provided with appropriate training, support and supervision in order to carry out their role effectively and safely. However, it is important to note a similar proposal was set out in 2016 - known as the 'Better Births' initiative (Dunkley-Bent, 2016). This presented a five-year vision to improve outcomes within maternity services in England. Aims to encourage collaboration and open communication between all services involved in birthing people and their families' care, including NHS, local authorities, and any additional local organisations. In doing so, it hoped that seamless care could be achieved, aiding transitions between maternity services and community-based care (e.g., health visitors). The need for safe, compassionate, kind, and respectful care was noted, with the importance of ensuring that care is centred around the individual. Despite these efforts, a recent parliamentary report regarding maternity services in England highlighted that in 2023, over one-third (39%) of maternity services were noted as 'requiring improvement', increasing from 33% in 2022. Further, for the domain of 'safety', 15% of services were considered inadequate (Brader, 2024). Given the outcomes of the reports discussed here, there is a clear gap between these policies and recommendations, versus what is happening on the ground (Ockenden, 2022).

Unsurprisingly, the continued reports of avoidable deaths, as well as unsafe care in which compassion and kindness towards birthing people is lacking, have driven social media and societal responses. The 'Make Birth Better' was an online initiative set up by a Clinical Psychologist in 2017 due to the continued reports from birthing people that they had experienced elements of their birth as traumatic (Svanberg, 2017). In addition, awareness weeks for birth trauma have been launched by the Birth Trauma Association, which has continued to gain traction and coverage across leading media and news outlets (e.g., BBC News (Parkinson, 2017)).

1.7.4 Inclusive Language

A drive towards inclusive language in healthcare settings has developed momentum of late, particularly in relation to one's preferred pronouns. Individuals identifying as LGBTQ have highlighted the importance of feeling accepted by healthcare professionals, including asking about and adopting their preferred pronouns, which they have related to feeling respected by services (Brown et al., 2020; Carlström et al., 2020). The British Medical Association (BMA, 2022) acknowledged this in their guidance on 'inclusive care of trans and non-binary patients', recommending all staff within healthcare should "respect the dignity of patients with respect to pronouns and gender-markers on any communication with the patient".

This is interesting to consider alongside recent proposals regarding language adopted within maternity settings and research, with Brighton and Sussex University Hospitals (BSUH) (2021) calling for greater inclusivity such as the term 'birthing person'. Adopting preferred language has been linked with promoting autonomy and choice in maternity care (Crossan et al., 2023), which are key elements of RMC noted by the WHO (2018). This has been related to some initiatives suggesting the removal of sexed terminology (e.g., 'women' and 'mothers') when discussing female reproduction. Replacement terms of "bodies with vaginas" have been proposed, with "Women" and "mothers" carrying meanings relating to both sex and gender (Botelle et al., 2021). In response to queer theory, a drive to change language in services by refraining from the use of sexed terminology is apparent (Sullivan, 2020). However, some individuals who identify as 'mothers' have described these terms as 'dehumanising' (Gribble et al., 2022), and in an attempt to be inclusive, these changes appear to have excluded those that identify with the female terms. Therefore, to promote inclusivity and address the lack of research using alternative language, the present study has adopted both ‘mother’ and ‘birthing person’, recognising that individuals will align with different terminology during pregnancy, birth, and beyond.

1.8 Study Rationale

Research and policy within the area of midwifery and maternal health have continually highlighted the importance of delivering RMC and enhancing psychological safety within maternity settings. However, existing definitions have been critiqued for being vague and broad, with multiple calls for further research to offer birthing people and their families the opportunity to share their visions for respectful care (e.g., Belizan et al., 2020; Oladapo et al., 2018; WHO, 2018).

When considering the existing policies regarding RMC, and the UK initiatives aimed at reforming midwifery care (e.g., NHS Long-Term Plan (NHS, 2019)), establishing factors that may enhance or prevent RMC being experienced are required. Given continued reports of uncompassionate, unsafe and inadequate care in NHS services, there is a need to give voice to those with lived experience in order to understand how services may need to adapt in order to deliver their vision of RMC (Brader, 2024; Ockenden, 2022).

Worse birthing and pregnancy outcomes for birthing people from BAME groups, and those living in greater areas of deprivation, are documented at a global and UK level (Collins & David, 2009; Knight et al., 2023; McLemore et al., 2018). Further, individuals in these minority groups have been identified within the literature as high-risk groups for experiences of mistreatment and disrespect during childbirth. Despite this, there is a paucity of research offering them a voice to share their meaning and experiences of what constitutes RMC and psychological safety during pregnancy and birth, with research often limited to homogeneous groups (Mayoh, 2019). Consequently, further research exploring their views and experiences are warranted.

In response to recent initiatives aimed at increasing inclusivity regarding the language and terminology used in maternity service (BSUH, 2021), research broadening recruitment with inclusive language is needed, with the majority of the literature to date discussing ‘mothers’ experiences. As reports highlight, not all individuals identify with this term, and therefore this study adopted both ‘mother’ and birthing person’ as a means of addressing these recommended changes.

Further, research in the domain of RMC has focused specifically on childbirth and birth trauma/post-birth adjustment. Given the importance of control, decision-making and autonomy incorporated within definitions of RMC (WHO, 2018), and that key decision-making regarding birth and preferences occurs during earlier stages of pregnancy (e.g., through birth plans and during antenatal appointments) and not just during labour, there is limited research exploring the meaning and experiences of RMC throughout this period.

2. Extended Method

2.1 Study Design

2.1.1 Rationale for a Qualitative Approach

Quantitative research designs aim to identify and predict how differing variables are related to one another, and any interactions that may occur between and within these factors. Resultantly, patterns across populations are established, allowing critical comparisons to be made between different groups. However, nuances and meaning attached to experiences and behaviours are not captured (Robertson et al., 2018). Instead, this deeper understanding is offered through qualitative approaches which enable direct exploration of one’s personal experiences (Willig, 2013). Resultantly, qualitative studies are often applied when the literature within a particular academic field is limited in its understanding of the targeted phenomenon. In the case of the presented thesis, this relates to RMC and psychological safety in maternity settings.

The multiple calls for research that this study aimed to address focused on ‘defining’, ‘understanding’ and ‘exploring their vision’ of what RMC and psychological safety means to mothers and birthing people (Tuncalp et al., 2015). Similarly, opportunities to share suggestions for increasing RMC were proposed (Belizan et al., 2020). Given the literature in the field was mainly conducted with samples of white middle-class mothers

(Mayoh, 2019), deeper understanding of how experiences may differ based on certain characteristics and demographics (e.g., ethnicity and SES) was needed.

Whilst several global definitions of RMC exist, with key constructs associated with RMC identified (e.g., autonomy, control etc), these have been criticised as vague and unclear, and aiming to operationalise these constructs may be reductionist. Therefore, given the various systemic and individual factors that may influence experience of RMC, utilising methods in which one's experiences can be considered within their wider context is crucial. Whilst narrow, qualitative research produces rich meaning of individual experiences, in which patterns and divergence between accounts can be recognised (Braun & Clarke, 2013). To date, qualitative research in this field has offered greater understanding and insight regarding experiences of birth trauma (e.g., Taghizadeh et al., 2013; Zhang et al., 2020); positive and poor childbirth experiences in non-UK settings (e.g., Essén et al., 2000; Mukamurigo et al., 2017); and experiences of childbirth fear (e.g., Eriksson et al., 2006; Wigert et al., 2020). Bringing this together, alongside the paucity of research directly exploring individual experiences of RMC in a UK hospital setting, a qualitative methodology was considered most appropriate for this study.

Semi-Structured Interviews. A selection of qualitative data collection methods are frequently used across the literature, including interviews, focus groups, observations and open-ended questionnaires (Liamputtong, 2020). Guidance was also sought from a member of the Trent DClinPsy SUCAP who had participated in multiple research studies adopting various qualitative approaches. We discussed reservations with focus groups, such as feeling uncomfortable to share sensitive experiences in front of others, which they believed may be particularly critical for minority groups. Similarly, whilst open-ended questions can be useful, the extent to which people would provide enough information or expand on their experiences is unpredictable, and the opportunity to seek clarity is not offered. To overcome this, SUCAP felt interviews would be most appropriate to ensure that enough recognition of the importance of pregnancy and childbirth was given.

Semi-structured interviews provide space and unique opportunity for participants to explore and reflect on any of their lived experiences that they feel are relevant to the topic being discussed. Further, the researcher has freedom to query and clarify pointers that are beyond the pre-determined interview questions, including how an individual's experiences are understood in the context of their social setting (Adams, 2010; Harding & Gantley, 1998). Following a review of the literature and study aims, alongside SUCAP advice and consultation with supervisors, it was determined by the researcher that one-to-one semi-structured interviews would be the most appropriate method of data collection.

2.1.2 Epistemological Position

To form the research paradigm and establish rigour within qualitative methodologies, acknowledgement of one's epistemological position is imperative. Epistemology, or 'theory of knowledge', considers how information is obtained (i.e., how do we know what we know) (Clarke & Braun, 2013; Smith & McGannon, 2018), with differing viewpoints regarding how this is achieved. Positivism recognises participants and the researcher as independent, with meaning of experiences developed purely from participant accounts, with the researcher having minimal impact on how the study findings are shaped (Braun & Clarke, 2013). Therefore, knowledge is developed through an individual's objective experience of reality. On the contrary, constructivism views knowledge as being obtained through a socially constructed process, thereby a more critical lens is taken to aid understanding of how experiences relate to the social world, regardless of objective reality (Burr, 2015).

By considering both of these positions, Bhaskar (1979) proposed 'critical realism' (CR). In a research context, whilst CR recognises reality, the influence of personal characteristics and interpretations on sense-making and how one understands their experiences are acknowledged (Harper & Thompson, 2011). Whilst data offers information regarding reality, this is not necessarily a direct portrayal of reality (Harper, 2011), and to offer explanation to the factors maintaining and reinforcing reality, additional evidence needs to be considered (Willig, 2012). CR accepts that knowledge is restricted and will be influenced by societal pressures and constructs (Benton & Craib, 2010). Therefore, by adopting a CR epistemological position throughout this study, it is recognised that how one experiences pregnancy, childbirth, and RMC will be influenced by their personal experiences and expectations, alongside broader societal and cultural factors relating to these events and concepts (e.g., respect), as well as general perceptions of parenthood. In line with a CR stance, the researcher also recognised that their own experiences and beliefs, including no personal direct or indirect birthing experience, alongside employment in the NHS and physical healthcare, would have a level of influence on the way in which this study was constructed, including design, data collection, analysis, and final interpretations. This is further explored in the following section (2.1.3).

2.1.3 Researcher's Position

In line with recommendations in the wider literature, and the CR stance taken, offering a summary of the researcher's beliefs and views regarding the study phenomenon is key. This enables readers to consider the reliability and validity of the research findings (Elliot et al., 1999; Tong et al., 2007).

My interest in the interaction between psychological well-being and physical health initially developed during my teenage years. Following the death of one of my grandparents, I noticed a rapid decline in the physical health of a close family member, who later ended up diagnosed with Myalgic Encephalomyelitis (ME). I have witnessed the significant impact this has had on their mental health and unfortunately resulted in them dropping out of midwifery training. This was something that had been a lifelong dream for them, but they had not been able to pursue this due to financial constraints and having small children. Looking back, I believe this likely influenced my constant back and forth during my secondary school education regarding whether I wanted to study psychology, or train to be a midwife. After undertaking work experience and shadowing in both areas, I recognised that I was particularly interested in the psychological variables that influenced pregnancy, childbirth, and beyond.

Following completion of my Psychology BSc, I ventured to Sri Lanka to participate in a five-week mental health placement. I undertook a range of placements, including time on a mother and baby unit. I witnessed a huge level of distress amongst those individuals, whilst also hearing the views and opinions of medical professionals regarding how these individuals should be treated. I was particularly struck by the idea that these women were “possessed with demons”, and therefore needed to be “locked up” and heavily medicated, to the point that many spent their days heavily sedated. During this time, I reflected on the contrast between my own upbringing and culture, including spiritual and religious beliefs, and how delivery of healthcare and treatment of patients is significantly impacted by these factors. These experiences developed my previous belief that respect and compassionate care is detrimental to one’s recovery, including greater recognition for one’s psychological well-being when offering any form of care.

At the time of writing this thesis, I have worked consistently in the NHS for six years. Throughout, I have witnessed the impacts (both positive and negative) of funding, staffing and resources on the delivery of care. In addition, I believe that my time spent in paediatric and child health settings (e.g., craniofacial, CAMHS and brain injury) has developed my awareness of how systems and organisations influence adjustment and recovery following periods of heightened stress, particularly those involving hospital stays.

I believe it is also crucial to recognise that I entered this field of research with no personal experiences of pregnancy and/or birth. Whilst I have indirectly witnessed the pregnancy journey of my family members and friends, I had limited understanding of what this may be like to directly experience in terms of bodily and hormonal changes, as well as the differing options and decisions to be made in relation to birthing methods and locations (e.g., home vs hospital). Resultantly, I entered this field of research with limited knowledge of what pregnancy and birth may be like, and what mothers/birthing people may need in those situations to feel respected and psychologically safe. Having a supervisory team with personal and professional birthing experiences and/or as birthing partners, covering more positive to negative experiences and various modes of delivery (e.g., unplanned c-sections to vaginal delivery) was helpful for extending my knowledge of these areas. However, at times I belief my lack of direct personal birthing experience may have been helpful, particularly during the interview process. I found myself seeking clarity regarding specific medical terminologies and experiences because of this, which may have enhanced the depth of the data collated.

I also recognise that my perceptions of this study area were influenced by a systematic literature review that I completed during my first year of clinical psychology training. The review focused on factors affecting the implementation of RMC on a global scale from the perspective of healthcare professionals. This qualitative review and meta-synthesis highlighted the influence of both individual and systemic factors on delivering RMC, and the importance of RMC differed across accounts.

In summary, I recognise that I have had a range of experiences that have driven my interest in the study phenomenon, influencing my position and beliefs as a researcher undertaking this project. By reflecting on these experiences and what sparked my interest during the infancy stages of project development, including any biases, I have been able to put strategies in place to manage the impact of these. This has included regular reflexivity through my reflective diary and research supervision, and my general reflections after undertaking this project are explored further in section 5.

2.2 Ethical Considerations

Ethical approval for this research was granted by the University of Nottingham (UoN) Division of Psychiatry and Applied Psychology ethics sub-committee on 1st February 2023 (Appendix B). No amendments were made to the ethical application for the duration of this research project. The Code of Human Research Ethics (The British Psychological Society (BPS) (2021) was adhered to throughout conduction of this study. Whilst NHS ethical approval was considered, in line with the aims of the thesis, the researcher did not wish for this study to reflect an evaluation of a particular NHS/maternity service. As ethical approval would have to be sought at an individual trust level, and given the time constraints of completing a DClinPsy thesis, ethical approval from the university was felt to be appropriate to promote broader recruitment. Further recruitment details are provided below (see section 2.4).

2.2.1 Confidentiality

Prior to registering their interest through the online screening questionnaire, and before conducting interviews, all participants were provided with an overview of confidentiality. This was detailed in the participant information sheet (Appendix C) and consent forms (Appendix D). Given the sensitive nature of the study area, and as guided by the Code of Human Research Ethics (BPS, 2021), the doctoral researcher aimed to treat all participant information collated with confidence, care, and respect. For example, all interview participants were provided with a unique ID number to ensure that their data could be identified and deleted should they wish to withdraw from the study. When transcribing participant interviews, the doctoral researcher removed any identifiable information (e.g., names of baby/partners/family/healthcare professionals, hospital names/locations). Pseudonyms were assigned when writing up the report to ensure anonymity when providing quotes and demographic details.

2.2.2 Data Protection and Storage

In line with requirements from the UoN ethics submission process, a data management plan was developed prior to this study commencing and adhered to throughout (Appendix E). All data was handled in accordance with the General Data Protection Regulations (GDPR) and the Data Protection Act (2018). Electronic data (e.g., consent forms, screening questionnaire responses, transcripts and researchers notes/reflective log) were password protected and securely stored on the researchers UoN OneDrive. One Drive is a secure, cloud storage technology and is the UoN's preferred location for storing personal and commercially sensitive data. Only members of the research team had access to the One Drive files.

Individual folders were made on One Drive to ensure that participant consent; demographic information; contact details for interview; contact details if they wished to receive a research summary on completion; interview audio-recordings; transcripts; and research notes were stored separately from one-another and all required passwords to access. Following completion of the research component of the DClinPsy, anonymised research data will be deposited in the UoN data archive and electronically stored by the researcher's primary supervisor. The UoN data archive is underpinned by commercial digital storage which is audited on a twice-yearly basis for compliance with the ISO 27001 standard. Any identifiable data will be destroyed three months after the study is completed. All remaining data, in accordance with the UoN and GDPR guidance, will be retained for a period of seven years and then destroyed.

2.2.3 Participant Information and Informed Consent

When inviting participants to register their interest in participating in an interview, a brief summary of the research project was included within the study advert (Appendix F). On following the QR codes/web link provided, individuals were then presented with an electronic participant information sheet detailing what participation would include, noting that this was entirely voluntary and there would be no obligation to take part when contacted if they no longer wished to do so. Contact details of the doctoral researcher and primary supervisor were provided should they have any further questions regarding the study (Appendix C). Consent to contact the individual for further participation, and to collate a series of demographics as part of the screening process, was then obtained on the following screen. Individuals who registered their interest were clearly advised that they may not be invited to interview and would be contacted within a period of four weeks from the point at which they completed the screening questionnaire (Appendix G).

On contacting participants with invites for interviews, in which their preferred contact method was used (indicated as email for all participants), a copy of the participant information sheet was again provided by attaching the Word document to the email (Appendix A). Individuals were further reminded that participation was entirely voluntary, and they did not need to provide any reason for not partaking. A phone call to discuss any queries was offered to all interviewees, however no one requested this. As consent for interviews was collated during the screener questionnaire, no further consent was required as per UoN ethical recommendations, with response to invitation emails considered consensual.

2.2.4 Participant Withdrawal

The right to withdraw was detailed prior to participation in the study, with details provided in the information sheet and consent form (Appendix C and D). Participants were advised that they could withdraw from the study at any point without reason. During interviews, individuals were reminded that participation was voluntary, and to let the researcher know should they wish to end the interview or not wish to answer a particular question. Following interviews, participants were verbally informed that they would need to notify the researcher within one week from the interview taking place if they wished to withdraw, which was also stated in participant debrief forms (Appendix H). This cut off was set as the point at which data was anonymised and included in analysis, and therefore it would no longer have been technically possible to withdraw their data. However, no participants withdrew from this study.

2.2.5 Adverse Effects

No physical or psychological harm was expected to be caused by this study. However, when undertaking research in areas where harm, suffering or social injustice may have occurred, recognition is given to the impact this may have on participants and researchers (Morse, 1994). Given the potentially sensitive nature of the interview topics, the researcher drew on experiences of working clinically and monitored any signs of participant distress throughout interviews. Participants were offered breaks and regularly reminded that they did not have to answer any questions that they did not wish to do so. No significant signs of distress were noted throughout interviews; however several participants did become tearful when discussing their pregnancy and birthing experience. For some, this was due to positive memories, and was not felt to indicate distress. When related to more difficult experiences, the researcher paused and conducted a well-being check-in (e.g., asking if they were ok to continue, offering a break, or moving the interview along). Full debriefs were provided to all participants (see below – section 2.2.6).

From a researcher perspective, supervision was provided throughout the study period. The doctoral researcher was aware that should any personal distress arise from conducting interviews, this could be raised with their primary supervisor. If they were not available, contact with another member of the research team was agreed. Whilst the researcher recognised the topics and experiences discussed were emotive at times, this did not lead to any significant distress for the researcher. Further reflections on the researcher's experiences are explored later in section 5.

2.2.6 Debriefing

On completion of the interview, the doctoral researcher led a debrief with participants (e.g., how are you feeling after taking part in the interview?). If the researcher felt the individual was a risk to themselves or others, or that someone else may be at risk of harm, the researcher would access appropriate UoN safeguarding policies. However, no concerns were raised. Following the researcher-led debrief, participants were provided with a debrief sheet which was emailed immediately after the interview. This included a summary of the main research aims and a list of supportive and informative organisations should the participant wish to access these (Appendix H). Contact details of the researcher and primary supervisor were again provided, alongside details of how to make a complaint should the participant wish to do so. No complaints were raised during the study being conducted.

2.2.7 Participant Reimbursement

Participant incentives are helpful in reducing power imbalances between researchers and participants, and their usage is therefore recommended (Thompson, 1996). In line with the UoN preferred means of participant reimbursement, and to acknowledge the time offered by participants to register their interest in the study and completion of a screening questionnaire, individuals were provided with the opportunity to leave their contact details to be entered into a £20 Amazon voucher draw. Further, an Amazon voucher totalling £15 was offered to all interview participants, with all individuals opting to receive this. As vouchers were provided electronically, they were sent to participants immediately after interviews, and all individuals were advised they would receive this even if they wished to withdraw. Therefore, the researcher budgeted for additional vouchers should they be required; however this was not needed due to no participants withdrawing. When initially contacting participants to invite them to interview, individuals were given the option of face-to-face interviews, noting travel costs would be reimbursed. However, all participants selected Microsoft Teams as their preferred interview platform.

2.3 Participants

2.3.1 Sample Size

Unlike quantitative approaches that draw on power calculations, there are no set guidelines for determining sample size within qualitative research (Malterud et al., 2016). Instead, researchers need to balance collating enough data that a deep and rich understanding of the study phenomenon is provided, alongside an amount of data that is manageable (Sandelowski, 1996). Considering the analytical approach taken in this study (i.e., Thematic Analysis (TA)), the sample size should be large enough that meaningful patterns and nuances can be identified across the dataset (Braun & Clarke, 2006, 2019). When reviewing literature utilising a TA approach in the field, and recommendations proposed by Braun and Clarke (2019), it was anticipated that the final sample size would consist of approximately 12 to 15 individuals.

Until recently, the concept of ‘data saturation’ was commonly discussed by researchers when determining the end point of qualitative data collection. Saturation refers to the point at which no new information or codes are discovered (Saunders et al., 2018), and consequently has been criticised by scholars for its ambiguity, with many questioning whether saturation can ever be achieved (Vasileiou et al., 2018). Instead, ‘data adequacy’ has grown in popularity, describing the point at which enough data has been collated that provides “information richness” across participant accounts (Braun & Clarke, 2022, p.16), which overlaps with the notion of theoretical sufficiency (Dey, 1999). Indicators of data adequacy draw on concepts from saturation, including the point at which a minimal amount of new codes are constructed during analysis (Clarke & Braun, 2013; Guest et al., 2006). Therefore, determining the end point of interviews was guided by data analysis, drawing on concepts of data adequacy and theoretical sufficiency, with a total of 15 interviews completed.

2.3.2 Eligibility Criteria

A series of inclusion and exclusion criteria were applied in the presented study. An overview of each criterion, with corresponding justifications that guided these decisions during the design phases of this project are outlined below.

Inclusion criteria:

1. Mothers/Birthing people aged 18+ who had given birth at full term (i.e., 37+ weeks) in a UK hospital within the last five years (i.e., since 2018).

Rationale: Individuals must be aged 18 or over to give informed consent. It is recognised that birthing people may become pregnant or give birth before the age of 18, however legislation and guidelines for obtaining consent and sharing of information is modified for those individuals. As consent forms a crucial element of RMC and existing literature regarding experiences of mistreatment, inclusion of those aged less than 18 sits outside the scope of this study.

Infants born at <37 weeks before their due date are categorised as premature. Care pathways therefore differ for this group, and it was therefore decided that experiences of premature births would need to be considered as a separate population, again falling outside the scope of this study.

As explored extensively within the introduction sections of this thesis, two key publications regarding RMC and reforming of maternity services have been shared in the last five years: the Intrapartum Care Model for Positive Births by the WHO in 2018 (Oladapo et al., 2018; WHO, 2018) and the NHS long-term plan in 2019 (NHS England, 2023). Therefore, to explore how RMC has been experienced and implemented since being recognised by the WHO and NHS, a retrospective cut-off of five years since giving birth was applied.

2. Ability to read and verbally communicate in English.

Rationale: To be able to provide informed consent and communicate with the doctoral researcher who is only fluent in English. This criterion is explored later within the limitations of this study (see section 4.6).

Exclusion criteria:

1. Home Births

Rationale: The majority of UK births take place within a hospital or birthing centre, with only 2% occurring at home (NHS Digital, 2021). Care pathways differ for home births, and whilst some services provide home birth plans, this is not universal and depends on individual facilities. As continuity of care is a key concept explored within the field of RMC, it was decided that exclusion of home births would reduce ambiguity, and likely warrants a separate study. Recognition has been given to this within the study limitations as the experiences explored by individuals within the presented study cannot be applied to home births, this instead suggested as a future direction for further research (see section 4.7).

2. Individuals currently seeking psychological support/therapy for trauma relating to their pregnancy and/or birthing experience, and/or those who experienced birth trauma within the last six weeks.

Rationale: It is well established across psychological literature that exploring a traumatic event/s shortly after it has occurred can have negative implications on an individual's recovery (Brewin, 2001), heightening distress and helplessness (Everstine & Everstine, 1993). As topics included within the interview schedule focused on exploring and revisiting experiences during pregnancy and birth, this may have impacted any normal trauma processing, or that being addressed within therapy, presenting risk of re-traumatisation for the birthing person (Sweeney et al., 2018).

3. Individuals who experienced infant death or unexpected serious health outcomes as a result of pregnancy/childbirth.

Rationale: As topics included within the interview schedule focused on exploring and revisiting experiences during pregnancy and birth, this may have caused distress for individuals who'd experienced bereavement or had serious health outcomes. Further, experiences of care and care pathways for bereavement and/or additional health conditions differ to standard intrapartum pathways offered in the UK, which may have impacted the extent to which the study could address its original aims.

4. Any birthing person personally known by the doctoral researcher.

Rationale: To minimise bias when interpreting data and limit the risk of boundaries between the researcher and participants from being broken.

2.4 Recruitment

Mother's/Birthing people were recruited using a study advert that was advertised on social media platforms (i.e., Instagram, X and Facebook), and shared with birthing and parent organisations (e.g., NCT and Maternity Action). As per the conditions of ethical approval, separate social media accounts were set up for the study on Instagram and X. As this study aimed to recruit a diverse sample of birthing people (i.e., to address the limitations of existing research in the field with predominantly white middle-class mothers (Mayoh, 2019)), particularly those from ethnic minority groups (i.e., due to disparity in birthing and pregnancy outcomes), organisations specifically aimed at these populations were contacted (e.g., fivexmore and the centre for ethnic health research). Details of the study and a link/QR code to the screener survey were provided in writing to all gatekeepers (Appendix I). Whilst the option of recruiting through NHS services was considered, in line with the aims of the thesis, the researcher did not wish for this study to reflect an evaluation of a particular NHS/maternity service. As ethical approval would have to be sought at an individual trust level and given the time constraints of completing a DClinPsy thesis, this did not seem feasible or necessary for this study. Instead, a broader approach to recruitment was taken, utilising social media and contacting birthing organisations.

Purposive sampling can promote rigour and trustworthiness in qualitative research by enhancing the opportunity to match participants with the study aims (Campbell et al., 2020). Therefore, when using this technique, the research selects participants who they believe will be most likely to offer relevant and valuable information (Kelly, 2010). As this research aimed to explore experience and meaning of RMC, and consider how demographic factors may have influenced this, a purposive sampling was selected. To aid this process and determine which individuals to invite to interview, a demographics hierarchy was developed based on the existing evidence base (see Table 1). When applying the hierarchy, the researcher aimed to capture a range of birthing experiences primarily, whilst also including those from various ethnic and socioeconomic backgrounds. A detailed overview of the variables included, and rationale are presented in Table 1. After one month, a total of 71 individuals had completed the screening questionnaire, 11 of whom did not meet inclusion due to currently seeking psychological support for birth-trauma. At this stage the survey was closed, and the recruitment poster was no longer circulated or posted on social media.

Table 1

Demographics Hierarchy Applied to Select Interview Participants

Demographic/Variable	Rationale
1. Birthing experience rating (5-point Likert scale including: Very positive, Somewhat positive, Neutral, Somewhat negative, Very negative)	The primary aim of this study was to explore experiences of RMC. Within the existing literature, establishing RMC is often related to enhancing a positive birthing experience (WHO, 2018). Similarly, more negative and traumatic birthing experiences have been discussed in the context of mistreatment, coercion and disaffirmation (WHO, 2018). Therefore, in order to understand the meaning of RMC, and how birthing peoples' experiences related to respect and safety, a range of birthing experiences were felt to be crucial.
2. Ethnicity	As discussed extensively within the introduction, the existing literature has identified groups of birthing people most at risk of experiencing mistreatment and poor outcomes during pregnancy and birth, including higher rates of mortality. Black and ethnic minorities are repeatedly identified as an at-risk group worldwide (e.g., Collins & David, 2009; McLemore et al., 2018), with a recent UK survey highlighting black birthing people were four times more likely, and Asian women were twice as likely, to die during pregnancy and childbirth compared to white mothers (Knight et al., 2023). Existing literature is critiqued for its homogeneity, with the majority including white mothers (Mayoh, 2019). Further, by including different ethnic groups in this

	study, similarities and differences between participants could be identified, thereby addressing the thesis aims.
3. Socioeconomic Status/Deprivation	UK specific research has highlighted that pregnant women living in the most deprived areas are twice as likely to die than those living in the most affluent areas. This was measured using postcodes at the time of birth (Rayment-Jones et al., 2019). Again, to address the secondary aims of this thesis and compare experiences between groups, the index of multiple deprivation (IMD) was calculated and used to select participants from various socioeconomic backgrounds.

2.5 Data collection

2.5.1 Demographic Data

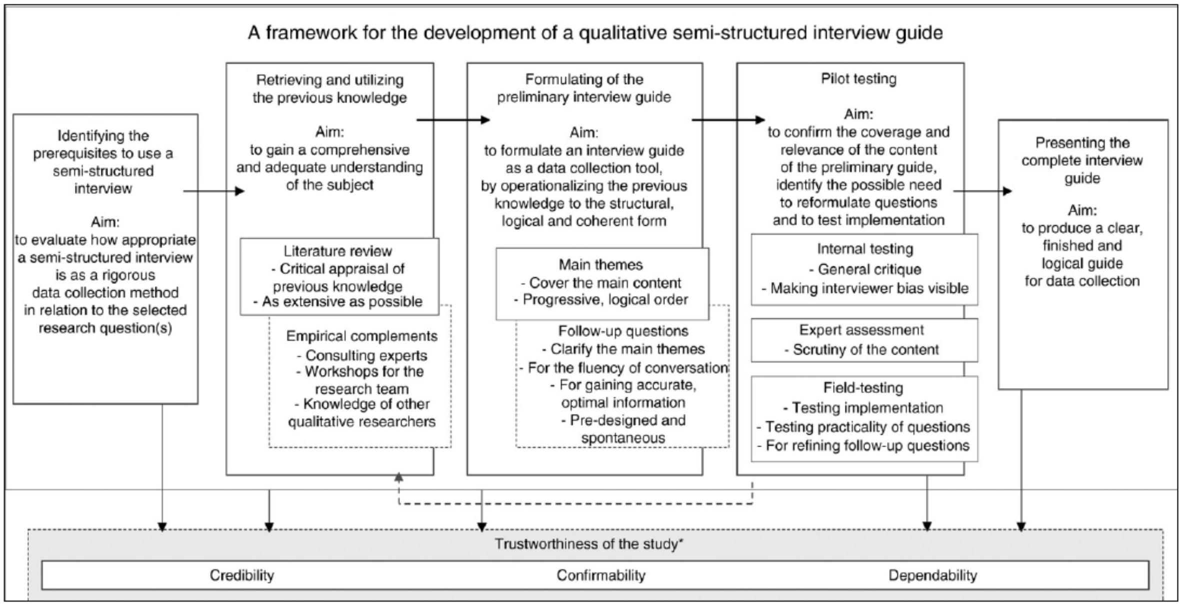
Participant demographics were collated as part of an initial screening questionnaire, which was completed when individuals wished to register their interest to take part in a single one-to-one interview. The questionnaire was hosted via the survey platform ‘Online Surveys - Jisc’, consisting of a series of fixed-response questions that were developed by the researcher based on factors included in the demographic hierarchy (see Table 1). Following collation of consent, individuals were asked to select their ethnicity; age at most recent birth; year/s in which they had previously given birth; postcode based on residence at the time of their most recent birthing experience; and to use a 5-point Likert scale to rate their overall hospital birthing experience (Very positive - Very negative) (Appendix J). Responders were also asked to confirm that they had given birth in a UK hospital setting since 2018; if they were currently seeking psychological support for pregnancy/birth-related experiences; and/or had experienced loss of an infant and/or serious unexpected health outcomes for the infant or birthing person as a result of pregnancy/birth (in line with exclusion criteria – see section 2.3.2).

2.5.2 Semi-Structured Interviews

As discussed in section 2.1, interviews were selected as the most appropriate qualitative method for this study. The researcher devised a semi-structured interview schedule (Appendix J), with pointers designed to target the research aims. To facilitate this process, the framework for qualitative interviews (Kallio et al., 2016) was used, which was devised from a systematic review of the literature regarding strategies used to develop interview schedules. Five key stages were proposed, aiming to enhance the rigour of interview schedules (see Figure 3).

Figure 3

Framework for the Development of Qualitative Semi-Structured Interviews (Kallio et al., 2016)



The interview agenda was devised following consideration of the existing literature and within the domains of RMC and psychological safety (e.g., the Intrapartum Care Model (WHO, 2018) (Appendix A)), alongside the aims of this study. Open questions were incorporated throughout to promote participant-led discussions and reflections, providing deeper understanding of the participants' context and lived experience (Charmaz, 1990). The initial questions aimed to allow the participant a chance to settle and feel safe with the researcher (e.g., summarising their most recent pregnancy and birthing experience), before addressing more personal and potentially sensitive areas (e.g., whether they experienced their care as harmful or abusive) (Appendix K). Whilst a semi-structured approach was taken, the research was flexible throughout, prompting and asking individuals questions specific to their experience to provide a deeper understanding of their care.

As suggested within the interview guide, once the interview schedule had been developed and discussed with the research team, a pilot interview was conducted by the doctoral researcher with a member of the DClinPsy SUCAP. This provided opportunity to reflect on times when follow-up prompts would have been helpful, and to ensure that questions were asked in an appropriate and sensitive manner, with clear and inclusive language. Data collated from the pilot interview was not included in the thesis data analysis due to the individual’s experience not meeting the study inclusion criteria (i.e., giving birth prior to 2018).

2.6 Data Analysis

2.6.1 Selecting Reflexive Thematic Analysis

To determine the most relevant and appropriate method of analysis to apply in this study, several qualitative approaches were considered alongside the questions that this study aimed to address. An overview of each methodology and justifications for selecting reflexive thematic analysis (TA) are provided below.

2.6.1.1 Interpretative Phenomenological Analysis (IPA). Interpretative Phenomenological Analysis (IPA) is a qualitative methodology that provides a deep and detailed exploration of participant’s major life events (e.g., bereavement of a loved one, or diagnosis of a physical health condition). Resultantly, IPA is commonly adopted in the field of health psychology, aiming to discover how individuals make sense of their experience (i.e., ‘meaning making’), sharing similarities with that of symbolic interaction theory (Blumer, 1986). When taking an IPA approach, the concepts of ‘data saturation’ and ‘data adequacy’ are less relevant given that the aims of an IPA study are more focused on the individual case. It is only following individual analysis that convergence and divergence across accounts is considered. Similarly to TA, the role of the researcher is recognised in IPA by “double hermeneutic”, which describes the parallel process of participants making sense of their experiences, whilst the researcher attempts to make sense of their sense making (Pietkiewicz & Smith, 2014).

Given the intensity of the IPA approach, sample sizes tend to be small, typically consisting of 6 - 10 participants (Smith, 2015). Whilst IPA aligns with a CR epistemological position taken in this study, and would offer an understanding of experiences during pregnancy and birth, this study aimed to understand common meanings of RMC and psychological safety, and what may hinder or enhance the execution of these concepts in practice. Considering this, one of the main criticisms of IPA is a lack of exploration regarding factors that may have influenced an individual’s experience, which was particularly relevant for the secondary aims of this study. As my primary supervisor (DDB) had extensive experience of using IPA, we discussed the appropriateness of this approach, and agreed that TA aligned with the aims of establishing a broader understanding of RMC and its associated factors with a larger heterogenous participant pool. Due to the limited research exploring RMC in a UK context, the study aims were intentionally broad to prevent bias or assumptions regarding what may be important for birthing people in relation to respect and safety throughout pregnancy and birth.

2.6.1.2 Discourse Analysis (DA). Discourse Analysis (DA) is a more distinct approach when comparing qualitative methods, with a clear focus on how language is constructed. DA is associated with a social constructivist epistemological position, with the view that reality is formed through social constructs (e.g., language) (Georgaca & Avdi, 2012). As this study did not aim to focus on the language used to develop meaning of RMC and psychological safety, instead focusing on meaning and experiences of these concepts, DA was not felt to be an appropriate methodology. Similarly, DA does not align with the CR epistemological position taken by the researcher.

2.6.1.3 Grounded Theory (GT). Within the field of qualitative research, GT is one of the most widely adopted approaches following its development by Glaser and Strauss (1967). GT is concerned with developing a new theory, and therefore is often utilised within areas that have limited research due to lacking understanding of the phenomenon of interest (Chun Tie et al., 2019). Resultantly, following analysis of participant experiences, GT aims to offer explanations regarding key processes that are pivotal to a specific setting, situation, or experience (Strauss & Corbin, 1994). However, as existing theories and definitions regarding RMC exist (e.g., Intrapartum Care Model (WHO, 2018) and social/behavioural psychological theories of respect (Huo & Binning, 2008; Lind & Tyler, 1988)), this study did not aim to develop a theory from the findings. Instead, understanding how experiences and meaning of RMC converge or diverge within the context of the current evidence-base and consider how this could be adopted to inform future practice and care pathways. Therefore, GT was not considered a suitable approach for this study.

2.6.1.4 Reflexive Thematic Analysis (TA). TA offers a theoretically flexible analytical approach, which can be applied over various epistemological positions (Braun & Clarke, 2006, 2019). Given the independence of TA from theory, it is a particularly useful approach when conducting research in areas where this is a paucity of literature (Braun & Clarke, 2006). Whilst criticism exists regarding how TA is applied, a deep and rich understanding of complex phenomena can result from TA when practiced efficiently (Braun & Clarke, 2013). Further, in response to ambiguity regarding effectively using TA, Braun and Clarke (2019, 2021) responded to common criticism and offered suggestions regarding how these could be addressed in future research drawing on this approach, including when the use of TA may or may not be appropriate. One particular area of importance was the concept of reflexivity, with the authors clarifying that a rigid application of their six-staged approach to TA (Braun & Clarke, 2006) should not be prioritised over a reflexive process. Therefore, the authors noted a preference to re-name the approach “Reflexive Thematic Analysis” (Braun & Clarke, 2019).

TA proposes two main approaches to analysis: inductive and deductive. Inductive is considered a ‘bottom-up’ approach in that codes and themes develop explicitly from the data and are therefore not influenced by existing theory or literature. In contrast, deductive takes a ‘top-down’ approach, drawing on knowledge and theories that have previously been established within the field of interest (Frith & Gleeson, 2004). When taking a deductive approach, the researcher develops a coding framework, incorporating concepts associated with the study area/phenomena of interest (Fereday & Muir-Cochrane, 2006). These approaches can be used in isolation, or TA offers researchers the opportunity to combine both inductive and deductive methods to produce a hybrid analysis (Joffe, 2012). The researcher reviewed Braun and Clarke’s (2022) “typology of suitable research questions for TA” (Appendix L) and felt this approach aligned appropriately with the study aims. In comparison to other analytical approaches, TA was therefore selected based on the research aims and epistemological position taken. Further, given that definitions and models of RMC exist on a global scale, a hybrid TA approach allowed for these to be incorporated, alongside developing a deeper meaning of experiences through inductive analysis. It was felt that a hybrid approach was important for addressing the existing limitations in the field, including the lack of research exploring the meaning of RMC from a birthing persons’ perspective. When conducting TA, the six-staged approach was applied (Braun & Clarke, 2006), including: 1) Data familiarisation; 2) Generation of initial codes; 3) Theme searching; 4) Reviewing of themes; 5) Refining, defining, and naming themes; and 6) Writing-up reports in a report format.

2.6.2 Inductive Reflexive Thematic Analysis

This section offers further details regarding the analytical approach taken, which is to be considered alongside Table 2 of the journal paper. All interview participants opted for video interviews, which took place on Microsoft (MS) Teams. Therefore, the in-built record function on MS Teams was used, with interview recordings automatically uploaded and saved to the researcher's password protected UoN OneDrive account.

Data Familiarisation. When transcribing and checking accuracy, any identifiable information relating to the participant was removed (e.g., if they named their partner, this was changed to (partner's name)). Initial impressions of the data during the familiarisation phase were noted in the researcher's reflective diary and returned to in later stages of analysis. These were also taken to research supervision sessions as a way of recognising any personal biases that the researcher may be applying to data interpretation, which is further explored in section 5.

Generating Initial Codes. When inductively coding the dataset, two approaches to coding are possible: semantic and latent. Semantic coding is considered to take a more descriptive approach, with codes identified based on the surface meaning of participant reflections. Latent instead goes beyond this descriptive level, conceptualising the underlying meanings of the data (Braun & Clarke, 2006, 2022; O'Connor & Joffe, 2020). In the presented study, both a semantic (e.g., 'Birthing partner helped advocate during labour') and latent (e.g., 'Familiarity through companionship offered safety') approach to coding was applied.

Generation of Initial Themes. During candidate themes construction, the researcher aimed to capture patterns and meaning from participant accounts that highlighted something crucial or interesting in relation to the research questions (Maguire & Delahunt, 2017). Codes were considered at an individual level, and then grouped together to form initial themes. For example, birthing people often spoke about the importance of healthcare professionals providing space for their opinions to be voiced and recognised (Appendix M and N). These accounts were constructed into a candidate theme of "Individualised Care: Feeling Heard and Valued". As indicated by this example, the themes at this stage were mainly descriptive in nature. Any codes that did not align with these initial themes were place into a 'miscellaneous' category.

Theme Development. Initial candidate theme ideas from stage three were presented to the research team during a supervision session. The researcher presented a thematic map (Appendix O), and shared a table with codes, example quotes, and candidate themes/subthemes devised in Microsoft Word (Appendix P). Each theme was reviewed individually, with the research team considering questions to help modify and develop as needed (e.g., “do they make sense?”). The quotes were used to guide whether the data coded into this theme was accurate and truly representative of the overarching theme. It was noted at this meeting that the researcher had tried to include all of the data collated, and that it would instead be helpful to hold their research questions and aims in mind to help refine the themes and ensure the participant voice was given equal weight to interpretation across the dataset. Consideration of how individual accounts sat within the broader patterns were considered, with recognition of divergence, and the importance of distinct themes was explored by asking questions such as “am I trying to fit too much into a theme?” (Maguire & Delahunt, 2017). We discussed the idea of *“cutting the cake”* in the context of saliency, aiding the researcher to consider what the most important messages were from the data and how this could be presented in the least repetitive and clear way. Supervisors noted that theme names were often broad, and therefore taking this back to the participants language to ensure the meaning of each theme is captured in the name may be helpful.

Refining, Defining and Naming Themes. Following this team meeting, the researcher returned to the initial themes. When establishing demarcation between themes and sub-themes, the researcher used mind maps to consider how concepts may overlap, and how they could be presented in a way to ensure themes were distinct. To aid this process, the researcher used pointers such as - “what is this theme saying?”; for theme one, the relationship between the overarching theme and the subthemes were considered to ensure these were relatable but also that the narrative of each subtheme was unique; and finally, “how do the themes overall relate to each other”. Following this, the theme of “one size doesn’t fit all” was instead considered to be an overarching narrative of the data, rather than an isolated theme. The researcher returned to the data to consider the most appropriate names for themes, utilising quotes as much as possible to keep this close to participant meaning and avoiding only using one word (Braun & Clarke, 2022).

Writing-up. When writing-up themes, participant pseudonyms were assigned. The researcher considered the existing literature regarding biases that readers may attribute based to pseudonyms (e.g., assuming ethnicity or age) (Corden & Sainsbury, 2006). However, where studies have instead assigned individuals a number or initial, following participant narratives is reported as more challenging due to a sense of depersonalisation (Saunders et al., 2014), and therefore pseudonyms have been used throughout. Participant demographic data was also presented to minimise reader biases by acting as a point of reference.

When writing-up themes, the author was guided by Braun and Clarke's (2022) recommendation that the researcher's interpretation should be balanced with participant quotes. When selecting data extracts, the researcher aimed to ensure representation from all participants across the data set, with the most compelling and meaningful quotes utilised (Braun & Clarke, 2022). Further, one minor sub-theme was not included in the journal paper (JP) due to word capacity and being less related to the research questions (e.g., post-birth experiences). However, the researcher noted the importance of these data, and this has been incorporated within the extended results section below (see section 3).

2.6.3 Deductive Thematic Analysis

To minimise influence of existing theory, the researcher conducted the deductive element of TA secondary to the inductive analysis. To facilitate the deductive analysis, the researcher developed a codebook (Braun & Clarke, 2022), drawing on the definition and components of RMC presented in the WHO Intrapartum Care Model for a Positive Childbirth (Oladapo et al., 2018; WHO, 2018). Further, the researcher reviewed a recent systematic scoping review operationalising RMC at a healthcare professional level to allow for comparisons between existing understanding of RMC from multiple perspectives (Jolviet et al., 2021). The final coding framework applied in this study consisted of 13 codes (see JP Figure 1).

The deductive analysis was completed after the inductive phase, and therefore data familiarisation had already occurred (as detailed above). After producing themes and subthemes, a separate NVivo file was created. All clean transcripts were again imported and re-coded alongside the codebook. Codes were created for each domain of the codebook (e.g., ‘autonomy’), and quotes corresponding to these concepts were coded accordingly. Following this, the researcher created a table in Microsoft word with three headings - deductive code (from the framework), summary of findings relating to that codes, and illustrative quotes (Appendix R) as guided by existing examples of deductive TA (Fereday & Muir-Cochrane, 2006). During this process, the researcher considered how the data aligned with existing models and definitions of RMC, and in inductive findings, recognising convergence and divergence. Extended deductive findings are presented in section 3.

2.6.4 Establishing Methodological Quality

When assessing quality of findings, quantitative research methods refer to validity, reliability, replicability, and consistency. However, these domains are often not applicable to qualitative research, and therefore alternative ways of measuring methodological quality have been proposed. Most commonly, the concepts of rigour and credibility are used in quality appraisal tools for qualitative research (Spencer & Ritchie, 2012). Kitto et al. (2008) suggested six key areas that are important for qualitative researchers to consider to enhance the credibility and quality of their studies. These will now be explored, noting how each domain was addressed throughout the research process:

Clarification and Justification. To establish this domain, researchers are advised to clearly state their research questions and aims, rationale for the chosen methodology (i.e., qualitative), as well as justification for the analytical approach selected. These are presented for the reader’s reference in sections 1.8, 2.1 and 2.6.

Procedural Rigour. The researcher should offer an accurate and descriptive account of how the study has been conducted, including how data was collated and analysed. Recognition of how rapport was built with participants, how data was recorded and stored, and details regarding key decision-making during the research process should be offered. To address this domain, the key questions proposed by Kitto et al. (2008) were considered by the researcher: how participants were recruited; the number and length of interviews/observations required; topics/questions asked during participant interviews; the overarching rationale and scope of the interview; and finally, how data was stored and managed securely. Resultantly, the researcher has aimed to include sufficient detail to address these areas within section 2.5.

Representativeness. This pointer related to the sampling strategies applied, and how this relates to generalisability of the findings. As a qualitative research project, this study did not aim to produce generalisable results, but instead provide a springboard for further research in this field by providing a detailed account of the meaning and experiences of RMC. As detailed in section 2.4, a purposive sampling technique was used, with the aim of establishing representativeness across the domains of ethnicity; SES; and age. Similarities and differences are reported throughout the results, and sample characteristics are provided in Table 3 of the journal paper.

Interpretive Rigour. Interpretive rigour has been compared to the concept of inter-rater reliability and encourages the use of triangulation within qualitative research (Noble & Heale, 2019). Recommendations on how to establish this domain were considered in the reflexive TA literature, with Braun and Clarke (2022) noting that multiple coders are not required. Instead, the primary supervisor (DDB) reviewed the first two transcripts that the researcher coded, with interpretations and the need to provide more accurate descriptions noted. Following this, research supervision meetings were also held throughout the duration of the study and incorporated into the six-stage process of TA, providing opportunity for multiple perspectives to be explored (Liamputtong, 2020) (see section 2.6). Participants were offered the opportunity to review transcripts, however no individuals wished to do so.

Reflexivity and Evaluative Rigour. As established in the naming of “reflexive TA”, reflexivity is a key process for all qualitative researchers to acknowledge. This allows recognition of the researcher’s position, including any biases or experiences that they may have which could influence their interpretations of the data. To address this, the researcher has included a detailed account of both their position (see section 2.1.3) and epistemological stance (see section 2.1.2). Further, final reflections following the conduction of this research are offered in section 5.

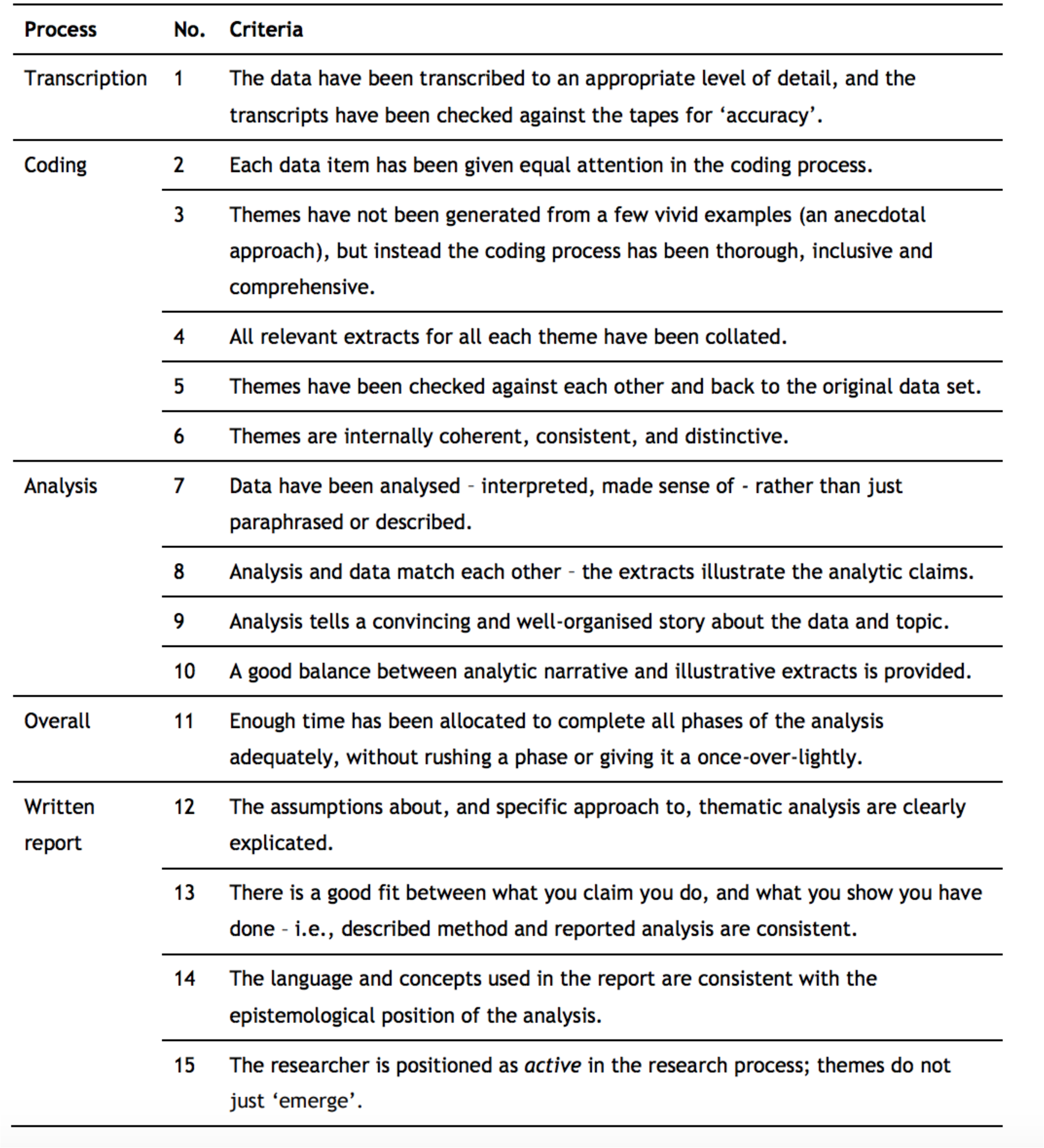
Alongside reflexivity, evaluative rigour considers the importance of ethical considerations and approval. Details of the information provided to participants, how informed consent was obtained, risk of harm and how this was minimised should be explored. These pointers are detailed in section 2.2.5 and a copy of the ethical approval obtained for this study is provided in Appendix B.

Transferability. Finally, Kitto et al. (2008) note the importance of the researcher exploring how their findings may relate to the wider literature, and consequently how these may be applied in practice. Study implications are offered in both the JP and the extended discussion, alongside consideration of the findings in the context of existing theory (see section 4.3 and 4.5).

To further promote rigour in the presented study, 15-point checklist of TA (Braun & Clarke, 2006) (see Figure 4) was used when applying the six-staged analytical approach. Finally, when writing up the study findings, the researcher consulted the 32-item consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) (Appendix S). The COREQ is tailored specifically to studies involving interviews and focus groups, incorporating three key domains: Research team and Reflexivity; Study Design; and Analysis and Findings. Further, in line with the chosen journal and their requirements for submission, the Standards for Reporting Qualitative Research (SPQR) were also consulted for the journal paper.

Figure 4

Braun and Clarke's (2006) 15-Point Checklist for Conducting Rigorous Thematic Analysis



Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

2.7 Patient and Public Involvement (PPI)

PPI was incorporated throughout this study. As noted earlier, a member of the Trent DClinPsy SUCAP was consulted on several pointers regarding the design and conduction of this study, including: type of qualitative approach taken (with interviews selected); study documents (i.e., study advert, information sheet, consent form and demographic screener); and reviewing of the semi-structured interview schedule, including reflections of their experience taking part in a pilot interview. Resultantly, several changes to language were made, particularly times when jargon has been used, or were definitions needed to be provided to aid understanding. Alongside this, given the aim of targeting ethnic minority groups, The Centre for Ethnic Health Research were consulted regarding the study advert and participant information sheets. Following this, the organisation agreed to share the advert across their network.

3. Extended Results

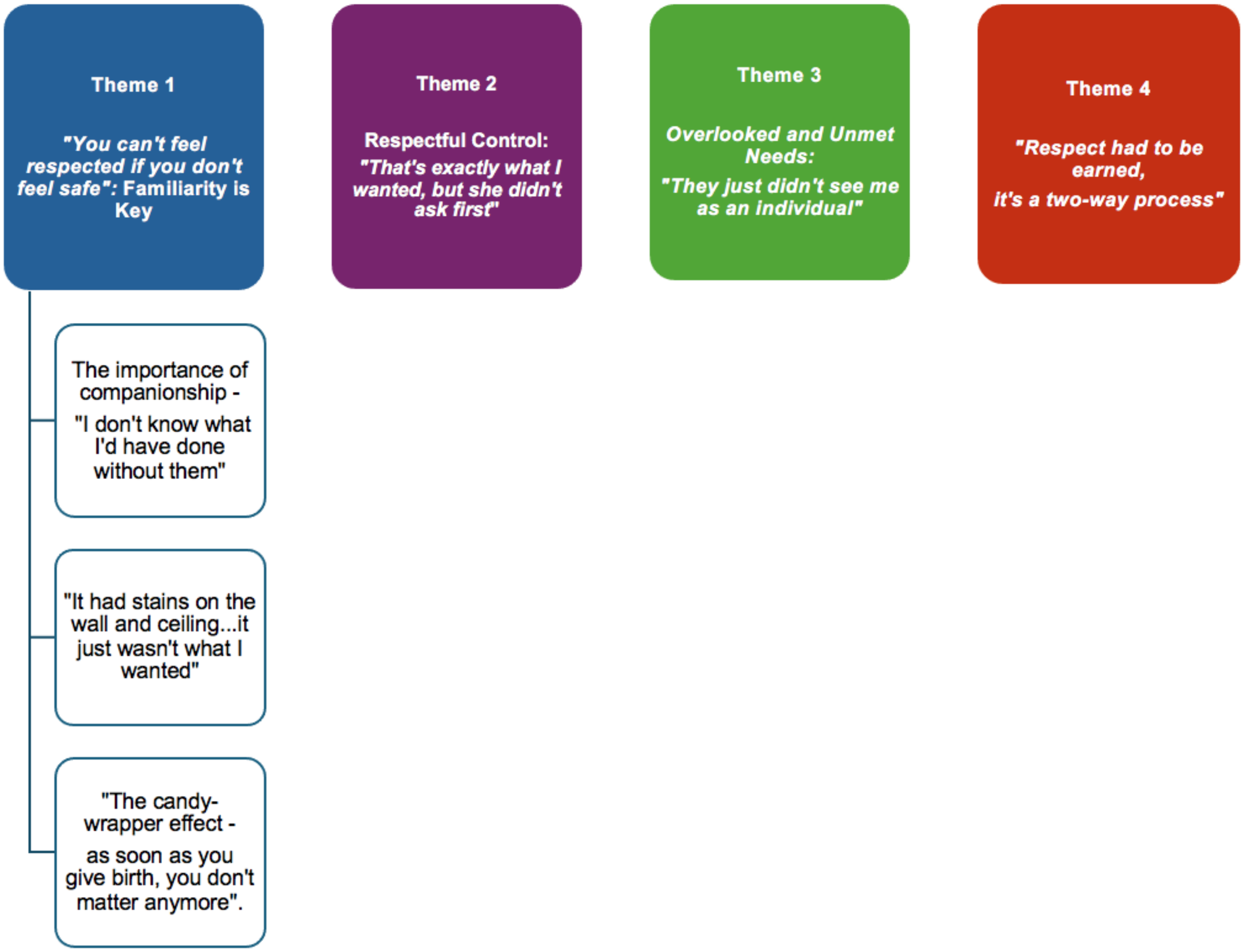
This section offers expansion on the inductive themes presented in the journal paper, including supplementary quotes illustrating each theme. An additional sub-theme is also presented (*“The candy-wrapper effect – as soon as you give birth, you don’t matter anymore”)*. This subtheme did not feature in the main journal paper due to having less relevance to the main study aims which specifically focused on pregnancy and childbirth (i.e., sub-theme explores factors relating to post-birth). Greater detail of the deductive findings is also included.

3.1 Inductive Analysis

Four themes were constructed: 1) *“You can’t feel respected if you don’t feel safe”:* Familiarity is key; 2) Respectful Control: *“That’s exactly what I wanted, but she didn’t ask first”;* 3) Overlooked and Unmet Needs: *“They just didn’t see me as an individual”;* and 4) *“Respect has to be earnt, it’s a two-way process”*. Additionally, three sub-themes were identified in relation to theme one: i) The importance of companionship - *“I don’t know what I’d have done without them”*, ii) *“It has stains on the wall and ceiling……it* *just wasn't what I wanted", and ii) "The candy-wrapper effect – as soon as you give birth, you don't matter anymore"* (Figure 5).

Figure 5

Inductively Constructed Themes and Subthemes from Interviews with Birthing People



3.1.1 Theme 1: “You can’t feel respected if you don’t feel safe”: Familiarity is key

In theme one, both safety and respect were often related to trust, and having a companion (e.g., birthing partner or staff member) during birth promoted safety due to a sense of familiarity. Familiarity with the physical environment also appeared protective, and for some, represented an external representation of whether the birthing experience was prioritised by the hospital and maternity staff, which impacted one’s sense of safety and feeling respected. Post-birth care appeared to be particularly lacking, with a sense of “loss” following a period of regular contact with healthcare services and professionals. Findings are presented across three subthemes exploring different factors that either enhanced or prevented ‘safety’ throughout pregnancy and birth.

Subtheme: The importance of companionship *- “I don’t know what I’d have done without them”*. This sub-theme captures the importance of companionship during pregnancy and labour, with most describing this as a “crucial” element in promoting a sense of safety, with several noting “I don’t know what I’d have done without them” (Maya, Dani, Charlie and Lou). Dani shared that “having (husband) there beforehand (labour), having him there after (birth), it made such a difference to me….I just felt really safe”. Charlie spoke about how her husband had to leave for a short period of time due to being unwell, and that whilst he was away, she felt “scared”, which reduced on his return: “...I did feel better as soon as he was back, I like clung on to him and was just like, don't go again because I need you”. When individuals were not able to have birthing partners present, or staff did not have time for them, which was heightened during COVID-19, individuals experienced distress due to a lack of understanding regarding the labour process and felt that safe and compassionate care was lacking:

> I was told I could not leave the room, I went out three times crying to them (ward staff), saying I'm scared, my contractions are getting worse, I don't know what's going on, when can I see my partner. I felt like a prisoner. And she (midwife) was like, we don't have time for you right now, you need to go back in, we will come to you when we have time. There's only one person right now, and we can't help you. (Aubrey).

Sam, who worked as an anesthetist in the hospital in which she gave birth, interpreted these interactions differently, with experience of working in the NHS appearing to influence lower expectations of care: “there’s something like 52 women and 4 midwives, and I knew those ratios, so I kind of was like, I’m not expecting a great deal here”.

The safety that birthing partners provided often related to having a familiar individual who they knew they could trust. Alex reflected on her ethnicity when discussing this, noting she was uncertain if this had an influence, but may have contributed to the importance of having her partner present:

> There were definitely times where, I don't know if it was necessarily a because of my colour, or because of how I was feeling in that moment and because I was a bit out of it, but I was just really glad to have his support there.

When Casey was asked what respect and safety meant for her, she explained “I do think that continuity of care…having that same midwife”, with Blake sharing that “building a relationship” with her midwife was one of the things she “loved most” about pregnancy, adding that this allowed her to feel safe and respected because “..my midwife could look at me and know if I wasn’t myself…she knew exactly what I wanted”. Jo described how she felt “respected” because their midwife “remembered things I’d told her really early on”. The impact of this relationship was highlighted when midwives were not on shift when birthing people arrived at the hospital after going into labour, leaving them “scared” due to a sense of mistrust with other healthcare professionals due to them being “strangers”.

However, not all birthing people were able to build positive midwifery relationships, with several feeling they didn't have "chemistry", and whilst they felt safe with the individual due to them being "professional", they didn't feel respected as the interactions were only ever "clinical" (Aubrey, Charlie, Jamie and Taylor).

Maya and Sam again shared how their familiarity with staff due to working in the hospitals in which they gave birth promoted safety, which appeared to positively impact their care for which they felt grateful:

> I can't help but feel really privileged that I gave birth in a hospital that I knew the staff….having her (midwife previously worked with) there on that day, and then having her come back in the morning once I'd given birth, that was just really lovely. I just felt so cared for and safe with her. (Maya).

> One of the registrars is a friend, who wasn't working, but said to the registrar doing my operation – oh I know this girl. And a few times when I was sat in the hospital people would say hello. And then the morning I went in I knew the doctor coming off handover. So there was a lot of that…I'd always see someone I knew basically…it did make me feel more looked after and safe yeah, definitely. (Sam).

Another way in which birthing people discussed feeling safer was if staff took the time to introduce themselves, particularly if they were not healthcare professionals that the birthing person had met before. Robin noted that due to the sense of vulnerability they experienced during birth, which was further heightened due to prior trauma, this felt particularly important:

> Like little things like everyone came up to my face and told me their names and who they were. And took their masks off so I could visualise. Like because I had no idea who these ten people were. There was a paediatric consultant there, and

> they were seeing me in my most vulnerable half naked state. So I said to them like I need you to come up to me and tell me who you are, I need to know your name, who you are and what you look like, because I don't know who you are. And if I don't know who you are, I feel unsafe.

Continuity of care developed a sense of trust for most birthing people due to familiarity with the individual and reassurance that they knew the birthing person and would therefore execute their wishes. Birthing partners allowed individuals to feel safe, offering a calming presence. However, when staff were slow to response to needs, and/or partners weren't present (i.e., during COVID), birthing people felt disrespected and unsafe as "no one cared" (Aubrey). Those with experience as doctors, and therefore had existing relationships with staff teams, attributed different meanings to staff not being available, and noted that their familiarity with healthcare professionals positively impacted their care (Maya and Sam).

Subtheme: *"It had stains on the wall and the ceiling….it just wasn't what I wanted"*. Several birthing people shared how the lack of space and resource when arriving at the hospital left them feeling uncared for, which impacted their sense of safety:

> Then they said we don't have space for you, so you need to wait in the hall. So I was standing in the hall with like semi contractions for an hour, just walking around out there. And then I came in and they put me in this tiny little room because there were no beds on the other…I just felt so uncared for and wanted to be at home where I knew I'd be safe. (Aubrey).

When hospital environments were described more positively and in line with expectations, birthing people appeared to relate to this the care they received, which they described as respectful (Blake, Dani, Jordan, Lou, Robin):

> It's (the hospital) just beautifully set up and so it was all really calming and chilled. I had a midwife there pretty much constantly and so as soon as I was moved onto the labour ward, it was just really lush. They were just so supportive and so lovely. (Blake).

The physical environment was also felt to impact birth progression for several individuals, noting that despite having a partner and doula present, "it got so diluted from being in that hospital environment…", which Charlie related to the distinction between the hospital and her home birth set up that she'd hoped for: "...and that's the kind of thing that causes you to need a c-section in itself because labour just totally stalls when you're in that position. It just didn't feel like my own space".

Subtheme: "The Candy-Wrapper Effect - as soon as you give birth, you don't matter anymore". Whilst birthing people reflected on the importance of staff being attentive during pregnancy and birth, several individuals explored how this was "lost" very soon after birth (Frankie, Jo, Lou, Taylor), contrasting with regular appointments and check-ups during pregnancy and birth, leaving birthing people lonely and isolated:

> I just think like it's a shame that it's like, during your pregnancy you get checked, and checked, and checked. But as soon as you give birth, you don't matter anymore. Like no one checks up on the mom after. And it's just a shame. (Lou).

> But yeah, it was really bad. Afterwards I did speak with the health visitors, but no one was screening me really, no one checked up on me like they did when I was pregnant, so that felt really strange to be honest, I felt quite alone. (Taylor).

For some, this particularly linked to their mental well-being. Whilst most felt further support was needed for this during pregnancy (as explored further in theme 3), several individuals indicated that this became enhanced following birth, with a sense that they "didn't matter anymore", despite their mental health "dipping" due to the "tiredness" and "exhaustion" experienced following labour (Aubrey, Casey, Frankie, Jamie, Jo, Lou, Taylor). Opportunity to “debrief” following birth was suggested to promote safety and respect in relation to these experiences:

> Definitely, I think having had a bit of a debrief, maybe not immediately afterwards, but given that I was in hospital for, you know, four days afterwards, I feel like at some point someone could have sat down with us and gone - this is what happened, this is why it happened. And I did have a chat with my midwife when I was discharged, when she came to do like home visits and stuff, and we sort of talked about it a little bit, but it wasn't in any great detail, it wasn't like a formal like, let's sit down and talk about this. (Jo).

Jamie related the lack of post-birth support to perceptions of healthcare professionals regarding what respect and safety means, viewing the fact that her and the infant were “alive” was all that mattered to professionals, which she felt represented a lack of respect for her experience:

> I think it really represents the, what I call the candy wrapper effect, like as soon as you give birth you don’t matter anymore, you're just the lovely candy wrapper for the baby. And if you come out of it alive, we don't care too much about your mental health. Like, that's kind of how I've always felt.

The way in which healthcare professionals communicated regarding the birthing person’s well-being post birth also appeared to impact whether or not the individual felt respected. Similarly to pregnancy and birth being a time of heightened “vulnerability”, this continued to be experienced post-birth, with some healthcare professionals appearing to lack empathy by minimising their post-birth emotions:

> But she also said to me, listen, you need to pull yourself together now, you can't just sit and cry all the time. You need to start thinking positively here. And I was just thinking, you're saying this on the third day, where everyone knows that it’s like the most vulnerable. (Aubrey).

Whilst birthing people appreciated that hospital healthcare professionals may not have the capacity to offer as much support post-birth, the lack of signposting or follow-up services to help “normalise” difficulties with “low mood” and “anxiety” following birth was described as “unsafe” and “disrespectful”, again symbolising that “no one cared” (Aubrey, Casey, Frankie, Jamie, Jo, Jordan, Lou, Taylor). There was a sense that a more transitional approach following intensive support throughout pregnancy would help with post-birth adjustment:

> So like, I didn't really seek any support with my mental health because how do you know if you have a problem? It sounds ridiculous, but like, how do you know that you need support? Because you just think so much is going on. You're so overwhelmed, like being a parent itself is crazy. And you’re like, is this normal? Is this you know, how should this feel and yeah like not knowing what normal means, means that you just crack on and get on with it, because you just think, wow, this must be normal, so I'll just get on with it. So yeah, so I do think there was no, like it did feel very abrupt, especially for the midwifery service because you’ve seen them for like nine months and then suddenly its like, ok, bye! Obviously there has to be a cut-off point at some point, but it just yeah, there was no sort of interim of feeling like if you need help this is who you talk too. (Jordan).

> No, I think the only thing I found quite strange I guess was obviously this was like a huge traumatic major event and then you get discharged by your midwife at like 10 days after birth. And you're not really at that point given any signposting or support like for your own mental well-being y’know? Like we had a health visitor who came to see us, and she weighed him. She must have come back another time but I can't remember, but it was like, yeah, that was the only other sort of professional, if you like. I remember seeing my GP at our six-week check, and again it was just very like a tick box exercise, like there was no discussion really of like what had happened, or like what support you might need. (Frankie).

When post-birth care was offered for a couple of participants, this had a positive impact on birth satisfaction as the individual continued to feel safe and respected due to having someone to contact who they could trust:

> The follow-up care as well, was amazing, that definitely helped me feel safe psychologically. We discharged, and then within two days a midwife was at your house, and then the day after. It feels like, there was always somewhere I could go, I could always call the midwife if I got stuck. (Blake).

Post-birth care relating to breast-feeding appeared to be particularly important, with most birthing people sharing that this was something they "really wanted to try" (Aubrey). Whilst most knew it could be difficult, supporting birthing people to attempt breast-feeding was related to respectful care, which appeared to help adjustment when returning home:

> Because as soon as she helped me, I was like ahh that's what a fed baby looks like. And they were really supportive with the breastfeeding and helping me express and by the time we left hospital, I was breastfeeding, pumping the bear, giving about half expressed breast milk and then half bottle milk too. (Maya).

However, when this was not supported or offered, some felt lost as they "didn't know what to do", which was particularly crucial for first-time mothers/birthing people. Charlie shared how she asked for support, but this was never offered which left her feeling upset following birth:

> Also no one helped me with breastfeeding, no one told me what to do, and I did say I need help with breastfeeding because I have no idea. And I really wanted to breastfeed, it was like the biggest dream that I had. I really wanted to breastfeed.

Offering support following birth, particularly regarding psychological well-being, adjustment to parenthood, and breastfeed allowed individuals to feel safe and respected by healthcare professionals. This was attributed to showing that the healthcare professional cared about their experience, and prevented a sense of isolation after a period of regular contact with professionals and health services.

3.1.2 Theme 2: Respectful control: "That's exactly what I wanted, but she didn't ask first".

Theme 2 explores the experiences of birthing people in relation to whether they felt in control and had a choice during pregnancy and birth, including what factors appeared to influence these domains. Having a choice and voice in decision-making was often discussed in the context of feeling respected:

> I felt like, even though my birth was very medicalised, and I hate that word, because it didn't feel medicalised. It actually didn't feel medicalised. Like when I view medicalised, I view it as someone making the decision for me, and actually for me, I was still making the decisions, so it didn't feel medicalised. (Robin).

> It was his attitude. He came in, he sat on the bed, he spoke to me, he outlined everything – and kind of said, I've been watching your baby in the back room and like monitoring…..but I want to ask you, what do you want? How would you like this to go? (Alex).

Control was also established by regularly checking-in on the individual, whilst also enacting their wishes which led them to feel heard and listened to, particularly when new members of the care team also appeared to follow this, which they related to feeling respected:

> So with respect, it was like, they were asking me a lot about what I wanted, if I was okay, like kept asking how I felt. And they were just really like hands off, which is what I asked for. So it was just like a lot of leaving me be, and listening to my choices really. (Maya).

> They called another midwife in, there was a student midwife as well, and they were all just really respectful of all my decisions, they just let me be, which is what I asked them to do, and yeah it was absolutely brilliant. It was a definite shift from the midwives upstairs who weren't really listening to me, to them who were. I mean the student midwife came and asked me if I was happy for her to be there. (Dani).

At times, choices were limited due to medical needs. When birth plans could not be adhered to due to medical complications, the sense that their preferences and options had been recognised appeared to influence feeling respected:

> The room I had had a birthing pool should I want it, and as soon as I had the epidural that obviously wasn't an option, but it was that thing of it was there should I have wanted it. (Jo).

> And you know he said do you want to go into theatre? And I was like, no, I'm scared to go into theatre, please do it here. So they brought everyone into me…. (Casey).

Style of communication and the language used by healthcare professionals was also related to respect by most individuals. If healthcare professionals used the birthing person's language, or "calm and accessible" language, they were more able to "understand what was happening" (Lou). This offered a sense of control, and the language used appeared particularly protective for allowing birthing people to feel respected even when births didn't go as "planned", with healthcare professionals not rushing conversations:

> I think it was just, she was never rushed, she spent loads of time, just the way she spoke. She spoke very, she wasn’t like dictating or telling us what to do, it was very much like we are in control, we are making the decisions, she’s just advising. She spoke really softly. She was just a really calming personality, which is what I respond to. (Frankie).

Similarly, when birthing people were made to feel that “it wasn’t my fault” that the birthing plans had to change, Robin felt this promoted cohesion by “working together and being on the same team”:

> The doctors came in, and they didn’t describe it as me failing, they said you’re not well, you’ve done everything you can, but your body is exhausted. And I think we are going to need to help you now, and your baby is feeling abit unwell, and we also need to help her now. So they worded in a way that made me feel like we were working together and on the same team, and I remember not getting upset at all because they made me feel like I’d done everything I could. (Robin).

However, this contrasted with experiences of other birthing people who reported more negative births. Aubrey described feeling like “an animal in a cage” as she was told she could not leave the ward, with this lack of freedom and sense of being “trapped” meaning she did not feel valued, and therefore felt her care was “disrespectful”. Jamie recalled an incident in which the language used by the healthcare professional led her to feel “humiliated” and lacking control over the situation due to the power imbalance in that situation:

> Then she said to me, you have too much fat on your belly, so I can't. I can't measure your child's heartbeat. You need to have an electrode on the head, and I was just lying there naked on that bed, feeling so humiliated that she just told me that I was too fat for them to measure my baby's heartbeat, like she could

> have said it in so many different ways. But because of the situation, I couldn't say anything, I just had to lie there and let them carry on.

A few birthing people offered views on why medical professionals may not provide opportunity for the individual to voice their wishes, including the idea that this culture of not asking has been "normalised" (Robin), which appeared to be heightened in hospital environments due to power imbalances between birthing people and healthcare professionals:

> When you go into hospital care, people will just come in and touch your body, or touch your child, without saying anything, introducing themselves, saying who they are, or what they are going to do. For me, that just makes complete sense to why you would, but it's just become normalised….but in a medical setting, you can grab me and you can do this and do that, and it's in a clinical room so the power imbalance is so much stronger in clinical settings that are even more medicalised. (Jordan).

For some, control also appeared to link with time and allowing space to process and make decisions. For example, Charlie shared that whilst their midwife had provided this, the consultant didn't due to their birthing options being delivered as "an ultimatum" and not given appropriate time or space to decide, which again meant they lacked control and therefore didn't feel valued/respected:

> But at that point I was sort of sat in front of this consultant, and she sort of said "yeah, so baby is still measuring big, you can either have, we ideally want you to have the baby at 39 weeks and you can either have an induction or you can have a c-section, so what do you want to do?". And it was just put very matter of fact, like you've got to make this decision now – and I was kind of like, what?! Because I'd gone to that appointment thinking I was really going to get the opportunity to discuss things with the consultant, have that conversation with them, come to an agreement about what would be the best option for me, or

> maybe even be sent away and asked to think about it and get back to them. So that was my first kind of, I guess poor experience, it was very matter of fact, you've got a choice one or the other, if you want to take a couple of minutes to chat to your husband about it just pretend I'm not here, and I was a bit shell shocked. (Charlie).

Those with medical backgrounds (i.e., Sam and Maya) tended not to view the need to make "quick decisions" as disrespectful, reflecting that they could understand why this was important from both a health outcomes perspective, as well as more systemic impacts such as limited staffing, time for appointments, and bed space. Interestingly, Jordan related their right to control and involvement in decision-making being reduced due to not paying for healthcare in the UK, and whilst they felt listened too, shared a sense of apprehension regarding challenging decisions given the lack of cost:

> So if I was paying I'd expect them to be a lot more, like listening to what I would want if that makes sense. Not that I felt they didn't listen to me, I just didn't even dispute it because I thought I don't want anyone to be annoyed. I just want to get the baby out, like I wasn't too fussed on anything else. I think if you're paying then you have more like demands and rights if you know what I mean.

Whilst some felt respected during pregnancy due to care feeling "individualised", this appeared to shift when they came to hospital during labour as it was "one in, one out", which left Lou feeling that if she voiced her preferences, they would be less likely to listen or be considered:

> Yeah, I definitely felt like I was on a conveyor belt once I was in a hospital. Like up to that point, I'd felt like it was individualised care and it was about what I needed and what I wanted and what I was doing. And then once I was in a hospital, it felt like, if I kicked up a fuss, it was gonna be harder to like get what I wanted if that made sense or at least that's my experience anyway. (Lou).

Finally, some individuals shared experiences of healthcare professionals making decisions that aligned with their preferences, however when this was assumed and the birthing person wasn’t asked, these factors appeared to matter less and instead being asked appeared to be more crucial due to providing a sense of control, and consequently respect:

> It sounds really silly, but the midwife turned off the radio and turned off the lights and put like a light projector on, which was lovely, that’s exactly what I wanted, but she didn’t ask me. I just remember noticing that at the time that she didn’t ask me how I wanted this room to be…like I was expecting to be asked, but I wasn’t. I remember feeling like I didn’t have a choice regardless, which I didn’t like. (Casey).

A couple of birthing people discussed opportunities that they “missed” soon after birth due to healthcare professionals not asking what they would like to happen, and just assuming they were “too tired” (Frankie) to do certain things (e.g., chest-to-chest) which left them disappointed in their care. Aubrey felt particularly angry about this, sharing:

> Also, one thing that annoyed me was the first nappy I didn't get to change. A midwife just changed it for me without asking me, she just changed his nappy. And I was like, okay, that was my baby's first nappy, it was something I would like to do.

As a result of these experiences in which birthing people experienced a lack of control and choice in the decisions made, those who had experienced another birth and/or pregnancy discussed how this changed the way they acted and prepared. Some individuals spoke about using “hypnobirthing” to help gain a sense of control, whilst Taylor shared that she “pushed back” after her previous experience that resulted in a distressing and painful experience:

> They then said, and again probably on reflection, which is why I think on my second birth I pushed back a lot more. So then they said ok, we will examine you now. So they didn't ask if I wanted them to examine me, it was just that they would do it. So I was like ok, fine. And it was horrendous, the pain, I was being sick at the same time, I was contracting, it was just awful.

3.1.3 Theme 3: Overlooked and Unmet Needs: "They just didn't see me as an individual".

Theme 3 captures reflections from birthing people in which the meaning of respect was explored in relation to feeling accepted, with positive interactions with healthcare professionals attributed to being seen as an individual, rather than a particular demographic:

> But I got told off by the midwife for calling myself a geriatric mum, she was like "you do not call yourself that", which was quite nice actually, that was a really nice thing because she was like you absolutely do not call yourself that. You're (Maya), and that's all that matters.

By naming and showing an awareness of different birthing outcomes for different groups in the UK, individuals felt respected as they believed this represented the healthcare professional wanting to change these statistics by openly discussing them and recognising that these may be a concern for the individual during their pregnancy and childbirth:

> And then also as a national thing across the UK, for example black and mixed-race people, the stats show you're more likely to have trauma in your pregnancy and birth if you're a black woman. But showing they acknowledge that, and saying we've done this, this and this. And this is what we do to make people feel more respected and comfortable. Because that would make someone feel more valued. (Alex).

For those identifying as black and ethnic minority groups, most felt frustrated that there was no recognition regarding poorer birthing and pregnancy outcomes for their communities indicating a lack of acceptance, which they felt demonstrated disrespectful care. Several birthing people felt that these conversations would be easier if there was greater diversity within the workforce:

> With midwives, like if you see someone who looks like you or represents you, you feel more comfortable. That's a whole different thing or process though. Like if you go to an appointment and you feel like you know what they are talking about, it makes it easier to trust them and more respectful. So I think those sort of things help. But you can't tell them to train more black people or whatever can you. (Jordan).

Whilst Jordan could not afford private healthcare, she shared how several of her friends had "paid to have like private hospital maternity care and made sure their midwives and all the staff were all black", which she felt would enhance respect and is needed in the NHS to promote fair treatment. Jordan shared similar views regarding a diverse workforce, however she explained that further support is needed to make midwifery more accessible for marginalised groups:

> Yeah, I mean I've got a situation at the moment where I've got a baby, and I had a conversation actually yesterday about this with my health visitor. And I was saying I would love to be a midwife, and I'm sure there's a lot of women who would love to be a midwife, but the circumstances of how things are set up in terms of the system for people in certain communities, it's not easy. It's expensive, and like with childcare, and I've got to balance childcare in order to be able to do that. But my health visitor said she trained at 33 to be a midwife, and she's 39 now as a single parent. And I think if they did things were they could entice people from certain backgrounds to do that, I think that would help, and then it would be tackling that barrier, and then bringing these minority groups into

> these kind of roles. Then people would feel more respected because they'd have people that basically are like them working in the role.

This appeared to be reinforced when Jordan attended a follow-up appointment, and the healthcare professional showed limited knowledge regarding her heritage, expressing disappointment that she had to explain about marks on his skin that are related to his ethnicity:

> I'm just trying to think about my son as well as I think there was an incident after he was born and they had to do all his tests and stuff. And he had to have a different test because of his heritage, and I think I had to explain to someone about that because they didn't know. I was like oh it's because of this. I think it was to do with his mark, because he's black, well mixed-race, they have like bruising on their skin and sometimes people don't know things like this. Like my friend had a similar incident as well because she's given birth recently. But they were just like oh let me just google how to spell the word 'melanin'. And it's just like those are common words, come on!

Similar feelings were expressed regarding the lack of regard for the birthing person's mental health during pregnancy and childbirth. Whilst birth plans and preparation groups offered by some services helped understanding of "the anatomy side of stuff" (Casey), Frankie recalled that acknowledgement of mental health was lacking: "how can you have birth preparation and not talk about someone's mental health? Especially during pregnancy when your hormones are just everywhere!". Robin was under perinatal services during pregnancy due to existing mental health difficulties, but noted that offering this as a more "universal" approach would allow people to feel respected and protect against birth trauma:

> But when I speak to other people who gave birth around that time, it's very different, no one gets asked about their mental health. I understand they didn't have the complexities that I did….I think that's a big thing, because I actually got

> a gold card there, however I had to experience horrific things to get it. And I think it’s a shame that some people don’t have trauma, but ironically will then get trauma because they then aren’t respected in their care. And then maybe will get a card for the next birth, but it just feels like a self-fulfilling prophecy that we are just always instilling trauma to get help, and then it’s kind of like well if you’re really that bad we will give it, so it’s like pushing you to the edge.

3.1.4 Theme 4: “Respect has to be earned, it’s a two-way process”.

This theme explores the idea of RMC as a transactional process. For some, respect was deemed to be a two-way process, which Maya and Sam particularly recognised as NHS doctors themselves. The potential influence on healthcare professionals who knew their job role was discussed, and how the healthcare professional may feel less experienced in comparison or expect them to undermine their roles, but showing kindness and compassion towards them allowed for this to be reciprocated:

> I think if you go into a hospital as a doctor, some people can be arseholes. They can be like – oh I know what’s going on, and it can put the person looking after you on the back foot. And feel like they don’t enjoy looking after you because they don’t feel they can show any vulnerability. I think it’s best to be a bit nicer and a bit softer. Like when you’re like that with them, they show that back, and then it’s like you’re both respecting each other if that makes sense? (Sam).

> I don't know, maybe because you’ve got an insight into how busy like hospitals are you, you’re just a bit more patient and less demanding. I think I made a conscious effort to be a bit more kind to the staff and maybe that’s why they showed that back to me.... (Maya).

However, some birthing people felt that respect was not reciprocated, which appeared to influence decisions during their next pregnancy. Whilst Taylor felt it was important to see how she was treated at a new hospital with new healthcare professionals and give them “the opportunity to earn my respect”, when she was made to feel that her well-being wasn't of the same importance as her infant's health, which left her feeling disrespected, she felt determined not to give birth in hospital again:

> I did go for one consultant appointment cause I was like, well, it's a different hospital, different consultants like give them an opportunity. And she was doing quite well, like she was talking about like, you know it must have been really awful the first time around, like I can see how that would have been really terrible for you. And then she said towards the end that she recommended that I either have an elective c-section this time, or I have a hospital birth with like all of these monitoring things in place. And I was like, OK, I respect your opinion, but I'm planning a home birth….And then she said I noticed in your notes that it says something about birth trauma. And I was like, yes, my first birth was extremely traumatic and like left me with lasting damage to my psyche. And that required a lot of therapy. And she went "ohh, but your baby was fine". And I genuinely at that point I just wanted to punch her in the face and was just like – oh, I I forgot that's all that matters. Like yeah, that was the point at which I was like, Nope, Nope. I'm not engaging with this again.

Healthcare professionals showing respect towards birthing partners also appeared important in the birthing person feeling respected. For some, this included partners "being offered a cup of coffee" (Lou) and Casey shared how the midwife provided her partner a blanket for her partner as the room was cold, which she "thought was lovely". However, when healthcare professionals showed a disregard for partners and didn't include them or ensure they were present for certain procedures, this left birthing people upset and anxious which Jo described as an "example of when we both weren't respected":

> She (midwife) was like yeah he can, yeah he can come in. But then when he tried to come in, they wouldn't let him. It was just ridiculous. So she just carried on anyway. So I was a bit frustrated by that and then I ended up just like, yeah, I remember going to the toilet and just having a massive cry just to try and get it

> out of my system and like, try and deal with all the anxiety which didn't really work.

The notion of “self-respect” and how this influenced respectful care from healthcare professionals was proposed by a few individuals. Lou expanded on this, explaining that because “I have respect for myself, and I know what I deserve, I’m then able to exert that from those around me”. A sense of self-respect consequently appeared to influence empowerment during pregnancy and birth:

> I think I really know myself, so I really respect myself because I know what I stand for and I know what I value in my life. I do it in a respectful way, but having that respect for me was really helpful, because I knew even if others didn’t treat me respectfully, that wouldn’t stop me respecting myself which is the most important thing when talking about respect in my opinion. (Alex).

3.2 Deductive Analysis

When applying the deductive framework, all deductive codes were evident in participant accounts. As detailed in the WHO model of Intrapartum Care for positive childbirth experiences and reviews of global RMC (WHO, 2018), the importance of dignity and respect was commonly identified, relating to feeling accepted and recognised as an individual. These accounts overlapped with the domains of ‘non-discrimination, equality and equitable care’ and inductive theme three, in which achieving equality and equitable care for all required acknowledgement, acceptance and naming of differences. These deductive domains were most often discussed by birthing people from BAME backgrounds.

In accordance with recommended practice (Oladapo et al., 2018; WHO, 2018) reports of harmful and abusive care were minimal, suggesting this domain of RMC had been achieved for most. One example of harmful care occurred outside of a maternity setting (i.e., during a visit to the emergency department during pregnancy when the individual felt suicidal). One birthing person felt mistreated when they were humiliated for being overweight and told they must have electrodes on their baby’s head because of this, overlapping with previous literature in which birthing people categorised as overweight will experience at least one negative interaction regarding their weight (DeJoy et al., 2016), and other domains of the deductive framework (i.e., dignity, respect, and autonomy).

Whilst continuity of care was important, this was mainly related to continuity of carer rather than consistency in sharing of information between professionals, which is recognised in existing RMC guidance (WHO, 2018). This related to a sense of familiarity which allowed birthing people to feel safe. However, the deductive code of continuous access to family and community support recommended was limited in the data, and similarly to findings which led to this domain being suggested in the WHO model (i.e., Shakibazadeh et al., 2017), individuals spoke of disappointment with post-birth provision. However, unlike Oladapo et al. (2018) practice recommendations, psychological safety was mainly attributed to companionship and familiarity, rather than whether or not the individual received postnatal care for a minimum of twenty-four hours. However, the need for longer term follow-up and support post-birth for maternal well-being was evident.

Companion of choice was frequently discussed, however given the recommendations of RMC were devised before the COVID-19, the impact of this time on preventing companionship was highlighted. This often impacted safety and well-being of the birthing person, highlighting the importance of this domain within existing recommendations of RMC.

Factors influencing control that were identified inductively in theme two may be considered in the deductive domains of ‘autonomy’, ‘informed choice’, and ‘effective communication’ (WHO, 2018). In particular, offering choice during decision-making promoted autonomy, and was enhanced when healthcare professionals communicated effectively by adopting a calm nature and used accessible language.

In alignment with inductive findings, the need to enhance the quality of the physical environment and resources was evident and appeared key to establishing respect and safety. This domain was identified in a qualitative synthesis of global respectful care in health settings (Shakibazadeh et al., 2017), and was often attributed to establishing a calm environment with adequate space in the presented study.

In summary, deductive findings highlighted that separating into the domains of RMC was often difficult, with overlap evident across concepts of RMC currently recommended. For example, distinguishing between the domains of ‘autonomy’ with separate domains of ‘informed choice’, ‘autonomy’ and ‘respecting choices and preferences’ was not possible. This suggests the meaning and method of achieving these factors differs at an individual level, and therefore a person-centred approach to these recommendations for practice is key, echoing the inductive findings that “one size doesn’t fit all”.

4. Extended Discussion

4.1 Person-Centred Care

Person-centred care is embedded within healthcare systems globally, including the NHS, and focuses on individual care needs by incorporating personal wishes, values, and preferences in clinical decision-making (Coulter & Oldham, 2016). Adoption of this within maternity care is recommended, particularly as a way of showing respect and compassion towards birthing people (WHO, 2018). However, findings in this study suggest that some individuals did not feel central within their care, particularly those from ethnic minority backgrounds and/or living in areas of greater deprivation. This may offer further insight into worse outcomes during pregnancy and childbirth for these individuals (Knight et al., 2023; Rayment-Jones et al., 2019), which increase when negative interactions with healthcare professionals are experienced. This may be understood when considering unconditional positive regard (UPR), which is commonly related to respect and promoting mental well-being of patients (Bhanji, 2013) by accepting individuals regardless of values, behaviours, or viewpoints. Whilst this is universally recommended across care and therapeutic settings, this study highlights why this is crucial within a maternity context, particularly for minority groups. Findings suggest that UPR is related to respect and safety, with a specific need for acceptance of differences to be verbalised and/or externally represented for these individuals to be acknowledged (e.g., through healthcare professionals discussing minority outcomes and tailored resources for specific cultures).

The impact of companionship and a sense of familiarity with healthcare professionals was explored in this study, suggesting continuity of care was particularly relevant to RMC and psychological safety in a UK maternity context, with reports of feeling cared for when professionals remembered information. The midwifery continuity of care model was introduced as a means of addressing reports of higher birth satisfaction when individuals have the same midwife throughout pregnancy and birth (Forster et al., 2016; Sandall et al., 2016). Previous literature has evidenced an increased risk of negative or traumatic births when emergency deliveries or birth complications occur (Simpson & Catling, 2016). Research notes that the need to transfer environments is common during hospital birth, particularly for caesarean and emergency deliveries. With every change, safety of the birthing person may be negatively impacted due to discontinuity of care and poor explanations of what is happening (Stichler, 2007). This study offers further understanding of why these experiences may be particularly impactful. When considering reflections of birthing people, these changes are likely to impact the sense of control that individuals desired in order to feel respected and safe, which most commonly related to involvement in decision-making. Further, if changing healthcare professionals and familiarity with professionals and/or the environment is lost, safety and respect is likely to be impacted. Therefore, offering opportunities throughout pregnancy to build familiarity with hospitals and maternity services (e.g., hospital tours/visiting labour wards) and trust with staff (e.g., meeting the maternity staff) may be beneficial.

A recent systematic review highlighted the continuity of care approach offers fulfilment for midwives with opportunity to develop meaningful relationships, however maintaining a work-life balance can be challenging due to the intensity and availability required (Pace et al., 2022). Therefore, when implementing relational models of care, both the needs of birthing people and midwives require consideration, with organisational and managerial backing to promote sustainability (Pace et al., 2022).

4.2 Psychological Safety

Findings also highlighted that a sense of familiarity through companionship was key to promoting safety and respect throughout pregnancy, and particularly during labour when birthing people felt particularly vulnerable. Similarly to existing literature, birthing partners played a key role in advocating (Alruwaili et al., 2023). However, this study uniquely highlights the impact of when they were not able to attend appointments or be present during labour, which was particularly relevant during COVID-19, birthing people felt unsafe and disrespected which caused increased distress. On reviewing definitions of “obstetric violence”, this adds an additional layer to aid understanding of why these experiences are particularly harmful, with these concepts frequently explored in the context of safety, respect, trust, and feeling valued. The “birthing alone” policies adopted during the COVID-19 pandemic have since been questioned in the context of ethics and patient safety, with conclusions that the omission of birthing partners during this time was unwarranted, with the harm caused outweighing the benefits (Friesen et al., 2021) which accounts in this study appear to indicate. A lack of professional or partner support heightens fears of childbirth, particularly amongst immigrant birthing people and those birthing in a foreign country (Migliorini et al., 2016; Rania et al., 2018). This offers an important point for future consideration if situations should arise in which the involvement of birthing partners may be limited (i.e., pandemics), or for individuals who may have no access to partner or family support.

Increased staff presence has also been shown to enhance psychological safety amongst patients (Kenward et al., 2017), which was echoed in this study, and opportunity for companionship is also proposed in the Intrapartum Care Model (WHO, 2018). The importance of familiarity with the companion proposed by birthing people in this study shares similarities with the literature regarding transitions in healthcare settings. When supporting paediatric patients in transitioning to adult services, individuals and parents have expressed worries regarding the ‘unknown’, including fears of trusting new staff. Strategies such as transitional clinics in which patients meet members of their new medical team help reduce anxiety (Coyne et al., 2019). Therefore, offering similar opportunities for birthing people and their families during pregnancy may be helpful for enhancing familiarity with both staff and the physical environment, building safety and resultantly respect.

High-quality support from professionals during birth has been evidenced to increase birth satisfaction and a sense of control for birthing people during labour (Attanasio et al., 2014; Hinic, 2017). Psychologically safe environments and RMC both incorporate the importance of patients having autonomy and control regarding decision-making (Downe et al., 2018; Martínez-Galiano et al., 2021; Oladapo et al., 2018), and when omitted this may be considered indicative of 'obstetric violence' (Bravo-Moreno, 2021; Diaz-Tello, 2016). The presented findings offer a greater understanding of the ways in which this can be achieved by healthcare professionals working in maternity care. Our findings further support the concept of choice when delivering RMC, which appears to be more important than adherence to birth plans and presents a potentially protective factor when changes have to be made during labour. This further supports the recent criticism from the RCM regarding changes to NICE guidelines for those considered to be 'high risk' during pregnancy (Brigante & Harlev-Lam, 2021), particularly when aiming to promote RMC. Hauck et al. (2007) corroborate these findings, suggesting that when changes to birth plans are required, the extent of choice and control that the birthing person retains is key to preserving a positive birth. Interestingly, whilst male birthing partners in Sweden also valued their childbearing partners involvement in decision-making, partners found it helpful when the responsibility and choice regarding mode of birth was placed onto the healthcare professionals rather than themselves (Johansson et al., 2014). This indicates potential difference in the needs and wishes of birthing partners during birth, and given their key role in advocacy described by birthing people in this study, warrants further exploration in a UK setting.

4.3 Respect: Theoretical Understanding

Transactional models of stress and emotion (Lazarus & Folkman, 1984; Smith & Lazarus, 1993) propose that extent of a stress response is mediated by one's appraisal of the situation, as well as the availability of support from others. Findings in the current study suggest similar processes may be relevant for respect and safety, with the birthing person's appraisal of healthcare professionals actions and behaviours impacting whether they felt respected and/or safe. For example, some individuals felt that not seeing staff for a certain time meant they didn't care, whilst others understood this as them being busy and they would be there if they really needed them too, highlighting contrasting appraisals. Further, individuals with less social support are more likely to experience poor psychological health and higher levels of stress (Murfield et al., 2020), which may offer an explanation as to why birthing partners were particularly critical in allowing people to feel safe, and why birthing people felt upset and stressed when they weren't present (i.e., during COVID-19).

Information that is considered helpful and trustworthy promotes empowerment and acts as a means of support for birthing people (Catling-Paull et al., 2011; Lagan et al., 2011) Primiparous birthing people in this study discussed initially trusting professionals, but when rushed to make decisions and experiencing a lack of control, this was disrespectful. This was heightened post-birth when individuals gained further information about the methods and options presented, with a sense of coercion and lack of control due to the realisation that not all avenues had been explored. Self-efficacy refers to an individual's belief in their ability to successfully complete a particular task, which requires self-confidence to gain control of one's motivation, behaviour, and social environment (Bandura, 1997). Consequently, self-efficacy has been widely used as a predictor of health behaviour (Lenz, 2002). When considering self-efficacy literature relating to childbirth, it has been shown to reduce anxiety and fear of childbirth experienced in the perinatal period (Khorsandi, 2008) Further, limited knowledge of childbirth correlates with lower rates of self-efficacy (Schwartz et al., 2015), which is more common in first-time mothers. This study builds on this previous understanding by highlighting the importance of control during pregnancy and childbirth, and how this can be achieved through involving birthing people in decision-making and providing accurate information even during times of medical complications. In doing so, this offers opportunity to increase birth satisfaction, even during times when plans and expectations require diversion. Further, tailoring information and resources to specific communities may offer greater chance of empowering minority groups.

Birthing people reported that if they were not treated with respect by healthcare professionals, they had considered changing their style of communication and behaviours during their second pregnancy/birth by being more assertive. This enhanced confidence to exert control in future birthing experiences may indicate greater self-efficacy (Bandura, 1997), which increases birth satisfaction (Ramie et al., 2014), and is higher among multiparous women (Schwartz et al., 2015). Self-efficacy is also highly relatable to self-esteem, which encapsulates one’s view of their own self-worth (Bandura, 2006; Mohajer & Earnest, 2009). The idea of respect as transactional was also explored in the context of self-respect, which has been proposed as a component of one’s self-esteem (Clucas, 2020). Lower self-efficacy and self-esteem reduce quality of life (Peters et al., 2019), and are associated with poorer mental health (MacInnes, 2006). Further, increased self-efficacy can lead to improved perinatal outcomes, including reduced emotional and cognitive distress (Tilden et al., 2016). Given the importance of birth satisfaction, control and self-respect in establishing RMC, as demonstrated in this study and wider research (e.g., Fair & Morrison, 2012), initiatives targeting development of self-efficacy/esteem for childbearing people warrant further exploration, particularly for primiparous individuals.

Reports of healthcare professionals seeming disinterested and spending minimal time with the birthing person may be explained by the social defence paradigm within psychodynamic literature. Menzies Lyth (1988) suggested that due to high levels of stress and anxiety experienced by healthcare professionals, defence mechanisms develop to aid managing these difficult feelings. Consequently, defence strategies minimise engaging with the patient as a whole, instead prompting a more detached approach as a means of self-protection. Evidence suggests that this is something that develops over time when working in healthcare settings, with GPs reporting progressive alienation from service users. As a result, organisations need to consider how to support the psychological elements of healthcare professional roles to address both the patient and professional impact that is observed (Napier, 2017). Whilst healthcare professional’s experiences were not collated in this study, the perceptions of birthing people regarding staff appearing burnout and, in some instances, lacking attentiveness, offers further insight regarding difficulties in delivering RMC and possible retention difficulties in the midwifery field (The RCM, 2018).

The experiences of the two participants in this study who were doctors offers a unique lens to understanding of RMC, who for the majority of their care reported feeling respected, which may relate to social and behavioural views of respect (Huo & Binning, 2008). Within these models, respect is conceptualised as a symbol of power and status, and therefore having experience as consultants in the healthcare system may have influenced their treatment. Interestingly, one doctor identified as an ethnic minority, and having a white male companion was key, which when considering societal views of power and status, this may offer further explanation as to why this promoted safety given evidence which suggests white males are more likely to be heard and respected (Lynd & Tyler, 1988).

The multiple factors explored regarding what constitutes RMC and promotes psychological safety in a maternity setting particularly aligns with a biopsychosocial model of health (Suls & Rothman, 2004). This approach captures the influence of biological, psychological, and social-environmental domains on an individual's health and risk of disease (Engel, 1977). Accordingly, biopsychosocial models are commonly adopted in healthcare settings, for example in coronary heart disease, psychological (e.g., depression) and social factors (e.g., socioeconomic status) have been correlated with mortality and morbidity (Krants & McCeney, 2002). By understanding the influence of these additional domains, the importance of psychosocial interventions for enhancing patient care and well-being have been recognised, with additional economic benefits when applied in cancer care (Carlson & Bultz, 2004). However, the omission of biopsychosocial considerations in childbirth literature and maternity care has been critiqued (Saxbe et al., 2017). To promote clinical efficacy, the model is most effective when considered in specific contexts and patient groups (Frazier, 2020). Reviewing this in light of the findings presented in this study, it appeared that biological models of care were more prominent, with individuals highlighting a lack of regard for their psychological well-being and factors relating to their social circumstances and culture. Therefore, alongside biological considerations, greater recognition of these factors in maternity services are key to promote respect and safety. Further, given high rates of poor mental health during the peri and postnatal periods and how these are linked to experience of mistreatment from healthcare professionals, consideration of psychosocial factors and interventions may enhance health and risk of further difficulties for birthing people and families (e.g., developmental difficulties in children and poorer health outcomes (Molloy et al., 2021).

4.4 Respectful Maternity Care: A UK Context

Meanings and experiences of RMC, and respect more broadly, share commonality with those reported from the perspective of healthcare professionals (Bagnasco et al., 2020; Jolivet et al., 2021). Given this shared understanding, this poses the question of why experiences of disrespectful care and mistreatment continue to be reported, both by birthing people in the current study, and across the wider literature (e.g., Bohren, 2014, 2015; Chadwick et al., 2014; Knight et al., 2023). Our findings offer several suggestions when answering this question, particularly in the context of the NHS. Those with personal experiences as healthcare professionals themselves noted current systemic issues, including small numbers of midwives to patient ratios. Further, birthing people shared stories of waiting in corridors due to inadequate resources and space.

The staffing crisis within UK midwifery services continues to grow, driving burnout and staff retention, with midwives reporting huge pressures due to unmanageable workloads and inadequate staffing (Cull et al., 2020). Consequently, UK midwives report higher rates of poor mental health (e.g., anxiety and depression), stress and burnout, both in comparison to the general UK population (Hunter et al., 2019) and midwives in different countries (Dixon et al., 2017; Creedy et al., 2017; Henriksen & Lukasse, 2016). In England, there is an estimated shortage of 3500 full-time midwives, driven by poor retention with only one in every 30 trained midwives working in the field (The RCM, 2018). Whilst appropriate commissioning for additional services is crucial, most services do not have adequate staffing to provide care (Kinds Fund, 2018). A response from the UK government has been to increase midwifery training places by 3000 (The RCM, 2018), however hesitation to how this will work in practice has been voiced. Given midwifery training relies on the availability and capacity of clinical and academic staff, and that over half of student midwives contemplated leaving training (McNeill & Kitson-Reynolds, 2023), greater attention to retention issues is needed.

Lack of representation within the midwifery profession that several birthing people from minority backgrounds identified impacted safety and respect. Whilst recent statistics show that diversity within UK nursing has increased, reports of discrimination and abuse towards black and ethnic minority staff has also risen, impacting staff morale, retention and quality of care (Nursing and Midwifery Council, 2023). Whilst the NHS long-term plan documents the desire to improve midwifery services (NHS, 2019), when considering staff shortages and reports in the presented study, this poses the question as to whether the current structure and funding within the NHS is designed to realistically support the delivery of RMC. This is not a question that the presented paper can answer, however accounts from birthing people indicate that the way in which the system is currently set up is likely to fall short regarding delivering RMC and psychological safety.

4.4.1 Post-Birth Care

Within a recent systematic review, Uddin et al. (2022) concluded that those who received no support following a traumatic birth experience reported increasingly higher rates of PTSD symptoms. Postpartum midwifery care has a significant impact on post-traumatic growth and maternal attachment (Turan & Derya, 2021). WHO (2022b) guidelines for positive postnatal care states that mothers and newborns should be visited on four occasions post-birth, and in the UK birthing people should be offered the opportunity to attend a confidential birth reflection appointment with a healthcare professional. However, on reviewing accounts of birthing people in this study, post-birth care for the majority was felt to be non-existent or limited in provision. When available, birthing reflections were often helpful, however many felt that they needed to occur earlier in their post-partum journey, and that more sessions to process their experience may have helped them adjust more quickly to parenthood post-birth. Further consideration of how post-birth provision for birthing people impacts experiences of RMC alongside maternal and infant outcomes is required, with findings suggesting that all birthing people, not just those with negative or traumatic experiences, may benefit from space to process their birthing experience.

4.5 The Role of Clinical Psychology in Perinatal and Maternity Care

The need for support and acknowledgement of mental well-being throughout pregnancy, and post-birth, is particularly important to consider in light of the high rates of poor mental health during this period, with suicide reported as the leading cause of death amongst birthing people post-birth (covering 6 weeks to 12 months following childbirth) (Knight et al., 2017). Whilst these difficulties are acknowledged within existing literature and policy, this study crucially highlighted the impact of recognising psychological well-being on feeling respected and safe during a time of heightened vulnerability.

Clinical psychologists play a key role in supporting perinatal mental health. A recent systematic review highlighted the positive influence on maternal distress and mortality when psychological assessment and/or intervention is offered during the perinatal period in the UK (O’Brien et al., 2023). However, at present, and as highlighted in this study, support from clinical psychology requires individuals to be seen within specialised community or inpatient perinatal services (NHS England, 2018; Royal College of Psychiatrists, 2018). Within other areas of healthcare, including brain injury and cancer care, clinical psychologists form a crucial part of the multidisciplinary team (MDT) by offering psychological support interventions to support patient well-being in hospital settings (Gómez-de-Regil et al., 2019; Humphris, 2016). Research has highlighted that offering psychological interventions during the perinatal period offers opportunity to enhance outcomes for birthing people and families, particularly when delivered in specialist services (Howard et al., 2022). During this time, many individuals experience difficult transitions to parenthood, and whilst physical healthcare is often considered, there is a lack of support for psychological transition (Martin & Redshaw, 2013; Migliorini et al., 2019). Resultantly, the WHO (2022a) has recognised the unique position of maternal and child health services accessed by birthing people during the perinatal period in offering support for all areas of women’s health. Given increased engagement and attendance in these settings, offering integrated support at this stage offers a key opportunity to enhance the well-being of birthing people and infants. The perinatal period can enhance vulnerability to psychological difficulties (Migliorini & Cardinali, 2022), which was echoed in participant accounts in this study. Considering this alongside the importance of recognising mental well-being that individuals shared, these findings suggest that integration of clinical psychology within maternity MDTs requires further exploration, particularly in the context of enhancing RMC and psychological safety for all birthing people.

4.6 Implications for Clinical Practice

The presented findings provide a greater understanding of the meaning and experiences of RMC, highlighting key factors that influence psychological safety and respect during both pregnancy and birth, thereby extending existing understanding which has focused specifically on childbirth. Resultantly, several implications for future clinical practice are proposed, including midwifery care and how the role of clinical psychology may be applied within this setting.

Birthing people from minority backgrounds proposed the need to diversify the midwifery workforce to promote acceptance and openness when discussing care relating to their demographics or culture. Whilst training places are increasing, staff retention is poor, particularly for black and ethnic minority groups. Therefore, organisations and training programmes may benefit from considering additional support for those most at risk of leaving the workforce, and addressing representation may therefore be a longer-term goal. Greater exploration of outcomes for different groups was also proposed, and therefore training for midwives regarding the literature and ways to approach these conversations with birthing people may be beneficial. Based on research suggesting that implicit biases are important for interactions and care, training regarding unconscious biases and raising awareness of this among midwifery staff may be beneficial. Further, one potential way to increase representation and validation in the shorter-term is the utility of mentoring schemes which have been beneficial in other areas of healthcare for both patients and staff (DiBrito et al., 2019), as well as tailored resources that are accessible and visible.

Familiarity with both the physical hospital setting and midwifery staff were key for developing safety and feeling respected. Due to the potential burden imposed with the continuity of carer model in maternity care, opportunities to meet multiple members of the maternity team through events such as “meet the midwife” and hospital tours were suggested. Given the impact of familiarity on trust, which enhanced safety and RMC, these strategies may be particularly helpful for enhancing positive birthing experiences. In addition, consideration of how therapeutic healing environments can be incorporated into maternity care is warranted given the negative impacts of poor hospital conditions, providing potential opportunity to enhance job satisfaction amongst maternity staff (Janakiraman et al., 2011).

Birthing partners played a crucial role in advocating and providing a sense of safety for the birthing person. When healthcare professionals included partners in decision-making and demonstrated caring behaviours towards them, birthing people indirectly felt respected. Therefore, adapting practice (e.g., through the use of technology/video) to enable easier access for partners during pregnancy appointments and scans is crucial for RMC.

A preventative rather than reactive approach is needed in relation to psychological well-being during pregnancy and birth. Recognition and exploration of psychological health and preferences should not be limited to those with pre-existing mental health difficulties and/or under perinatal mental health teams. Given increasing rates of poor mental health for childbearing people, incorporating psychological well-being within birth preparation may offer an opportunity to enhance safety and respect.

Bringing this together, the multiple factors explored regarding what constitutes RMC and promotes psychological safety in a maternity setting particularly aligns with a biopsychosocial model of health (Suls & Rothman, 2004). By considering biological, psychological, social and cultural factors, safe and validating care can be achieved. This supports a recent drive from scholars regarding the omission of the biopsychosocial model within the childbirth literature (Saxbe et al., 2017), with a clear gap for clinical psychologists within maternity care.

4.7 Extended Limitations

As noted in the journal paper, this study had several limitations that are important to consider when interpreting the research findings. Whilst this study was open to any individuals with birthing and pregnancy experiences in the UK, most participants resided in England at the time of their most recent birth. Consequently, the accounts collated in this study may be more relevant to English healthcare systems, compared to those in other UK regions. Given potential differences in funding and the systemic issues raised by birthing people in the present study that were influential in delivering respectful and safe maternity care, further research exploring region-specific experiences may be beneficial. However, research collating UK statistics and evaluations of maternity services report similar disparity regarding outcomes for minority groups and reports of mistreatment, and therefore the findings of this study regarding how RMC and safety were enhanced or reduced for these groups are of significance to all UK maternity services.

Mothers/birthing people included in this study had given birth in a UK hospital within the last five years, based on the introduction of the WHO model of intrapartum care for positive birthing experiences (WHO, 2018). Therefore, retrospective accounts collated in this study were reliant on recall with the potential for bias. Given recent social media and publications regarding poor maternity care in the UK, this may have influenced participant accounts. However, retrospective accounts appeared critical for this research, with individuals anecdotally sharing the time to process their experiences had been helpful for sense-making. This aligns with research recommending a delay between recent birthing experiences and involvement in research studies relating to these experiences (Sawyer et al., 2013; Waldenstrom, 2004).

Recruitment for this study mainly occurred online and through social media platforms. Whilst this offers a helpful strategy for reaching populations on a wider and more efficient scale with limited cost-implications (Lane et al., 2015), this may have prevented access to certain groups. For example, individuals would require internet access and social media accounts, which may not be realistic for those experiencing higher levels of deprivation. However, individuals across a range of socioeconomic backgrounds responded to the online advert, suggesting this did not limit scope of the presented study. Further, participants were required to speak English, potentially limiting access to minority groups. Similarly, the first author identifying as white may limit the depth of information disclosed by ethnic minority participants, however this was not indicated when considering transcript and interview length. Given the importance of effective communication in the domains of RMC and psychological safety, recognised in existing literature (e.g., Oladapo et al., 2018; WHO, 2018) and highlighted in this study, understanding how this may impact care for birthing people who do not speak the native language of the hospital in which they are giving birth is needed. The inclusion of interpreters, or native researchers, may bridge this gap.

The presented study aimed to capture a range of birthing experiences and consider how the meaning of RMC may be impacted by individual characteristics, particularly ethnicity and socioeconomic status/deprivation. Whilst the researcher believes this has been achieved to an extent, by exploring multiple characteristics, the influence of individual demographics in relation to RMC may not have been fully captured. Due to the homogeneity (i.e., white middle-class mothers (Mayoh, 2019)) in the existing evidence-base, a broad approach to sampling was taken. To further understand how specific demographics and characteristics impact experiences, further research specifically exploring these factors with large samples is required.

4.8 Extended Future Directions

These findings offer areas for researchers, managers, and NHS commissioners to further explore. When considering transactional models of stress, in addition to one's appraisal of a situation and availability of social support, coping behaviours are also influential in the level of stress experienced (Lazarus & Folkman, 1984; Smith & Lazarus, 1993). Further exploration of coping behaviours in birthing people may be helpful for determining any influence they may have on birthing experience, and how this may relate to feeling safe and respected, aiding identification of helpful strategies for reducing distress during this vulnerable time. Mindfulness-based stress reduction strategies show beneficial effects for reducing patient stress and enhancing levels of mindfulness within the perinatal phase (Dhillon et al., 2017). Mindfulness also improves emotional well-being, increasing empowerment and birth satisfaction (Fisher et al., 2012). This may be particularly important when changes to birth plans need to occur by promoting focus on the moment, prompting trust in the body (Sparkes, 2016). Given the importance of control and the need for greater focus on psychological wellbeing during pregnancy, exploration of mindfulness-based strategies during birth preparation may be helpful.

A recent systematic review highlighted that RMC definitions within existing measures are diverse, with the lack of a gold-standard measure (Cantor et al., 2024). The ability to quantify RMC would allow for larger-scale research in which patterns regarding impact and implementation can be established. Given key constructs of RMC and safety identified in this study, there is potential opportunity to develop a measure based on these findings. This may help address the existing evidence gap regarding how RMC can enhance maternal and infant outcomes (Cantor et al., 2024), providing further opportunity to influence clinical practice. However, based on reports in this study regarding the importance of nuances and individualised care, caution should be taken when using measures in isolation.

The importance of acceptance and validation expressed by birthing people may also link with associations between acceptance and self-efficacy (Zhang et al., 2022). Evidence suggests that individuals from marginalised groups report lower levels of self-efficacy, which is a strong predictor of mental health and psychological well-being (Siddiqui, 2015). Increased self-efficacy is associated with lower levels of stress during labour and higher birth satisfaction and sense of control (Campell & Nolan, 2016; Talbot, 2013). Therefore, further research exploring how a sense of acceptance during pregnancy may relate to enhanced self-efficacy, and consequently how this may increase one’s sense of control, offers potential opportunity to further establish ways of promoting RMC and safety. Similarly, themes of acceptance and the importance of recognising one’s values overlap with the underpinning foundations of Acceptance and Commitment Therapy (ACT) (Hayes et al., 2012). This may be important for services to explore moving forward with regards to psychological models of support when preparing for birth, and during follow-up, particularly given the high rates of poor maternal mental health in this setting, and the need for increased recognition of birthing people’s psychological well-being during this time.

Considering that birthing people reported indicators of burnout amongst midwives and how this negatively impacted care, alongside recent reports highlighting the need for greater psychological staff support in maternity care (Ockenden, 2022), one avenue may be to consider the utility of reflective practice groups (RPGs). Unsafe care in maternity services have been attributed to a lack of staff reflection and opportunities to learn from incidents of care that did not meet recommended standards (Ockenden, 2022). RPGs offer opportunities to learn from experiences and develop new knowledge, with emerging evidence supporting significant impacts on empathy towards patients, professionalism and well-being among medical students (Leung & Peisah, 2023). This further highlights a potential role of clinical psychology within maternity MDTs.

5. Critical Reflection

5.1 Project Development

Prior to clinical psychology training, I had experience of undertaking both quantitative and qualitative research, mainly focused in the areas of neuropsychology and self-harm. Whilst I felt passionate about these topics, I wanted to take the opportunity to undertake a project in a new field of interest that I had not yet explored, allowing me to further develop as a scientist-practitioner. As noted earlier (see researcher's position – section 2.1.3), I have always had an interest in the profession of midwifery, and the interaction between clinical psychology and physical health settings. When presented with the thesis project booklet by the course, I was drawn to the topics regarding birth trauma, and the idea of 'obstetric violence'. On researching further, I developed a deeper knowledge of the disparity in birthing and pregnancy outcomes for minority groups, and following my experiences in Sri Lanka (see earlier – section 2.1.3), and being personally brought up in a working-class family, this area really resonated with me. I was also surprised when reviewing the literature at the lack of studies including those with lived experience, particularly amongst heterogeneous groups (Mayoh, 2019), and the limited research in this field undertaken by psychological scientists (Saxbe et al., 2017). This led me to reflect on the pattern of areas that are under-researched, and how these are often topics that impact women more than men. I did question whether this may represent structures within our current society, in which men continue to hold positions of greater authority and power compared to women (Cameron, 2018). I believe this was further supported when reading the WHO and United Nations publications surrounding gender inequality, with increased barriers to accessing healthcare for women, resulting in a sustainable development goal of “achieving gender equality and empower all women and girls” (United Nations, 2023, p.22; WHO, 2014). Whilst this is not something that can be changed in one project or overnight, I felt very passionate about researching an area in which women’s voices are lacking. I also recognise that individuals experiencing birth may not identify with this term (i.e., ‘woman’), however with obstetric violence conceptualised as a “gender-based experience” (Kukura, 2018), I felt that birthing people of all genders were likely to be impacted by gender oppression. Whilst I have thoroughly enjoyed undertaking my thesis in this area, there have been several challenges along the way, as well as a crucial learning experience that I believe will influence my approach to research and clinical practice in the future. Maintaining a reflective log has been particularly important when constructing these reflections and will be referenced throughout.

5.2 PPI

During my previous research experience, I believe at times, I overlooked the importance of involvement and feedback from those with lived experience. When incorporated, I was able to learn so much, and enhance the effectiveness of previous studies by ensuring projects were in line with the needs of target populations. Therefore, the opportunity to seek advice and feedback from the Trent DClinPsy SUCAP when developing and conducting this project has been crucial. As noted earlier within the methodology section of this paper (see extended methods – section 2.7), I was able to receive input from SUCAP members during panel presentations offered by the course, particularly during the design phases. When initially presenting my ideas in November 2021 and January 2022, SUCAP noted the importance of a qualitative approach for this research, ensuring I offered appropriate space for individuals to share experiences that they felt were particularly significant and personal. Signposting resources were also recommended, which I was able to include in my debrief forms. Similarly, having the opportunity to conduct a pilot interview enabled me to develop my confidence with the interview schedule. Whilst I felt nervous beforehand, this process was helpful for considering how questions may have landed and been interpreted:

> I felt nervous for the pilot interview as it was the first time I had gone through the interview schedule in a more ‘interview’ context, and as a SUCAP member, I particularly wanted to create a good impression in terms of ensuring I managed the interview sensitively and appropriately. I did feel slightly apprehensive with regards to some of the questions (e.g., when asking about mistreatment), however I managed this by offering regular breaks and also reminding myself that the individual had opted to take part. (Reflective diary entry - 28/04/23).

Whilst feedback was mostly positive, the individual noted the importance of not asking too many questions at the same time, and allowing space for people to think back given that they were likely experiencing a lot of different emotions during this period. I believe this influenced the way in which I approached future interviews, and again highlighted the key role that service users play in developing research projects and the participant experience that has been recognised in the literature to date (Barber et al., 2011).

5.3 Conducting Interviews

Following the pilot interview, I began to collate data in May 2023, and arranged my first research interview. I noted feeling optimistic about this and pleased to be getting my project off the ground, whilst recognising the difficulty of balancing all my questions in mind and remaining true to the participants experiences and account:

> I felt really happy to have officially started data collection and to have carried out my first interview. I did feel slightly nervous in terms of feeling as though I needed to capture everything and making sure I asked everything I had hoped too, whilst also being validating and authentic. (Reflective diary entry - 16/05/23).

Interestingly, this first interview also raised an area that I had not considered prior to conducting the research, which was the birthing persons occupation. During two research interviews, it became apparent that the participant was an NHS doctor themselves, which appeared to give the interview a more medical focus and made it challenging to steer back to the interview schedule at times:

> I found out during the interview that the individual was from a medical background themselves. I felt this was influential in the tone of the interview with a more medical focus. I also found it interesting to think about how their own medical experiences may have impacted their experiences and the care they received. The individual did talk quite a lot and I found it hard to know when to interject, whilst also wanting to listen to everything they wished to share. (Reflective diary entry - 16/05/23).

I discussed this in research supervision and explored the distinction between my identity as a clinician, and as a researcher. The advice to take more of a 'journalist' stance was helpful and gave me permission to be more inquisitive in future interviews. I reviewed this initial transcript with my primary supervisor and noted opportunities for further questioning, which I aimed to carry forward for future interviews (e.g., if people didn't feel safe, what would have made it safe? What would have made it possible to feel respected in that situation? What did that interaction/experience mean for you?). This appeared helpful when interviewing my second participant, adding depth and understanding:

> I really enjoyed this interview. I think I feel more settled now that I have done the pilot and my first interview. I found myself more able to relax and follow the participants' lead rather than worrying about the interview schedule too closely. Instead, I tried to hold onto that 'journalist' approach by further exploring why the examples of care were respectful or disrespectful and what that meant for the individual, whilst also asking what they felt was needed. Helpfully this led the individual suggesting strategies (e.g., acknowledging statistics of poorer outcomes for ethnic minorities). (Reflective diary entry - 08/06/23).

Prior to conducting this research, I had discussed with my research team the impact that participant stories may have on me as a researcher. When conducting my third interview in which the individual had a particularly negative and traumatic experience, I noted the following:

> On an emotional level, that was definitely the toughest interview I've done so far. I could really see and hear the impact that experience has had on the individual, and I did feel myself getting a lump in my throat throughout. I feel upset at the thought that individuals put trust in us as professionals, and then people have these experiences whereby it's just totally disregarded and taken advantage of - I think I'm experiencing a mix of anger and sadness. (Reflective diary entry - 23/06/23).

After this interview, I drew upon my usual strategies for managing my own personal well-being. I decided to go for a run during my lunch break as the interview had taken place during a study morning, and this was something I often planned into my study days moving forward. Given that the majority of interviews were conducted in my own home via Microsoft teams, I drew on literature since the COVID-19 pandemic regarding the increase in home work, recognising the importance of creating a 'third place' (i.e., a space where I was not expected to work or do household chores) (Bifulco, 2022), as a means of creating separation and maintaining my mental and physical well-being.

5.4 Data Analysis

Throughout the interview process, I often noted in my reflective log how "privileged" I'd felt to hear people's birthing stories. Given the significance of the birthing experience that mothers/birthing people in this study discussed, and the vulnerable and personal experiences that they were willing to share with myself, I believe I felt a sense of anxiety and pressure when analysing the data. I felt I had to "get it right", which initially led to me coding large amounts of data that did not appear to relate directly to my research questions:

> I'm finding myself coding everything at the moment, and wondering if I'm feeling the pressure of having to capture everything and making sure I get it right with my findings. I just feel as though I need to make sure I voice these stories as participants thus far seem really passionate about my research and it making a difference. This is something to note for future supervision as I'm feeling uncertain about how to manage this today. (Reflective diary entry - 01/07/23).

This resonated with the CAT personal reformulation that I had the opportunity to develop during first year, in which I identified a common tendency to fall into a "rescuing" role when working with clients. When reflecting in July 2023, I noted a pull to "rescue" birthing people from these difficult experiences, to which my response was to code all the data to ensure I didn't miss anything important. At this stage, it was particularly crucial to draw on research supervision, sharing my coding and initial data annotations. Whilst these were felt to be interesting, it was noted that I had a tendency to be 'broad' and 'descriptive' with my coding. I was encouraged to hold in mind the question I was aiming to answer and consider nuances, and was able to reflect on the sense of pressure that I felt to share everyone's story. Validation from supervisors that this was normal at this stage, and drawing on Clarke and Braun's (2021, p.92) recommendations for managing anxiety when conducting data analysis was particularly helpful:

> I've had a screen with my research questions on today whilst coding, and I've found that really helpful for keeping me focused. Danielle has reviewed my codes again and feels these are much more accurate and representative of participant accounts and meanings which is reassuring (Reflective diary entry - 28/07/23).

When presenting candidate themes to the team, it was acknowledged that I had again fallen into a pattern of being largely descriptive and broad with my theme names (e.g., "Individualised Care" and "Continuity of Care and Carers") (Appendix O and P), with a sense that I was applying constructs that I may already be familiar with as a means of organising the data. This particularly resonated with the following reflective diary entry, in which I became aware of how my own experiences as an NHS worker may be influencing my analysis:

> I'm noticing patterns in the data today that I've definitely had my own experiences of when working in the NHS. Individualised care seems really crucial for participants to feel heard, which having the same healthcare professional throughout further aids. This again reminds me of the concept of continuity of care. (14/09/23).

Once again, research supervision was helpful for acknowledging this, and I was encouraged to again return to the data and aim to "cut the cake" in a different direction. My supervisors asked important questions which aided this process - e.g., what are people saying about individualised care in the context of respect? What does continuity of care mean and how is that done respectfully?. Following this, I aimed to address my own biases and minimise the impact of these on interpretation by regularly asking myself - where is the participant voice here? How did they understand this experience? What did respectful care mean for them in this situation?. Holding all this in mind, I believe I was then able to take a broader look at the data and consider what the key narrative was regarding RMC and safety - here I noted that the initial subtheme of "one size fits all" was instead a representation of the data set as a whole. Through this process, I was able to construct my final themes as presented in the results section of both my journal and extended paper.

5.5 Writing-up – Societal and Cultural Considerations

In line with the CR epistemological stance adopted, this project has led me to reflect on the wider societal and cultural factors surrounding this study and the findings. When writing up my thesis findings, I was struck by the amount of policies and practice guidelines in this field, and how many of the recommendations from existing literature appear to lacking in clinical practice. Whilst nuances were identified in this study, concepts such as effective communication and the need for individualised patient-centred care are not new phenomena. When hearing the experiences of birthing people in this study, two of whom were also doctors themselves, and the recognition of the ongoing systemic difficulties, I couldn't help but be reminded of the well-known 'This is going to hurt' novel by Adam Kay. This aired as a BBC tv-show in February 2022, following a junior doctor working in an Obstetrics and Gynaecology ward in a London-based hospital. Difficult working conditions and how this impacts on his personal life is shown, and sadly one of his colleagues dies by suicide as a result of the pressures. Whilst set in 2006, some of the reports in this study indicate that not much has changed. The impact of the lack of appropriate facilities and unsafe care were shown in the recent Ockenden reports, with families experiencing loss and trauma resulting from unsafe care within UK maternity facilities, highlighting the significance of reforming UK maternity care for both patients and healthcare professionals (Ockenden, 2022).

5.6 Challenges

One of the biggest challenges I faced was narrowing down my research question, and ensuring the scope and size of the project was feasible within a DClinPsy timeframe and available resource. On reviewing the literature and reaching out to my field supervisor who had proposed projects in this field (Dr Jenna Brough, who works in perinatal NHS services and as a doula), I recognised that further qualitative research was needed given the paucity of literature focusing on birthing people's experiences. Based on recent guidelines and recommendations regarding RMC, we discussed how terms such as 'respect', 'compassion' and 'kindness' are often central, but definitions and understanding of what this looks like directly in maternity practice, was lacking. This had been noted in the multiple calls for research in this field, and the importance of voicing families wishes regarding RMC were identified. Initially, I recognised the limited research within a UK hospital setting (which is where the majority of UK births occur), particularly with birthing people and their families. At this stage, I began to plan a project in which I would consider the views of birthing people, healthcare professionals, and birthing partners, as I felt understanding any similarities and differences regarding the meaning and experiences of RMC would be helpful for identifying areas of change. However, after discussing this with my research team at the time, it was felt that including all these groups would be too large, and potentially reduce the quality of data if minimising the numbers from each group to fit within my timescale. Therefore, we agreed that starting with the birthing person's voice was crucial, and that these findings would then allow me to consider whether additional views would be beneficial for future research, which are explored above (see section - future directions 4.7). Whilst initially disappointed not to include multiple perspectives, I have since reflected that I believe the depth of my study and understanding of RMC was enhanced by my specific focus on birthing people and mothers, highlighting the crucial role that supervisors play in supporting trainees in project design.

During my thesis journey, I was also made aware that my primary research supervisor would be leaving the course team during my second year. At this time, I had discussed my main ideas and rationale with this supervisor and was in the process of preparing my ethics application to the UoN. I was lucky that it was possible for my secondary supervisor to take the lead as primary and was then able to allocate another course staff member to join the team as a secondary supervisor. To provide an update on the project, I then met with my new supervisor to explain my rationale and design thus far, and my reasons for doing so. I believe this experience highlights the importance of being flexible, and ensuring I kept a clear log of all meetings and decisions to date to ensure I could clearly relay this to my new secondary supervisor.

In relation to supervision, I have also had the privilege of two field supervisors to offer further guidance and support on this project. It has been particularly helpful to have both a clinical psychologist perspective from working in perinatal services, alongside that of a midwife with direct experience of working in this area. However, at times, it has been challenging to arrange meetings and find times to meet as a team. Again, the ability to be flexible and update the differing team members (e.g., sending whole team emails after any meetings) has been something I found crucial on this journey to ensure that I was able to maximise the input and expertise of the whole research team.

Similarly, this theme of flexibility was also critical when conducting interviews. Given my target sample included those who had recently given birth, and therefore had small children, finding suitable times and days for interviews to take place required flexibility. On the DClinPsy course we are allocated set days for study time, however this did not always align with participant availability. Therefore, I conducted some interviews during evenings, and in some cases birthing people would have their baby with them or need to pause the interviews to breastfeed or to attend to their infant. Following a discussion with my primary supervisor, we agreed this was critical for inclusivity and ensuring I adapted to the needs of my target population.

5.7 Participant Feedback

When designing studies and reviewing ethical guidelines, consideration of the participant experience and potential risks or benefits of partaking are crucial. Whilst I did not collate formal feedback from participants, several individuals commented on their experience at the end of the interview, or sent me an email to share their thoughts, including the follow:

> It’s just been so nice to talk about it. Like I’ve not really had the opportunity to just sit down and like think and talk through it, it’s been lovely.

> It was just a really nice conversation actually. I was kind of worried that talking about it, because I haven’t gone through my birth in like a year or over so I worried that was going to leave me feeling sad or angry, or I wasn’t sure what was going to come up, but actually it felt quite nice in a viewing myself now, like my daughter is nearly two now, and putting that out, and it actually feels lovely to remind myself that I was advocated and cared for and I feel safe even in telling the story still. So it’s lovely of you to hold a space for people like this and I really appreciate it.

> And I just wanted to say thank you so much for doing this research. I’m really glad that I stumbled across it at the right time. Again that was what made me want to take part. It just seemed perfect, like serendipity that this came up. I wanted to be part of this and I was really hopeful of getting a chance to be interviewed. I’ve found it really cathartic, but also the selfish part of me that’s had

> the opportunity to just have a rant. And I’ve found this a really positive experience, so thank you. I think it’s really, really important.

When considering my earlier reflections regarding a sense of pressure to share all of the participants' experiences, I wondered whether these comments may have enhanced this. However, I think what this truly highlighted for me was the clear need for this research, and the importance of qualitative research in providing a space for individuals to reflect on and share their experiences. Further, I believe this resonated with my findings in which additional opportunities for space and exploration of experiences and well-being are crucial for enhancing RMC and psychological safety during pregnancy and beyond.

5.8 Implications for Personal Clinical Practice - Trainee Perspective

Alongside other aspects of clinical training, I believe the experience of conducting this research and hearing the stories of mothers and birthing people will impact my own clinical practice moving forward. Whilst ‘respect’ is a term we often use when listing trust values and important elements of patient-centred care, it has led me to further reflect on what these terms mean, and how my own perceptions of respect may differ compared to my clients and colleagues. Similarly, learning and educating myself further on the role of language and inclusivity in the maternity field has broadened my awareness of the terminology I may automatically apply when working with certain groups (e.g., ‘women’, ‘parents’, ‘mothers’, ‘fathers’). When considering this, I was reminded of the ‘unconscious bias’ and ‘toxic interactions’ training that I attended during first year on the course, and the importance of regularly questioning any assumptions that I may develop regarding the individuals I work with. I believe these experiences will encourage me to be curious in my practice and to challenge conclusions that I may make regarding terminology and language, with the aim of meeting individual needs that birthing people in this study discussed as central to respectful and safe care. On qualifying, I hope to work in a physical health setting, and feel particularly passionate regarding how I can take this forward into settings where individuals may experience power imbalances, with the aim of reducing this by drawing on the voice and guidance of participants in this study. One strategy I have considered is using the social graces model (Burnham, 2012) in supervision, recognising how aspects of my own identity may tailor and influence my thinking and clinical practice moving forward.

5.9 Dissemination

One element of research I feel particularly passionate about is that of dissemination, especially via channels that ensure those with lived experience and participants get to hear about the findings, alongside those who can action key areas of change that this study highlighted (e.g., healthcare professionals). Therefore, during this study I ensured that any individuals who completed the screener to register their interest, and those who took part in interviews, had the opportunity to leave contact details to be updated on findings. Following submission of this thesis, I am aiming to produce an accessible summary to share with these individuals, as well as those organisations who supported and shared the project advert across their networks (e.g., centre for ethnic health research). Further, in March 2024, my current trust (Nottingham University Hospitals) is hosting a research morning for all clinical psychologists working across multiple healthcare settings and I have signed up to present the findings from this study at this event. With my remaining study budget, I am also hoping to find an appropriate conference to present this research and will aim to submit for journal publication in the near future.

JP word count: 5000

Extended word count: 30,605 (excluding figures, tables, references and appendices).

Total word count: 35,605

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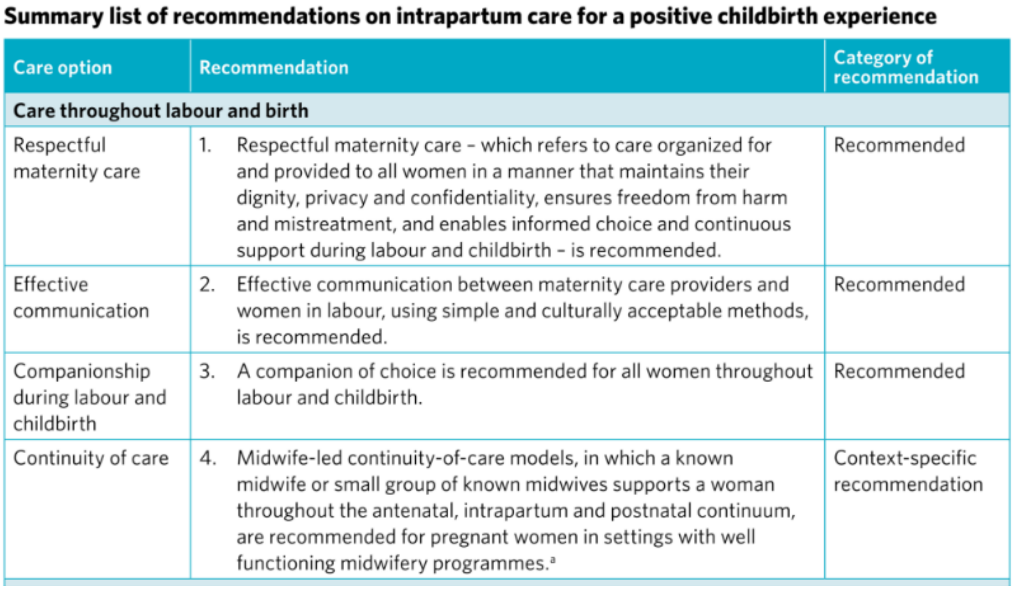
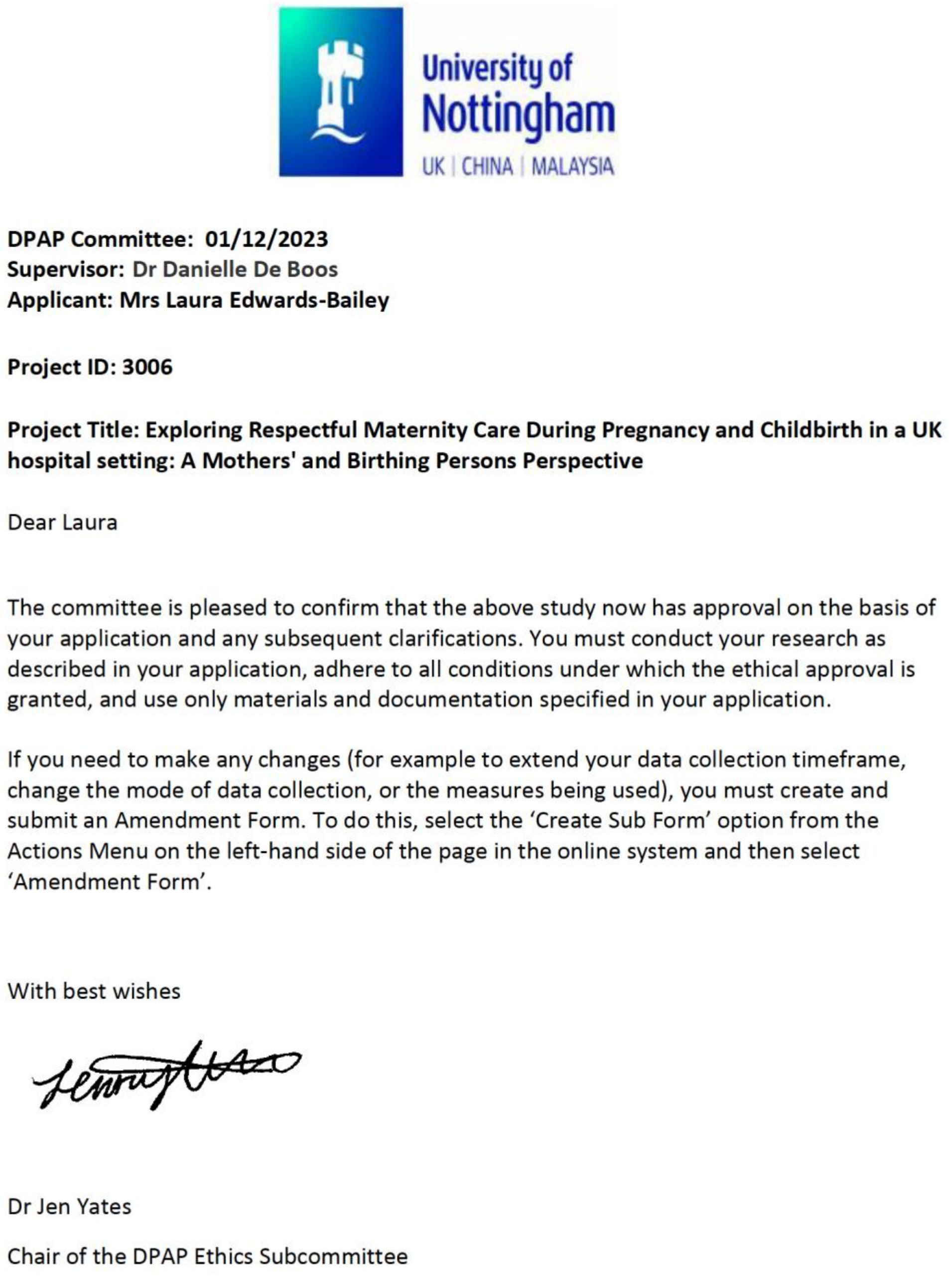
Appendix A: WHO Recommendations for a Positive Childbirth Experience (WHO, 2018).



Summary list of recommendations on intrapartum care for a positive childbirth experience

Care option	Recommendation	Category of recommendation
Care throughout labour and birth		
Respectful maternity care	1. Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended.	Recommended
Effective communication	2. Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
Companionship during labour and childbirth	3. A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
Continuity of care	4. Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes.[a]	Context-specific recommendation

Appendix B: University of Nottingham DPAP Committee Ethical Approval Confirmation Letter



DPAP Committee: 01/12/2023
Supervisor: Dr Danielle De Boos
Applicant: Mrs Laura Edwards-Bailey

Project ID: 3006

Project Title: Exploring Respectful Maternity Care During Pregnancy and Childbirth in a UK hospital setting: A Mothers' and Birthing Persons Perspective

Dear Laura

The committee is pleased to confirm that the above study now has approval on the basis of your application and any subsequent clarifications. You must conduct your research as described in your application, adhere to all conditions under which the ethical approval is granted, and use only materials and documentation specified in your application.

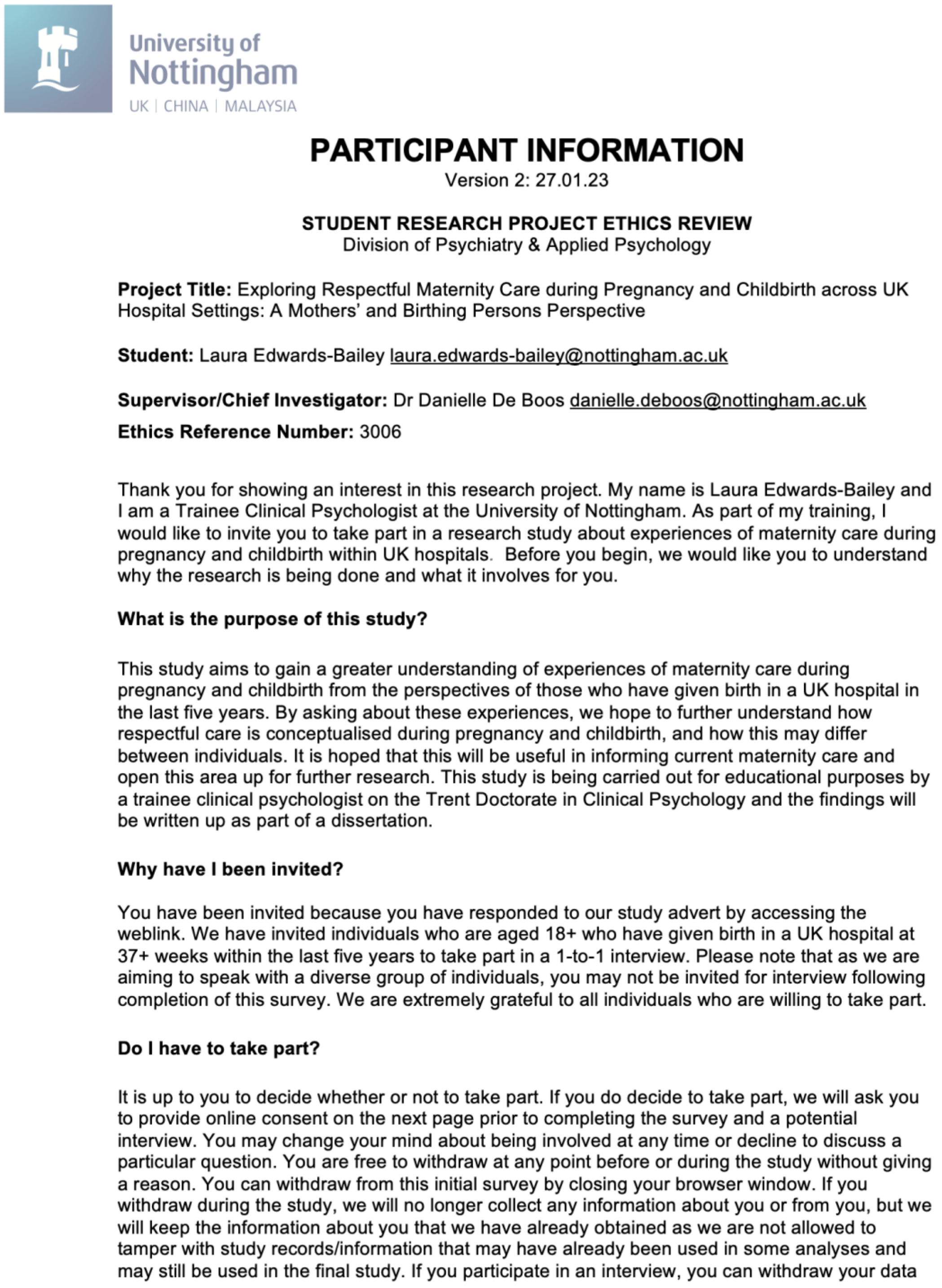
If you need to make any changes (for example to extend your data collection timeframe, change the mode of data collection, or the measures being used), you must create and submit an Amendment Form. To do this, select the ‘Create Sub Form’ option from the Actions Menu on the left-hand side of the page in the online system and then select ‘Amendment Form’.

With best wishes

Dr Jen Yates

Chair of the DPAP Ethics Subcommittee

Appendix C: Participant Information Sheet



University of Nottingham
UK | CHINA | MALAYSIA

PARTICIPANT INFORMATION

Version 2: 27.01.23

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Exploring Respectful Maternity Care during Pregnancy and Childbirth across UK Hospital Settings: A Mothers' and Birthing Persons Perspective

Student: Laura Edwards-Bailey laura.edwards-bailey@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Danielle De Boos danielle.deboos@nottingham.ac.uk

Ethics Reference Number: 3006

Thank you for showing an interest in this research project. My name is Laura Edwards-Bailey and I am a Trainee Clinical Psychologist at the University of Nottingham. As part of my training, I would like to invite you to take part in a research study about experiences of maternity care during pregnancy and childbirth within UK hospitals. Before you begin, we would like you to understand why the research is being done and what it involves for you.

What is the purpose of this study?

This study aims to gain a greater understanding of experiences of maternity care during pregnancy and childbirth from the perspectives of those who have given birth in a UK hospital in the last five years. By asking about these experiences, we hope to further understand how respectful care is conceptualised during pregnancy and childbirth, and how this may differ between individuals. It is hoped that this will be useful in informing current maternity care and open this area up for further research. This study is being carried out for educational purposes by a trainee clinical psychologist on the Trent Doctorate in Clinical Psychology and the findings will be written up as part of a dissertation.

Why have I been invited?

You have been invited because you have responded to our study advert by accessing the weblink. We have invited individuals who are aged 18+ who have given birth in a UK hospital at 37+ weeks within the last five years to take part in a 1-to-1 interview. Please note that as we are aiming to speak with a diverse group of individuals, you may not be invited for interview following completion of this survey. We are extremely grateful to all individuals who are willing to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, we will ask you to provide online consent on the next page prior to completing the survey and a potential interview. You may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. You can withdraw from this initial survey by closing your browser window. If you withdraw during the study, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records/information that may have already been used in some analyses and may still be used in the final study. If you participate in an interview, you can withdraw your data within one week of the interview taking place. After this time data may be anonymised and included in analyses, and it will no longer be technically possible to withdraw your data.

What will I be asked to do?

If you choose to take part, you will initially be asked to provide some demographic information via an online survey. This will include several questions related to your pregnancy and birthing experience. The survey should take appropriately 5 minutes to complete. On the next page, you will be asked to provide consent to be contacted by the lead researcher for potential participation in a 1-to-1 interview. You will also have the option to consent to be contacted with the outcomes/a summary of this research. If you wish to do so, you will be required to provide your preferred method of contact (e.g., phone number, email, etc). As it may be possible to link the contact information with participant identity, responses provided in the online survey may no longer be anonymous to the research team. However, any data reported or published as a result of this research will be anonymised. By providing contact information, this does not confirm that you will be invited to take part in an interview. We will invite approximately 15 individuals to take part in an interview and individuals will be selected on their demographics (e.g., ethnicity, age, location). This is in line with the aims of this study in which we hope to capture a diverse range of participant experiences. If you do not hear from the research team within one month of completing the survey, you will not be contacted to take part in an interview.

After providing this information, you may then be contacted by the lead researcher to arrange a convenient time for a one-off interview to take place. At this point, you will also be offered the opportunity to arrange a telephone appointment with the lead researcher to discuss any questions and to go through the information sheet. If you are happy to proceed, a mutually convenient time for the interview to take place will be agreed.

The interview will take place via Microsoft Teams or face-to-face depending on preference and travel feasibility, and will last approximately 60 minutes. You will be asked to provide some further demographic information prior to the interview. Face-to-face interviews will take place in a confidential space at the University of Nottingham, or in an agreed location such as your home. For the purpose of analysis, the interviews will be audio recorded using a password protected phone and/or the record function on Microsoft Teams. These recordings will be destroyed once the study has ended.

During the interview, you will be asked some questions about your experiences of hospital maternity care during your pregnancy and childbirth, including decision-making processes. You may take breaks at any time during the interview if needed, and a space to debrief after the interview will be offered.

Expenses and payments

All individuals who complete the online survey will have the option to be entered into a voucher draw for a £20 voucher. You will be contacted directly if you are the draw winner and will have 30 days to respond in order to claim your prize. Those who take part in a one-to-one interview will be individually offered £15 worth of vouchers for their participation in interviews. For face-to-face interviews, travel expenses will be offered for any visits incurred because of participation

Will the research be of any personal benefit to me?

There is no direct benefit to you from taking part but the information we get from this study may help us to identify ways that we can improve experiences and satisfaction of hospital care for mothers and birthing persons during pregnancy and childbirth in future. You will be asked at the end of this survey if you wish to be kept updated with the outcomes of this research and can provide contact details if you wish to do so.

Are there any possible disadvantages or risks in taking part?

We don't expect there to be any disadvantages or risks to taking part. Given that we are exploring experiences during your pregnancy and childbirth, it is possible that some of these questions may be sensitive and upsetting for you. We advise against taking part in this study if you are currently seeking psychological support for pregnancy/birth-related trauma/experiences. Previous research suggests that most participants do not experience extreme distress in these types of studies, with the majority not regretting participation and often finding it a positive experience. You will be offered breaks throughout the interview and there will be a debrief space afterwards. You may also stop the interview at any time.

What will happen to the information I provide?

To ensure confidentiality, only the research team will have access to the demographic data collected via survey, interview audio recordings and transcribed interviews. The audio recordings will be either transcribed verbatim by the student or by using a secure, automated transcription service provided by the University of Nottingham. All personal details that might identify any participants will be removed upon transcription. The transcripts will be uploaded into a password-protected database and once the analysis of the transcribed interviews is complete, the audio recordings will be destroyed. Participants will be identified by a participant number only. We would like to be able to quote what you say in reports or publications. We will make sure that your anonymity is protected, but if you do not wish us to quote you, please tell us.

The information that you provide will be used to write a dissertation for partial fulfilment of the Trent Doctorate in Clinical Psychology, and may also be used to write academic papers to be published in peer-reviewed journals and in presentations at conferences. If you would like a summary of the results, please email the supervisor Dr Danielle De Boos (danielle.deboos@nottingham.ac.uk) for a copy.

We will follow ethical and legal practice and all information will be handled in confidence. Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally–identifiable information possible. You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee rita.gohil@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

We believe there are no known risks associated with this research study; however, as with any online activity the risk of a breach is always possible. We will do everything possible to ensure your answers in this study will remain anonymous.

Sources of support

If answering the questions has made you think a bit about yours, or your child's, mental health– please visit your local general practitioner or doctor. If you are already in contact with a specialist service you may wish to discuss any concerns or queries with them.

GP (general practitioner): as a first port of call, you can visit your doctor/GP for any health concerns you have. Your GP should be able to asses and evaluate the patient through a series of questions and tests as appropriate. If you are not registered with a GP, you can use the online NHS Choices 'find GP services' tool to find your local surgery/practice: www.nhs.uk/Service-Search/GP/LocationSearch/4

Psychological therapies: if you are looking for NHS-run psychological therapies (also called 'talking therapies' or 'IAPT'/'Improving Access to Psychological Therapies': this includes therapies such as counselling, psychotherapy, cognitive behavioural therapy), you can look for your local psychological therapies using the online NHS Choices 'find psychological therapies' tool: http://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008. Please note that services will vary in whether patients can directly refer themselves to the service or require a GP to do so.

A mental health crisis usually refers to an episode where a person's mental health is at breaking point. For example, a person may be: experiencing suicidal thoughts and feelings, and be self-harming; may be having extreme anxiety or panic attacks; may be hearing voices, experiencing delusions and hallucinations, or feeling extremely paranoid; or other behaviour that feels out of control or out of character for the person, and may be likely to endanger themselves or other people. In a crisis, medical help is vital:

- A&E departments at hospitals are where the most serious and urgent medical emergencies are treated. If you're experiencing a mental health crisis, it's absolutely vital to take it as seriously as you would if you had a physical health emergency – and a person should attend A&E if they feel unable to keep themselves safe, may have serious harmed themselves, and need immediate help.

- Emergency GP appointments are available if you need to see your GP quickly in an emergency. These appointments can be used if it is felt that urgent mental health support is needed, but the person feels able to keep themselves safe until the appointment.

More information about crisis support can be found from Mind: www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/emergency-support/

NHS 111 / NHS Direct: If you need medical help or advice fast, but it's not a life-threatening situation, you can call NHS 111 (in England) by dialling 111, or NHS Direct (in Wales) on 0845 46 47.

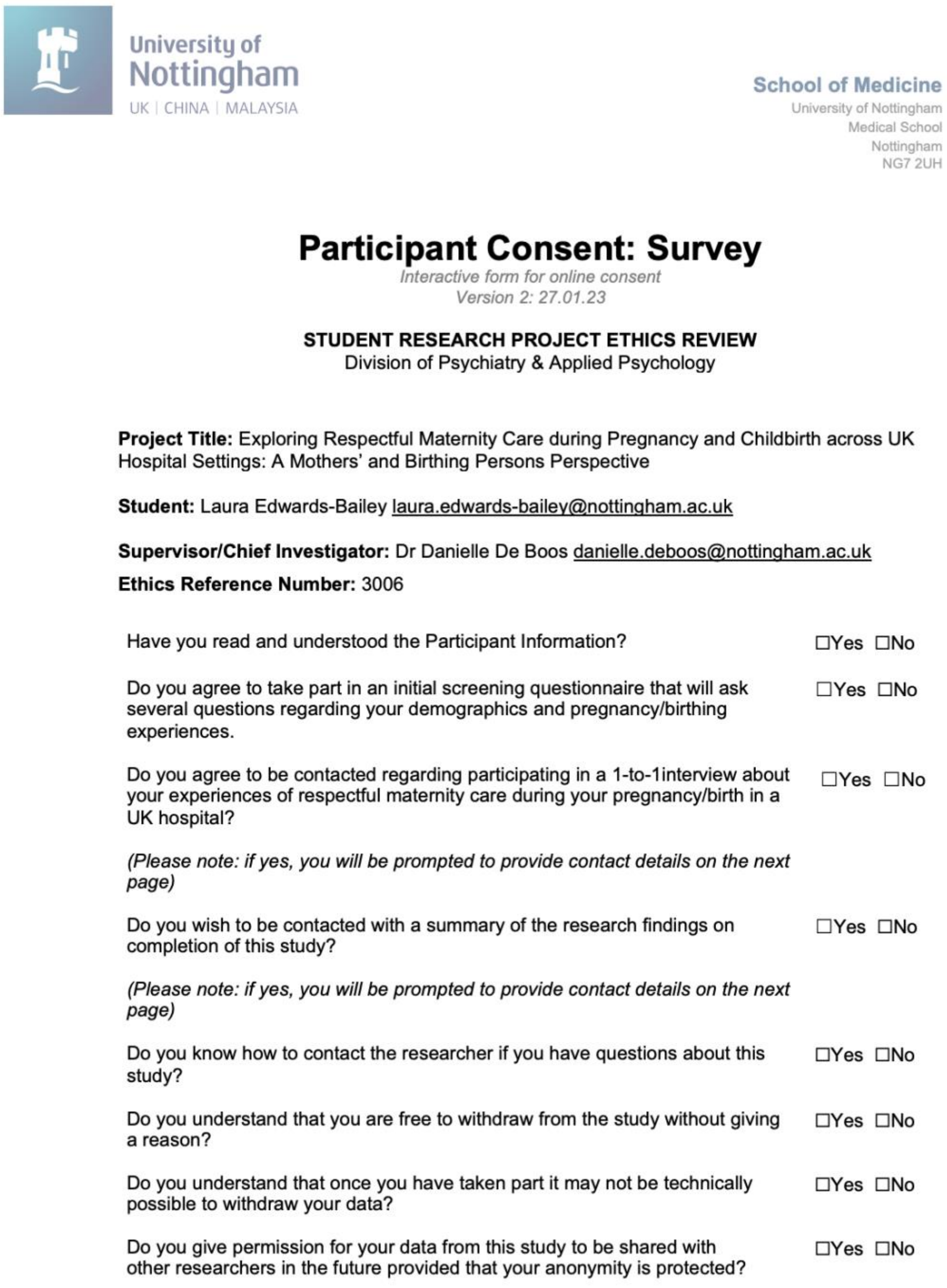
Listening and emotional support services

There are a number of national listening services available (usually via a telephone helpline or email) available to help people talk through their emotions and to provide confidential, non-judgemental support. They can help people struggling with difficult feelings who want to talk to someone immediately.

BabyCentre https://community.babycentre.co.uk/groups/a3857275/traumatic_birth_support_group.	**BabyCentre** offers a traumatic birth support group where you can chat and share your experiences with others going through the same thing.
Samaritans www.samaritans.org **Helpline**: 116 123 (free) **Email:** jo@samaritans.org Open 24/7	**Samaritans** are open 24 hours a day, 365 days a year, and trained volunteers provide confidential and non-judgemental emotional support for people who are experiencing feelings of despair or distress, including such feelings which could lead to suicide. They are there to listen to anything that is upsetting you, including intrusive thoughts and difficult thoughts of suicide and self-harm.
PAPYRUS HOPELine www.papyrus-uk.org **Helpline:** 0800 068 41 41 (Mon-Fri 10am-10pm; Sat-Sun 2pm to 10pm) **Email:** pat@papyrus-uk.org **Confidential text service:** 07786 209 697	Papyrus is a National UK Charity dedicated to the prevention of young suicide. They run **HOPELine** – a confidential non-judgemental advice line for children, teenagers and young people (up to the age of 35) who are worried about how they are feeling, or by anyone who is concerned about a young person. The helpline is staffed by professionals experienced in working with suicidal young people, families or carers.
SANE www.sane.org.uk **SANELine helpline:** 0300 304 7000 (open 4.30pm-10.30pm every day)	**SANE** is a UK-wide charity working to improve quality of life for people affected by mental illness. They provide emotional support, help and information for a range of mental health issues via SANELine, textcare and an online support forum (see their website for details).

Switchboard www.switchboard.lgbt Helpline: 0300 300 0630 (10am-10pm every day) **Email:** chris@switchboard.lgbt **1-to-1 webchat** available on their website	If you identify as gay, lesbian, bisexual or transgender, Switchboard is available to listen to any problems you're having. They also provide information, support and referral services. Phone operators all identify as LGBT+ and the helpline is confidential.
SHOUT https://giveusashout.org/ **Text SHOUT to 85258** in the UK to text with a trained Crisis Volunteer.	Shout 85258 is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope. Shout is available in England, Scotland, Wales, and Northern Ireland.
Frazzled Café Web: www.frazzledcafe.org	Feeling Frazzled? Join us for an online Frazzled Cafe meeting. We know how important it is to stay connected in these unprecedented and uncertain times. Frazzled Cafe meetings are a supportive online community where you can come and talk in a safe, non-judgemental space about what's really going on for you.

Appendix D: Participant Online Consent Form



University of Nottingham
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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

Participant Consent: Survey

Interactive form for online consent
Version 2: 27.01.23

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

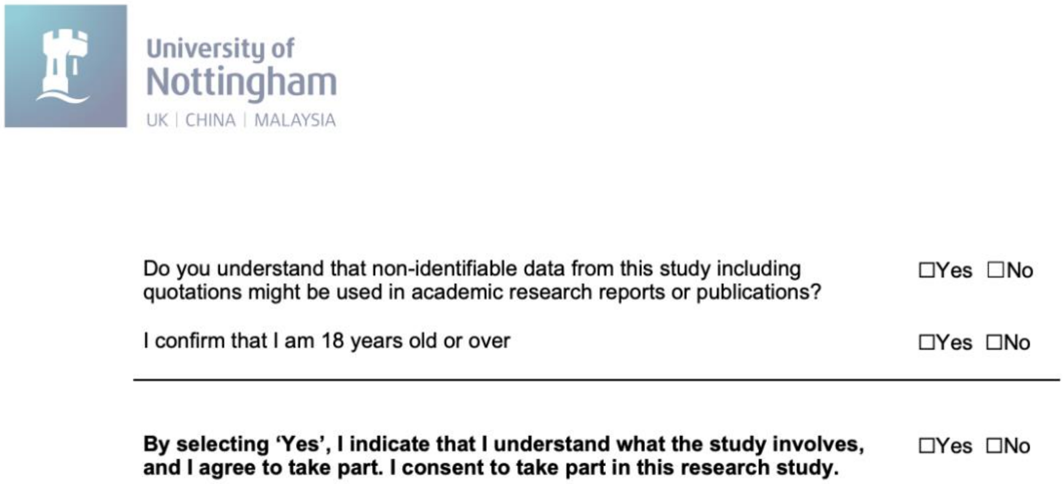
Project Title: Exploring Respectful Maternity Care during Pregnancy and Childbirth across UK Hospital Settings: A Mothers' and Birthing Persons Perspective

Student: Laura Edwards-Bailey laura.edwards-bailey@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Danielle De Boos danielle.deboos@nottingham.ac.uk

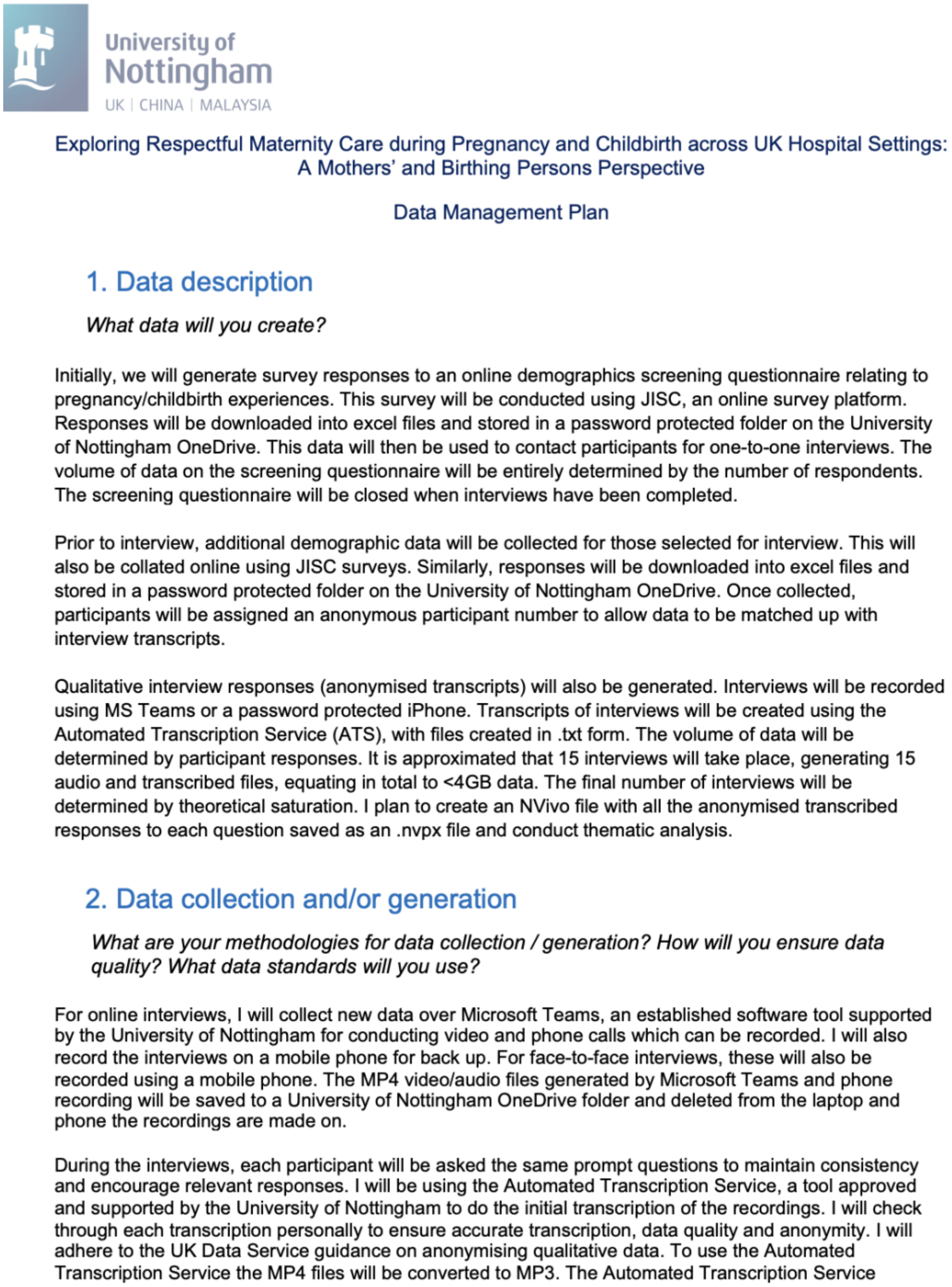
Ethics Reference Number: 3006

Have you read and understood the Participant Information?	☐Yes ☐No
Do you agree to take part in an initial screening questionnaire that will ask several questions regarding your demographics and pregnancy/birthing experiences.	☐Yes ☐No
Do you agree to be contacted regarding participating in a 1-to-1interview about your experiences of respectful maternity care during your pregnancy/birth in a UK hospital? *(Please note: if yes, you will be prompted to provide contact details on the next page)*	☐Yes ☐No
Do you wish to be contacted with a summary of the research findings on completion of this study? *(Please note: if yes, you will be prompted to provide contact details on the next page)*	☐Yes ☐No
Do you know how to contact the researcher if you have questions about this study?	☐Yes ☐No
Do you understand that you are free to withdraw from the study without giving a reason?	☐Yes ☐No
Do you understand that once you have taken part it may not be technically possible to withdraw your data?	☐Yes ☐No
Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?	☐Yes ☐No



Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?	☐Yes ☐No
I confirm that I am 18 years old or over	☐Yes ☐No
By selecting 'Yes', I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study.	☐Yes ☐No

Appendix E: Data Management Plan



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Exploring Respectful Maternity Care during Pregnancy and Childbirth across UK Hospital Settings: A Mothers' and Birthing Persons Perspective

Data Management Plan

1. Data description

What data will you create?

Initially, we will generate survey responses to an online demographics screening questionnaire relating to pregnancy/childbirth experiences. This survey will be conducted using JISC, an online survey platform. Responses will be downloaded into excel files and stored in a password protected folder on the University of Nottingham OneDrive. This data will then be used to contact participants for one-to-one interviews. The volume of data on the screening questionnaire will be entirely determined by the number of respondents. The screening questionnaire will be closed when interviews have been completed.

Prior to interview, additional demographic data will be collected for those selected for interview. This will also be collated online using JISC surveys. Similarly, responses will be downloaded into excel files and stored in a password protected folder on the University of Nottingham OneDrive. Once collected, participants will be assigned an anonymous participant number to allow data to be matched up with interview transcripts.

Qualitative interview responses (anonymised transcripts) will also be generated. Interviews will be recorded using MS Teams or a password protected iPhone. Transcripts of interviews will be created using the Automated Transcription Service (ATS), with files created in .txt form. The volume of data will be determined by participant responses. It is approximated that 15 interviews will take place, generating 15 audio and transcribed files, equating in total to <4GB data. The final number of interviews will be determined by theoretical saturation. I plan to create an NVivo file with all the anonymised transcribed responses to each question saved as an .nvpx file and conduct thematic analysis.

2. Data collection and/or generation

What are your methodologies for data collection / generation? How will you ensure data quality? What data standards will you use?

For online interviews, I will collect new data over Microsoft Teams, an established software tool supported by the University of Nottingham for conducting video and phone calls which can be recorded. I will also record the interviews on a mobile phone for back up. For face-to-face interviews, these will also be recorded using a mobile phone. The MP4 video/audio files generated by Microsoft Teams and phone recording will be saved to a University of Nottingham OneDrive folder and deleted from the laptop and phone the recordings are made on.

During the interviews, each participant will be asked the same prompt questions to maintain consistency and encourage relevant responses. I will be using the Automated Transcription Service, a tool approved and supported by the University of Nottingham to do the initial transcription of the recordings. I will check through each transcription personally to ensure accurate transcription, data quality and anonymity. I will adhere to the UK Data Service guidance on anonymising qualitative data. To use the Automated Transcription Service the MP4 files will be converted to MP3. The Automated Transcription Service automatically deletes MP3 files when the transcription is completed and generates a text file of the transcript which will be saved in another University of Nottingham OneDrive folder.

For the initial screening questionnaire data, and the additional demographics questionnaire specifically for interview participants, data will initially be stored on the online survey platform JISC whilst responses are being collated. A participant number/ID will be automatically generated to ensure anonymity. The same ID numbers will be used for interview participant transcripts. Once all data is collated it will be transferred to an Excel spreadsheet and kept anonymised for further analysis and write up.

Contact details used to enter the prize draw/for interview follow-up will be kept in a different study folder on the University of Nottingham OneDrive and destroyed once contact has been made with the winners/interview participants. Individuals will have 30 days from the date they were notified of winning to claim the prize/respond to interview invitation. All research data including consent and personal data will be password protected and stored securely in a locked archive.

I will create an NVivo file to conduct thematic analysis with interview transcripts, enabling me to efficiently code and theme each response. This document will only contain anonymised responses and no identifiable information.

3. Ethics & Privacy

Are there any ethical, commercial, or privacy issues that will affect the collection and storage of your data?

Demographic data (age, gender, ethnicity and postcode) will be collected during the initial screening questionnaire, with further demographics (e.g., sexuality and marital status) collated prior to interview. Participants will be assigned an identifier number to enable me to anonymise the individual. Participants will have the option to select 'prefer not to say'/skip questions that they do not wish to answer.

Contact details, either telephone numbers or email addresses, will be collected during participant recruitment to invite participants for interview, or contact regarding the voucher draw. For individuals opting for online interviews, these contact details will also be used for scheduling Microsoft Teams calls, and send a summary report if requested, but this information will not be used for data analysis or published in further studies.

All identifiable details will be removed from the study data and transferred to another folder and protected securely on OneDrive. Participants will be informed that they can withdraw from the online screener by exiting the questionnaire, however once submitted this will not be possible due to anonymity. For interviews, they can withdraw within one week of the interview taking place as after this point data will be transcribed and anonymised and all identifiable information will be removed. Interview consent forms will include subject ID numbers. These will be scanned and uploaded to the UoN OneDrive. Paper copies will then be shredded and destroyed. As I will be working with personal data, I will ensure that I comply with the Data Protection Act 2018, including GDPR requirements. This will include providing research participants with the relevant privacy information as part of the participant information sheet and ensuring appropriate safeguards for the storage and handling of data are in place - this is built into the OneDrive software which is GDPR compliant.

4. Data storage and security

Where and how your data will be stored, backed-up, transferred, and secured during the active phase (short to medium term) of research?

I will store data on the University of Nottingham OneDrive. OneDrive is a secure, cloud storage technology and it is the University's preferred location for storing personal and commercially sensitive data. I will only be using OneDrive and Teams to capture, store and back up data as they meet University Information Security and General Data Protection Regulation (GDPR 2018) standards for handling personal and commercially sensitive data and comply with the University of Nottingham Research Data Management Policy.

Using OneDrive means that the folders can only be accessed by me. I will ensure that raw data and original recordings of Teams calls are saved in a folder OneDrive. I will create a separate folder for the transcribed anonymised data, to ensure that no one could access either dataset and identify participants. I will save the demographic forms in another OneDrive folder. This way no one could identify a participant by their unique number, and only I can access each folder.

OneDrive storage and processing services comply with ISO 27001 international standard and BS7799 British standard of information management and security. OneDrive automatically backs-up data, offers continual failover support with a maximum of one hour data loss, and encrypts data both in transit and at rest. There are no associated budget costs to using OneDrive as it is freely available for University of Nottingham students.

5. Data management, documentation, and curation

What are your principles, systems, and major standards for data management and creation? What metadata and documentation will you keep?

All data will be managed according to the University of Nottingham's data management policy, ensuring that all the research data I generate is managed in a manner that is FAIR – Findable, Accessible, Interoperable and Reusable.

Questionnaire survey data will be generated using online survey managed by "Online Surveys" (Online surveys) Jisc, 4 Portwall Lane, Bristol, BS1 6NB, UK). All survey data through the JISC service is stored "...within Amazon Web Services (AWS), within the Republic of Ireland..." and the security of this data is guaranteed to ISO/IEC 27001 standard.

I will save data using a system of folders and file names. I will create folders labelled by data type and activity for example "Recordings", and "Transcriptions". Within the folders I will use good file name conventions including the date. For example, recordings of interviews will be saved in the following format: Int024_XX _2021-06-05.doc : interview with participant 024, interviewed by XX on DD/MM/YY.

As part of the University of Nottingham research ethics review, I will provide copies of the interview questions, demographic data collection sheet and online consent forms. I will provide descriptive metadata including the filename, DOI and date of creation.

6. Data preservation

How will you ensure the long-term storage and preservation of data?

I will adhere to General Data Protection Regulation, 2018 and ensure the protection of the research and protect participants rights and privacy.

The University of Nottingham uses Microsoft OneDrive for storage of data. Study datasets will be stored within the lead researcher's OneDrive. The specific folder will be accessible only to other members of the research team. There will be no physical samples or datasheets taken in this study.

Anonymised research data created by the project will be deposited in the University of Nottingham research data archive, https://rdmc.nottingham.ac.uk. Audio files will not be deposited as they could include identifiable data. A DataCite DOI is issued for each publishes dataset facilitating the ability to cite the data in associated research outputs. The University of Nottingham data archive is underpinned by commercial digital storage which is audited on a twice-yearly basis for compliance with the ISO 27001 standard. University of Nottingham will retain and preserve research data in line with University of Nottingham requirement for a minimum of 7 years, but data will be retained for longer periods of time where it is of continual value to users.

7. Data sharing, publication, and access

How will the data generated be shared and published?

All data will be anonymised, ensuring it would not be possible to identify an individual from their responses.

All data processing and sharing will adhere to the University of Nottingham Data Protection Policy. The dataset will not contain any personally identifiable or commercially sensitive information and thus will be shared via the University of Nottingham data archive under a CC-BY license. There will be no need to update the data past the project period. All published outputs will contain a Data Availability Statement including the data cite DOI which directs to the relevant data set. Data will be released at the same time as any published outputs which are underpinned by the data or by 1 year from the end of the project at the latest.

Appendix F: Study Advert

HAVE YOU GIVEN BIRTH IN A UK HOSPITAL IN THE LAST FIVE YEARS?

WE NEED YOU!

WHAT?

Hi, I'm Laura Edwards-Bailey, a Trainee Clinical Psychologist.
I am hoping to interview a diverse group of mothers/birthing people about their experiences of respectful maternity care during pregnancy and childbirth.
I am inviting you to complete an initial survey to register your interest and provide some demographic information.

WHO?

We would like to hear from individuals aged 18+ who have given birth in a U.K. hospital at 37+ weeks in the last 5 years.

WHY?

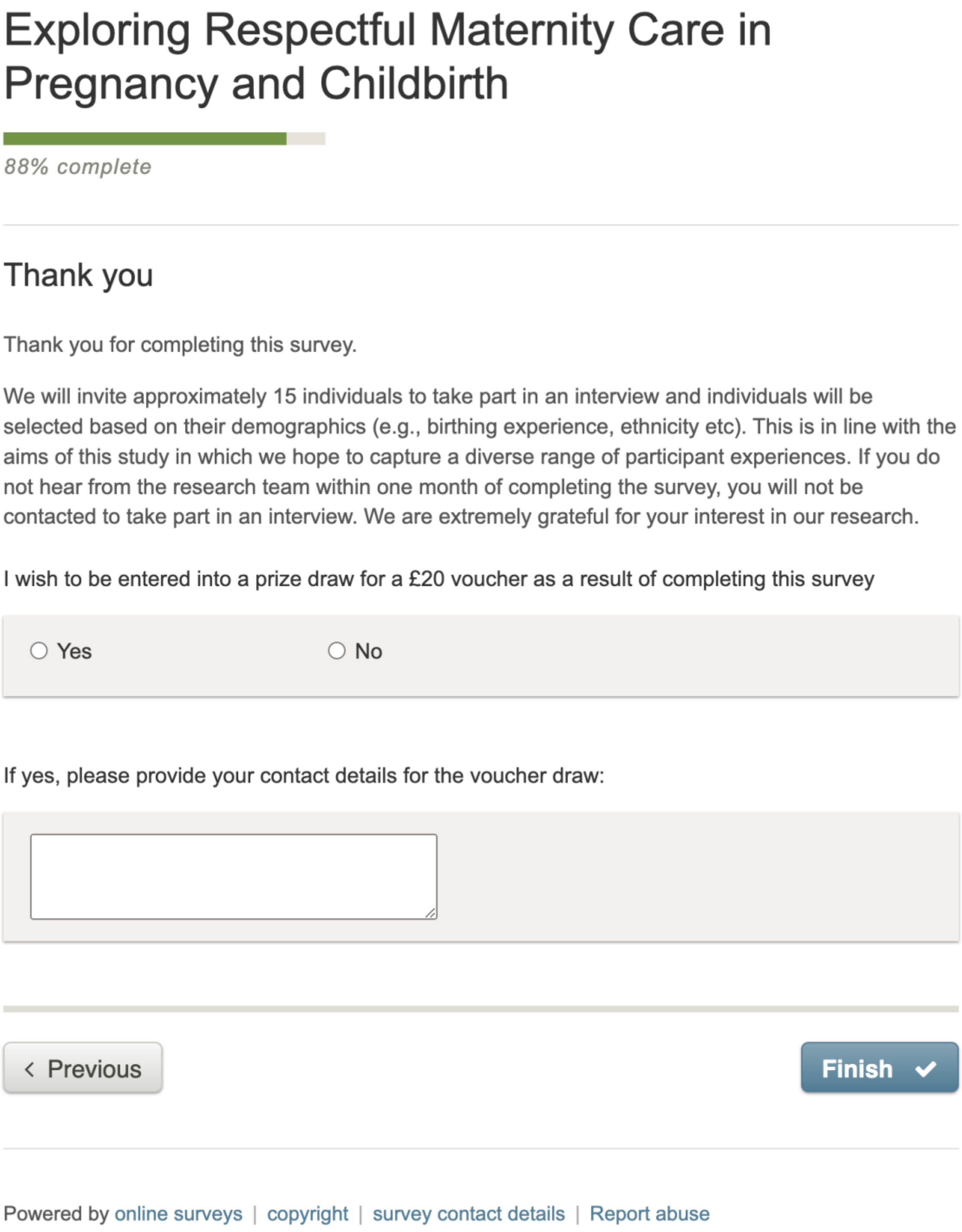
We are hoping to use the individual stories and experiences that we hear about during interviews to make recommendations for others receiving hospital maternity care in the future.

HOW?

You can access the initial questionnaire by scanning the QR code below or visiting
https://nottingham.onlinesurveys.ac.uk/rmc--pregnancychildbirth-uk

As a thank you for completing the survey, you can be entered into £20 voucher draw.
If you would like any further information, please contact Laura Edwards-Bailey
laura.edwards-bailey@nottingham.ac.uk

Appendix G: Online Survey Interview Selection Information



Exploring Respectful Maternity Care in Pregnancy and Childbirth

88% complete

Thank you

Thank you for completing this survey.

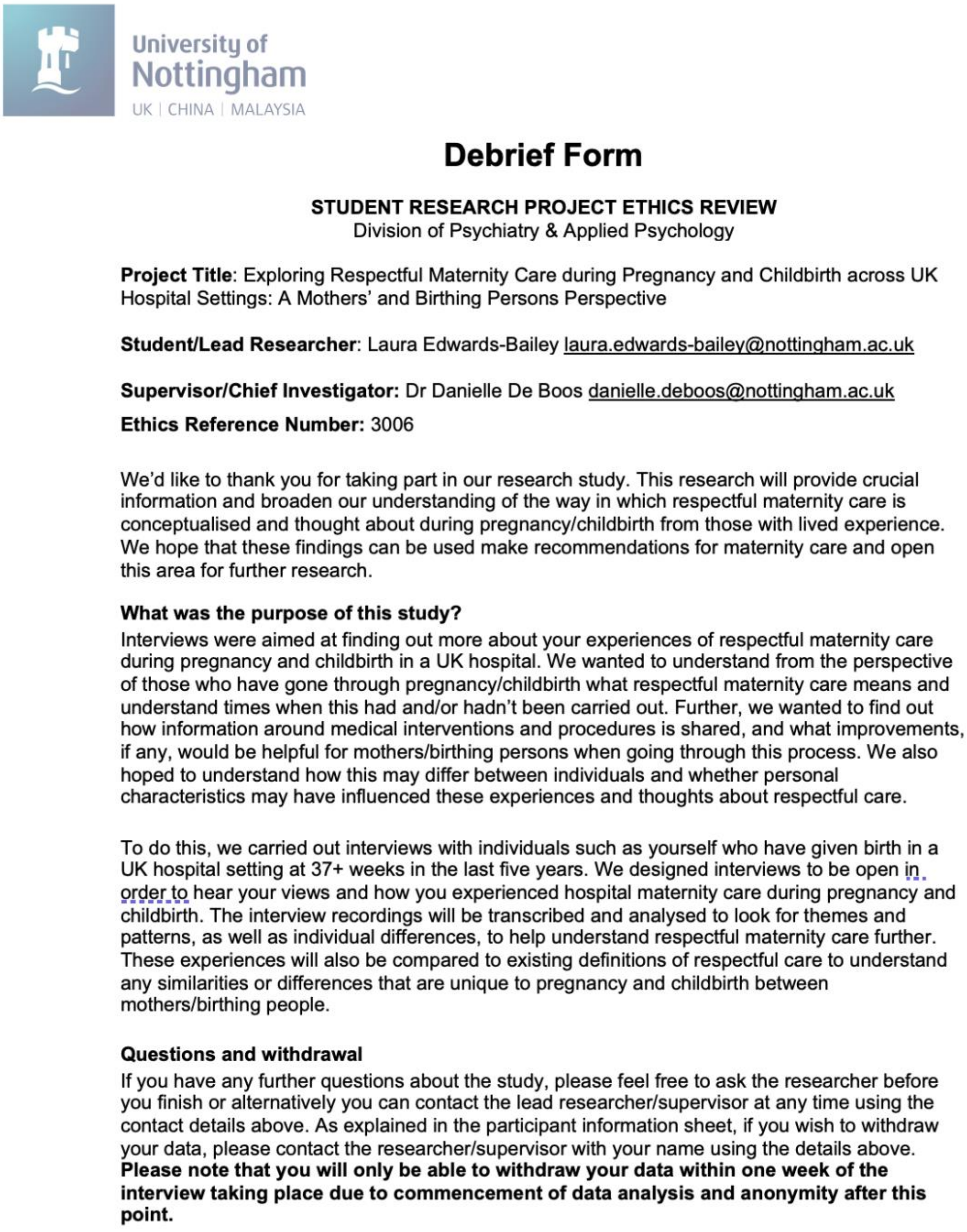
We will invite approximately 15 individuals to take part in an interview and individuals will be selected based on their demographics (e.g., birthing experience, ethnicity etc). This is in line with the aims of this study in which we hope to capture a diverse range of participant experiences. If you do not hear from the research team within one month of completing the survey, you will not be contacted to take part in an interview. We are extremely grateful for your interest in our research.

I wish to be entered into a prize draw for a £20 voucher as a result of completing this survey

○ Yes ○ No

If yes, please provide your contact details for the voucher draw:

Appendix H: Interview Debrief Form



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Debrief Form

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Exploring Respectful Maternity Care during Pregnancy and Childbirth across UK Hospital Settings: A Mothers' and Birthing Persons Perspective

Student/Lead Researcher: Laura Edwards-Bailey laura.edwards-bailey@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Danielle De Boos danielle.deboos@nottingham.ac.uk

Ethics Reference Number: 3006

We'd like to thank you for taking part in our research study. This research will provide crucial information and broaden our understanding of the way in which respectful maternity care is conceptualised and thought about during pregnancy/childbirth from those with lived experience. We hope that these findings can be used make recommendations for maternity care and open this area for further research.

What was the purpose of this study?

Interviews were aimed at finding out more about your experiences of respectful maternity care during pregnancy and childbirth in a UK hospital. We wanted to understand from the perspective of those who have gone through pregnancy/childbirth what respectful maternity care means and understand times when this had and/or hadn't been carried out. Further, we wanted to find out how information around medical interventions and procedures is shared, and what improvements, if any, would be helpful for mothers/birthing persons when going through this process. We also hoped to understand how this may differ between individuals and whether personal characteristics may have influenced these experiences and thoughts about respectful care.

To do this, we carried out interviews with individuals such as yourself who have given birth in a UK hospital setting at 37+ weeks in the last five years. We designed interviews to be open in order to hear your views and how you experienced hospital maternity care during pregnancy and childbirth. The interview recordings will be transcribed and analysed to look for themes and patterns, as well as individual differences, to help understand respectful maternity care further. These experiences will also be compared to existing definitions of respectful care to understand any similarities or differences that are unique to pregnancy and childbirth between mothers/birthing people.

Questions and withdrawal

If you have any further questions about the study, please feel free to ask the researcher before you finish or alternatively you can contact the lead researcher/supervisor at any time using the contact details above. As explained in the participant information sheet, if you wish to withdraw your data, please contact the researcher/supervisor with your name using the details above. **Please note that you will only be able to withdraw your data within one week of the interview taking place due to commencement of data analysis and anonymity after this point.**

Further help and support

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee rita.gohil@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If answering the questions has made you think a bit about yours, or your child's, mental health– please visit your local general practitioner or doctor. If you are already in contact with a specialist service, you may wish to discuss any concerns or queries with them.

GP (general practitioner): as a first port of call, you can visit your doctor/GP for any health concerns you have. Your GP should be able to assess and evaluate the patient through a series of questions and tests as appropriate. If you are not registered with a GP, you can use the online NHS Choices 'find GP services' tool to find your local surgery/practice: www.nhs.uk/Service-Search/GP/LocationSearch/4

Psychological therapies: if you are looking for NHS-run psychological therapies (also called 'talking therapies' or 'IAPT'/'Improving Access to Psychological Therapies': this includes therapies such as counselling, psychotherapy, cognitive behavioural therapy), you can look for your local psychological therapies using the online NHS Choices 'find psychological therapies' tool: http://www.nhs.uk/Service-Search/Psychological%20therapies%20(IAPT)/LocationSearch/10008. Please note that services will vary in whether patients can directly refer themselves to the service or require a GP to do so.

A mental health crisis usually refers to an episode where a person's mental health is at breaking point. For example, a person may be: experiencing suicidal thoughts and feelings, and be self-harming; may be having extreme anxiety or panic attacks; may be hearing voices, experiencing delusions and hallucinations, or feeling extremely paranoid; or other behaviour that feels out of control or out of character for the person, and may be likely to endanger themselves or other people. In a crisis, medical help is vital:

- A&E departments at hospitals are where the most serious and urgent medical emergencies are treated. If you're experiencing a mental health crisis, it's absolutely vital to take it as seriously as you would if you had a physical health emergency – and a person should attend A&E if they feel unable to keep themselves safe, may have serious harmed themselves, and need immediate help.
- Emergency GP appointments are available if you need to see your GP quickly in an emergency. These appointments can be used if it is felt that urgent mental health support is needed, but the person feels able to keep themselves safe until the appointment.

More information about crisis support can be found from Mind: www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services/emergency-support/

NHS 111 / NHS Direct: If you need medical help or advice fast, but it's not a life-threatening situation, you can call NHS 111 (in England) by dialling 111, or NHS Direct (in Wales) on 0845 46 47.

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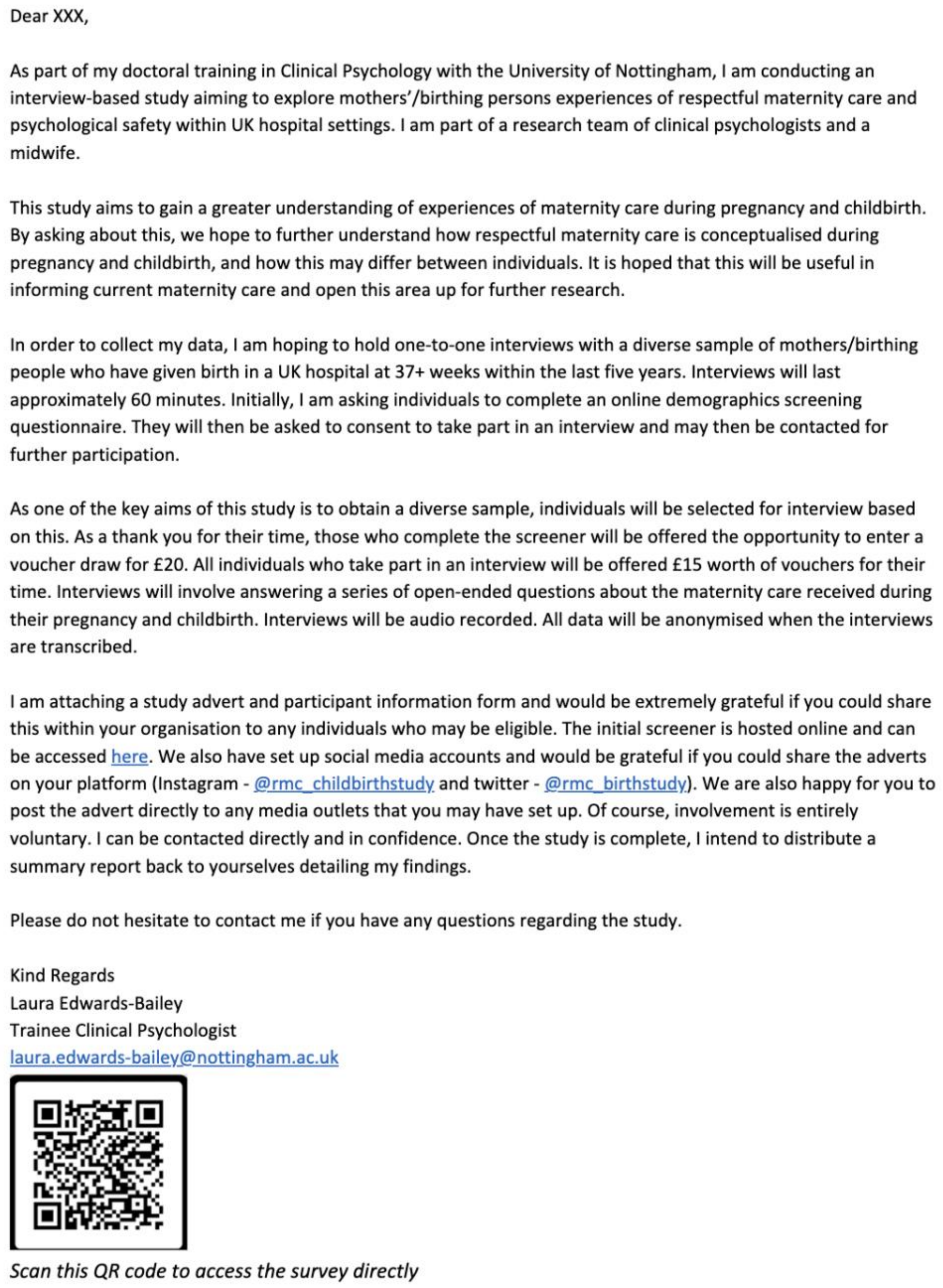
Listening and emotional support services

There are a number of national listening services available (usually via a telephone helpline or email) available to help people talk through their emotions and to provide confidential, non-judgemental support. They can help people struggling with difficult feelings who want to talk to someone immediately.

BabyCentre https://community.babycentre.co.uk/groups/a3857275/traumatic_birth_support_group.	**BabyCentre** offers a traumatic birth support group where you can chat and share your experiences with others going through the same thing.
Samaritans www.samaritans.org **Helpline**: 116 123 (free) **Email:** jo@samaritans.org Open 24/7	**Samaritans** are open 24 hours a day, 365 days a year, and trained volunteers provide confidential and non-judgemental emotional support for people who are experiencing feelings of despair or distress, including such feelings which could lead to suicide. They are there to listen to anything that is upsetting you, including intrusive thoughts and difficult thoughts of suicide and self-harm.
PAPYRUS HOPELine www.papyrus-uk.org **Helpline:** 0800 068 41 41 (Mon-Fri 10am-10pm; Sat-Sun 2pm to 10pm) **Email:** pat@papyrus-uk.org **Confidential text service:** 07786 209 697	Papyrus is a National UK Charity dedicated to the prevention of young suicide. They run **HOPEline** – a confidential non-judgemental advice line for children, teenagers, and young people (up to the age of 35) who are worried about how they are feeling, or by anyone who is concerned about a young person. The helpline is staffed by professionals experienced in working with suicidal young people, families or carers.
SANE www.sane.org.uk **SANELine helpline:** 0300 304 7000 (open 4.30pm-10.30pm every day)	**SANE** is a UK-wide charity working to improve quality of life for people affected by mental illness. They provide emotional support, help and information for a range of mental health issues via SANELine, textcare and an online support forum (see their website for details).
Switchboard www.switchboard.lgbt Helpline: 0300 300 0630 (10am-10pm every day) **Email:** chris@switchboard.lgbt **1-to-1 webchat** available on their website	If you identify as gay, lesbian, bisexual or transgender, Switchboard is available to listen to any problems you're having. They also provide information, support, and referral services. Phone operators all identify as LGBT+ and the helpline is confidential.
SHOUT https://giveusashout.org/ **Text SHOUT to 85258** in the UK to text with a trained Crisis Volunteer.	Shout 85258 is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope. Shout is available in England, Scotland, Wales, and Northern Ireland.
Frazzled Café Web: www.frazzledcafe.org	Feeling Frazzled? Join us for an online Frazzled Cafe meeting. We know how important it is to stay connected in these unprecedented and uncertain times. Frazzled Cafe meetings are a supportive online community where you can come and talk in a safe, non-judgemental space about what's really going on for you.

Appendix I: Example of Gatekeeper Contact Email



Dear XXX,

As part of my doctoral training in Clinical Psychology with the University of Nottingham, I am conducting an interview-based study aiming to explore mothers'/birthing persons experiences of respectful maternity care and psychological safety within UK hospital settings. I am part of a research team of clinical psychologists and a midwife.

This study aims to gain a greater understanding of experiences of maternity care during pregnancy and childbirth. By asking about this, we hope to further understand how respectful maternity care is conceptualised during pregnancy and childbirth, and how this may differ between individuals. It is hoped that this will be useful in informing current maternity care and open this area up for further research.

In order to collect my data, I am hoping to hold one-to-one interviews with a diverse sample of mothers/birthing people who have given birth in a UK hospital at 37+ weeks within the last five years. Interviews will last approximately 60 minutes. Initially, I am asking individuals to complete an online demographics screening questionnaire. They will then be asked to consent to take part in an interview and may then be contacted for further participation.

As one of the key aims of this study is to obtain a diverse sample, individuals will be selected for interview based on this. As a thank you for their time, those who complete the screener will be offered the opportunity to enter a voucher draw for £20. All individuals who take part in an interview will be offered £15 worth of vouchers for their time. Interviews will involve answering a series of open-ended questions about the maternity care received during their pregnancy and childbirth. Interviews will be audio recorded. All data will be anonymised when the interviews are transcribed.

I am attaching a study advert and participant information form and would be extremely grateful if you could share this within your organisation to any individuals who may be eligible. The initial screener is hosted online and can be accessed here. We also have set up social media accounts and would be grateful if you could share the adverts on your platform (Instagram - @rmc_childbirthstudy and twitter - @rmc_birthstudy). We are also happy for you to post the advert directly to any media outlets that you may have set up. Of course, involvement is entirely voluntary. I can be contacted directly and in confidence. Once the study is complete, I intend to distribute a summary report back to yourselves detailing my findings.

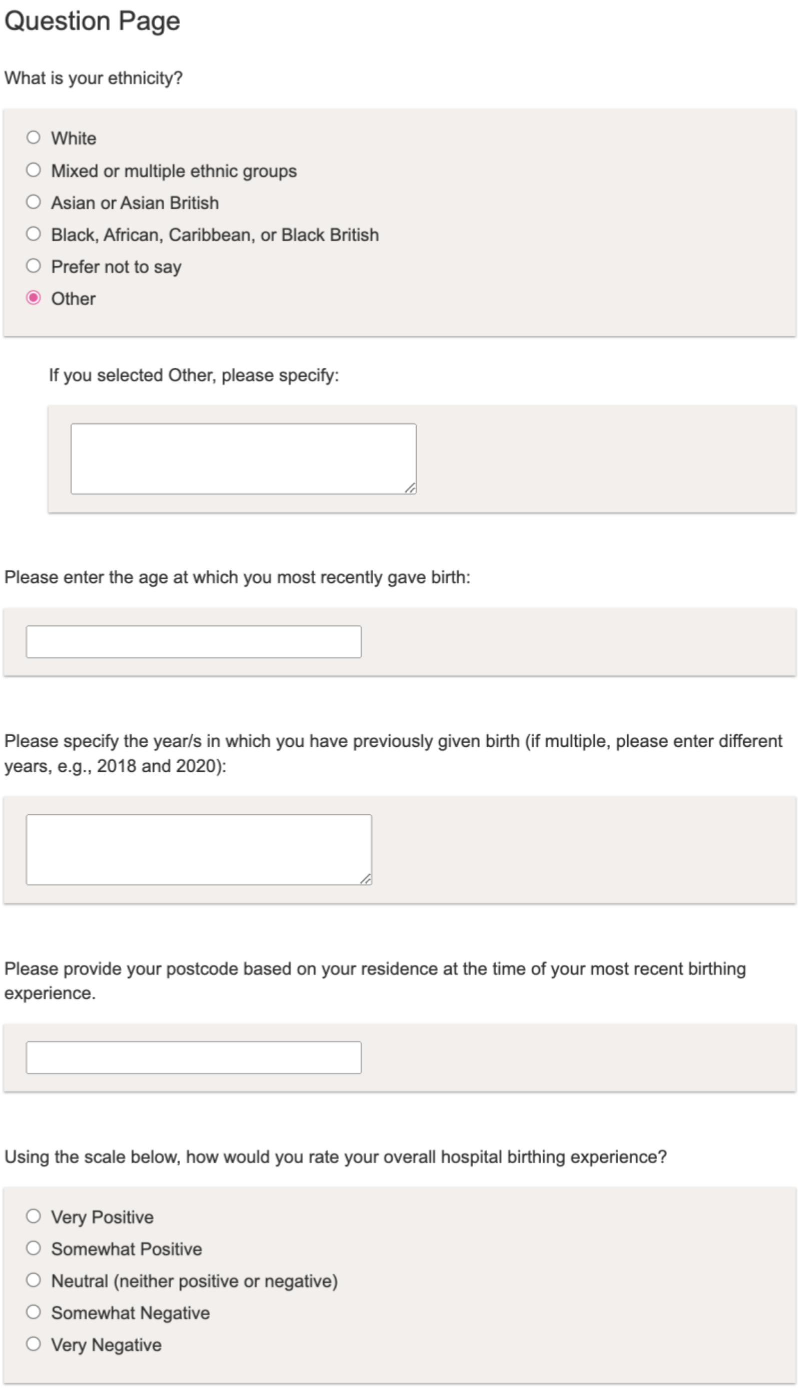
Please do not hesitate to contact me if you have any questions regarding the study.

Kind Regards
Laura Edwards-Bailey
Trainee Clinical Psychologist
laura.edwards-bailey@nottingham.ac.uk

Scan this QR code to access the survey directly

Appendix J: Screener Questionnaire Demographics

(Collated via Online Surveys Platform)



Question Page

What is your ethnicity?

○ White
○ Mixed or multiple ethnic groups
○ Asian or Asian British
○ Black, African, Caribbean, or Black British
○ Prefer not to say
● Other

If you selected Other, please specify:

Please enter the age at which you most recently gave birth:

Please specify the year/s in which you have previously given birth (if multiple, please enter different years, e.g., 2018 and 2020):

Please provide your postcode based on your residence at the time of your most recent birthing experience.

Using the scale below, how would you rate your overall hospital birthing experience?

○ Very Positive
○ Somewhat Positive
○ Neutral (neither positive or negative)
○ Somewhat Negative
○ Very Negative

Appendix K: Semi-Structured Interview Schedule

1. **Introduction**

Prompts:

- *Introductions – lead researcher to introduce self and purpose of the research*
- *Explain confidentiality and right to withdraw as detailed in consent form*
- *Overview of interview (approx. 45-60 minutes, will explore a range of factors but open as wish to explore their direct experiences)*
- *Any questions?*

2. **Can you tell me about your most recent experience of giving birth in hospital?**

Prompts:

- *How long ago did you give birth?*
- *Type of birth (i.e., induced, c-section etc?)*
- *How was the type of birth decided? (planned vs unplanned)*

3. **Was this your first pregnancy/birth?**

Prompts:

- *If yes, how was your experience of pregnancy/birth compared to what you expected?*
- *If not, how did this pregnancy/birth compare to previous experiences? Number of children?*
- *How did your experience compare to the information you had been given from maternity services/healthcare professionals?*

4. **Did you feel respected by maternity services and healthcare professionals during pregnancy/birth?**

Prompts:

- *Explore their interpretation of 'respectful' care here - what does this mean to them?*
- *If yes, what was done to make you feel respected?*
- *If no, what led to you not feeling respected?*

5. **What do you feel is important for hospital maternity services to do in order to promote respectful care during pregnancy/childbirth?**

6. **Did you feel safe during your pregnancy and birth in relation to the care you received?**

Prompts:

- *Explore psychological safety; what does this mean for the individual and in this context specifically?*
- *Thoughts on psychologically safe environments and what would help enhance this?*

7. **Can you tell me what was helpful and/or unhelpful about your pregnancy and birthing experience in the context of the care you received?**

8. **Can you tell me about your experiences of making decisions in relation to your own care during pregnancy/childbirth?**

Prompts:

- *Autonomy/involvement in decision-making?; active participant in their care/service experience?*
- *Consent – did you feel fully informed about what was going to happen/happening?*
- *Understanding of information?; was any provided?; what was helpful/unhelpful about the way in which information was shared?*
- *Were benefits & risks explained to you?*
- *If applicable: felt able to challenge decisions or question professionals? (if yes, what prompted this; If no, why?)*

9. **Did you have anyone present during hospital appointments when pregnant and during birth (i.e. birthing partner etc)?**

Prompts:

- *If yes, was this helpful?; how did healthcare professionals respond to the individual/s involvement?*
- *If no, was this out of choice? How did you find this experience?*

10. **Did you experience any of your maternity care during pregnancy/childbirth as harmful or abusive?**

Prompts:

- *If yes, could you tell me how you felt?; would anything have helped during this time to make you feel safer/cared for?*

11. **Do you think any of the experiences you have described today have had any impact on how you coped or adjusted post-birth?**

12. **Is there anything else that you would like to add about your experience?**

Interview End/Closing

- Debrief - how are you feeling now? Use of debrief sheet.

Appendix L: Braun and Clarke's (2022) "Typology of suitable research questions for TA"

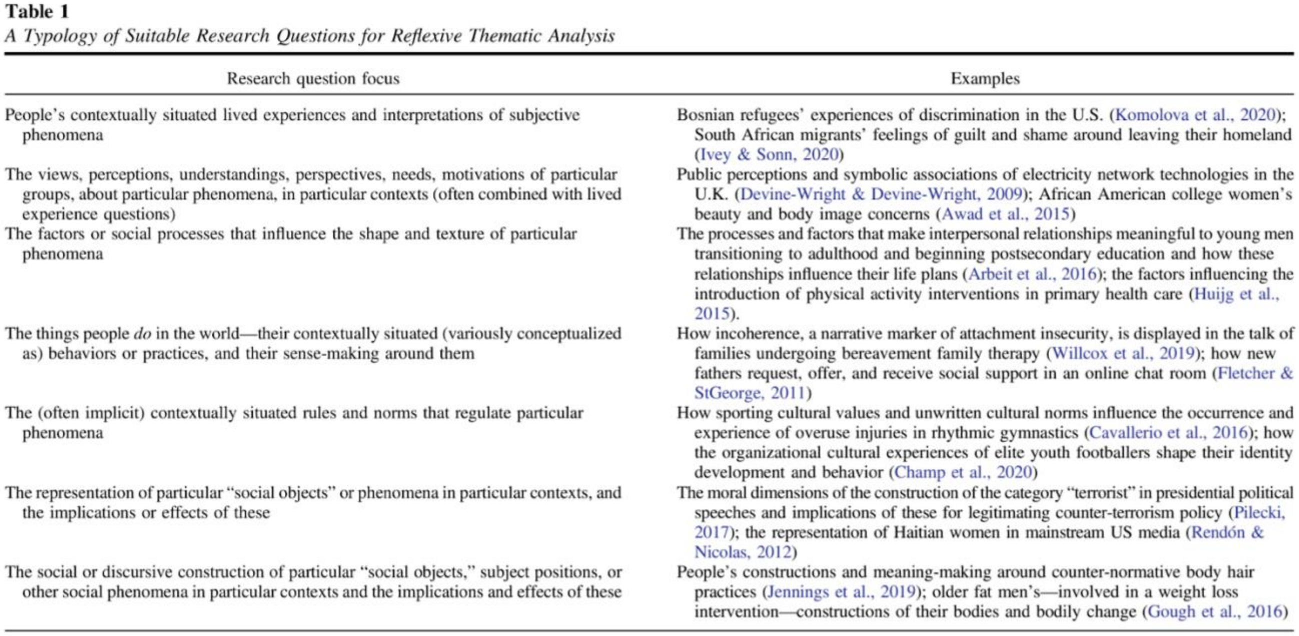


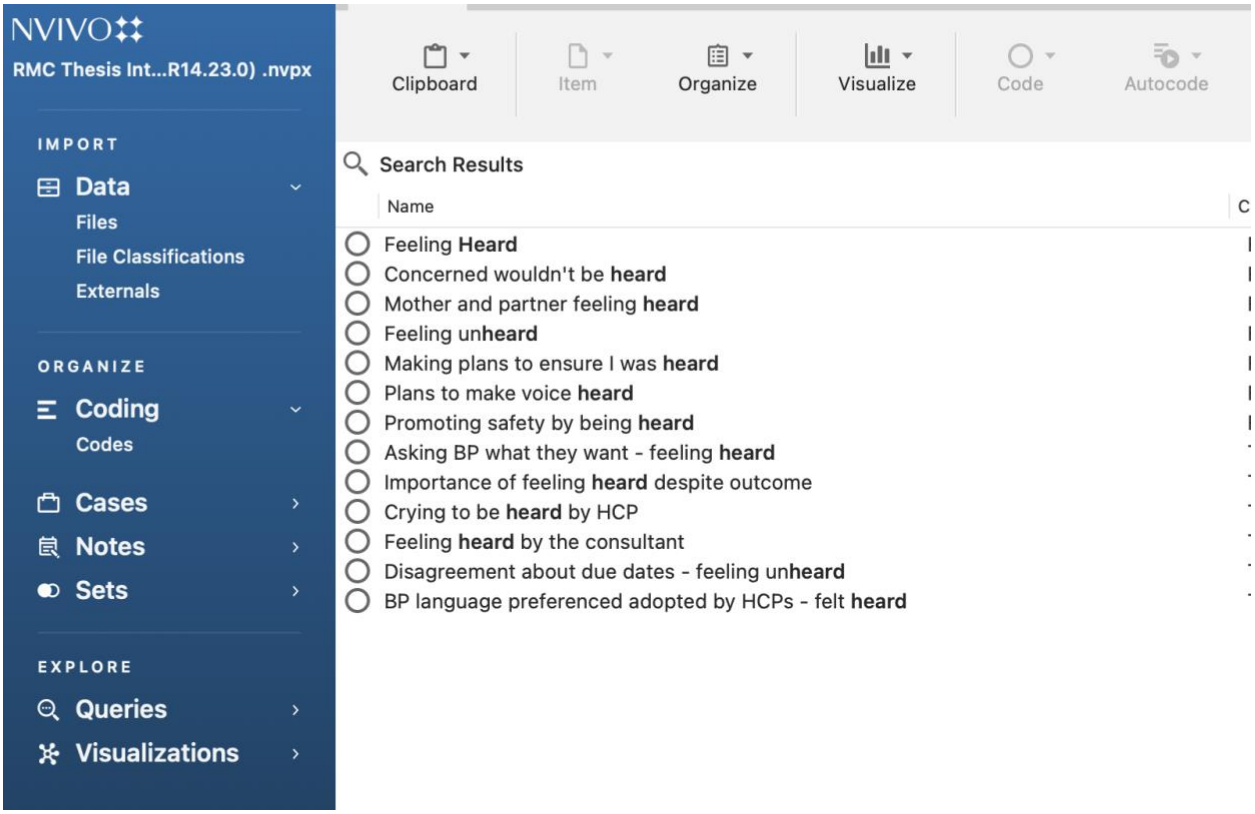
Table 1

A Typology of Suitable Research Questions for Reflexive Thematic Analysis

Research question focus	Examples
People's contextually situated lived experiences and interpretations of subjective phenomena	Bosnian refugees' experiences of discrimination in the U.S. (Komolova et al., 2020); South African migrants' feelings of guilt and shame around leaving their homeland (Ivey & Sonn, 2020)
The views, perceptions, understandings, perspectives, needs, motivations of particular groups, about particular phenomena, in particular contexts (often combined with lived experience questions)	Public perceptions and symbolic associations of electricity network technologies in the U.K. (Devine-Wright & Devine-Wright, 2009); African American college women's beauty and body image concerns (Awad et al., 2015)
The factors or social processes that influence the shape and texture of particular phenomena	The processes and factors that make interpersonal relationships meaningful to young men transitioning to adulthood and beginning postsecondary education and how these relationships influence their life plans (Arbeit et al., 2016); the factors influencing the introduction of physical activity interventions in primary health care (Huijg et al., 2015).
The things people *do* in the world—their contextually situated (variously conceptualized as) behaviors or practices, and their sense-making around them	How incoherence, a narrative marker of attachment insecurity, is displayed in the talk of families undergoing bereavement family therapy (Willcox et al., 2019); how new fathers request, offer, and receive social support in an online chat room (Fletcher & StGeorge, 2011)
The (often implicit) contextually situated rules and norms that regulate particular phenomena	How sporting cultural values and unwritten cultural norms influence the occurrence and experience of overuse injuries in rhythmic gymnastics (Cavallerio et al., 2016); how the organizational cultural experiences of elite youth footballers shape their identity development and behavior (Champ et al., 2020)
The representation of particular "social objects" or phenomena in particular contexts, and the implications or effects of these	The moral dimensions of the construction of the category "terrorist" in presidential political speeches and implications of these for legitimating counter-terrorism policy (Pilecki, 2017); the representation of Haitian women in mainstream US media (Rendón & Nicolas, 2012)
The social or discursive construction of particular "social objects," subject positions, or other social phenomena in particular contexts and the implications and effects of these	People's constructions and meaning-making around counter-normative body hair practices (Jennings et al., 2019); older fat men's—involved in a weight loss intervention—constructions of their bodies and bodily change (Gough et al., 2016)

Appendix M: Example of Individual Level Inductive Codes

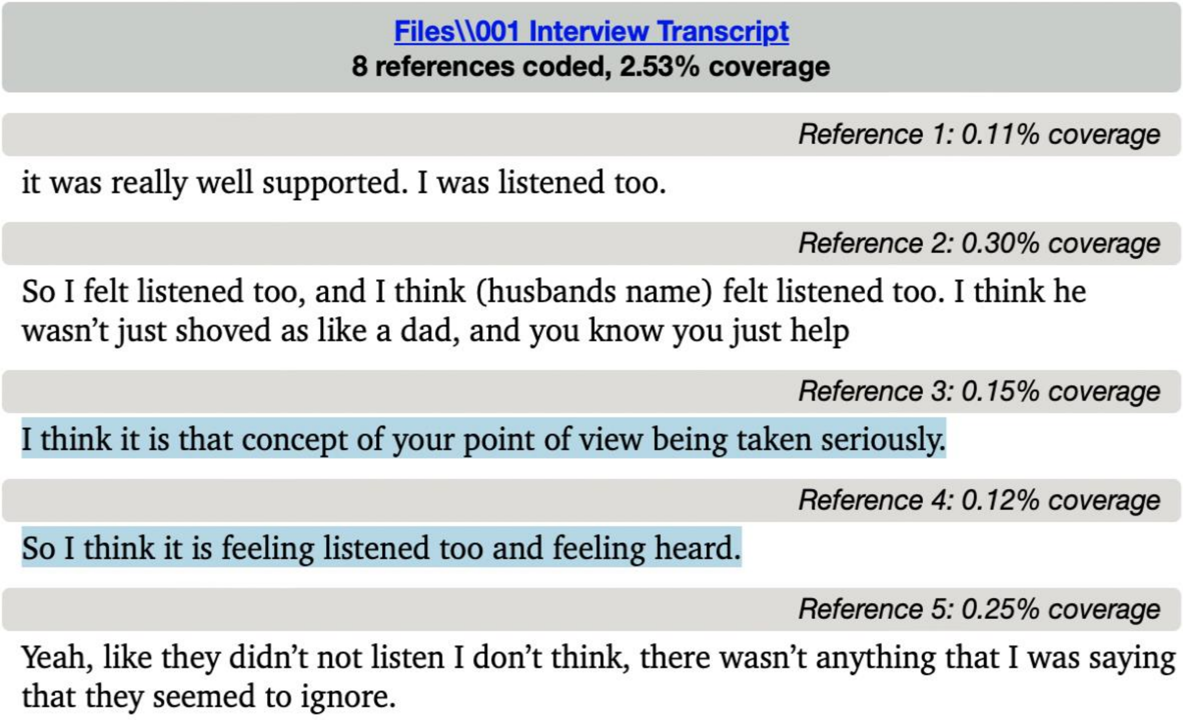
(Related to Feeling Heard)



- Feeling **Heard**
- Concerned wouldn't be **heard**
- Mother and partner feeling **heard**
- Feeling un**heard**
- Making plans to ensure I was **heard**
- Plans to make voice **heard**
- Promoting safety by being **heard**
- Asking BP what they want - feeling **heard**
- Importance of feeling **heard** despite outcome
- Crying to be **heard** by HCP
- Feeling **heard** by the consultant
- Disagreement about due dates - feeling un**heard**
- BP language preferenced adopted by HCPs - felt **heard**

Appendix N: Anonymised Example Transcripts Extracts for ‘Feeling Heard’ Inductive Code

(Note: Extracts not full transcripts are provided for anonymity)



Files\\001 Interview Transcript
8 references coded, 2.53% coverage

Reference 1: 0.11% coverage

it was really well supported. I was listened too.

Reference 2: 0.30% coverage

So I felt listened too, and I think (husbands name) felt listened too. I think he wasn’t just shoved as like a dad, and you know you just help

Reference 3: 0.15% coverage

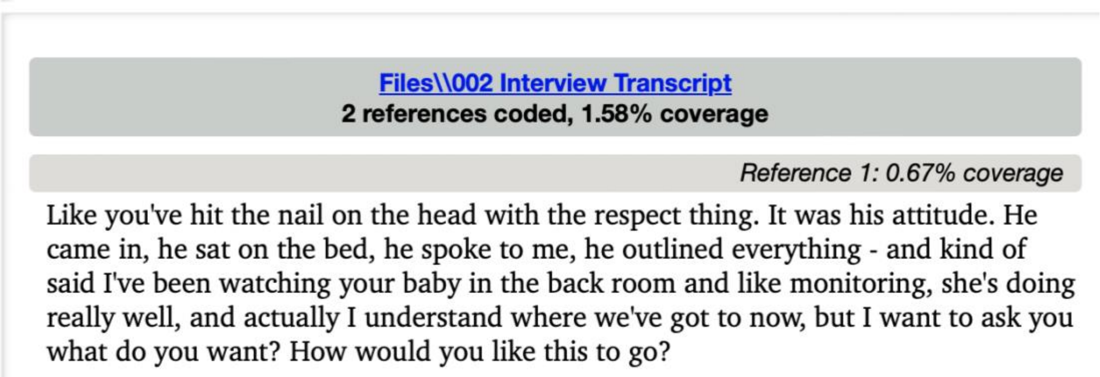
I think it is that concept of your point of view being taken seriously.

Reference 4: 0.12% coverage

So I think it is feeling listened too and feeling heard.

Reference 5: 0.25% coverage

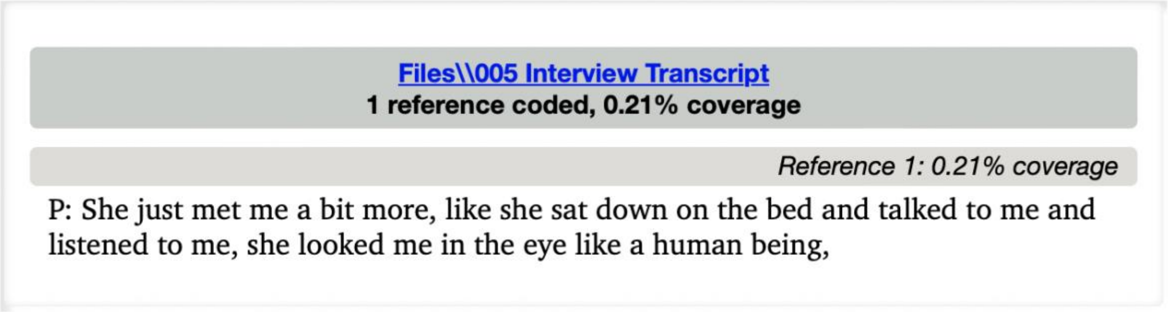
Yeah, like they didn’t not listen I don’t think, there wasn’t anything that I was saying that they seemed to ignore.



Files\\002 Interview Transcript
2 references coded, 1.58% coverage

Reference 1: 0.67% coverage

Like you've hit the nail on the head with the respect thing. It was his attitude. He came in, he sat on the bed, he spoke to me, he outlined everything - and kind of said I've been watching your baby in the back room and like monitoring, she's doing really well, and actually I understand where we've got to now, but I want to ask you what do you want? How would you like this to go?



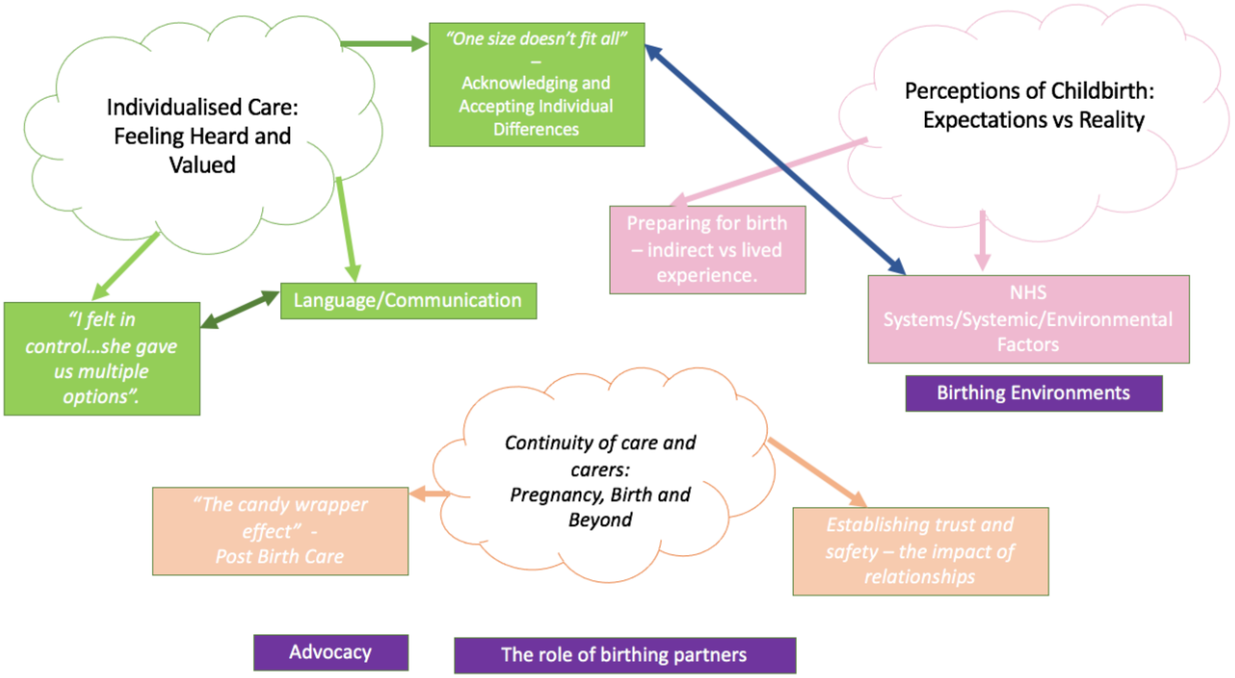
Files\\005 Interview Transcript

1 reference coded, 0.21% coverage

Reference 1: 0.21% coverage

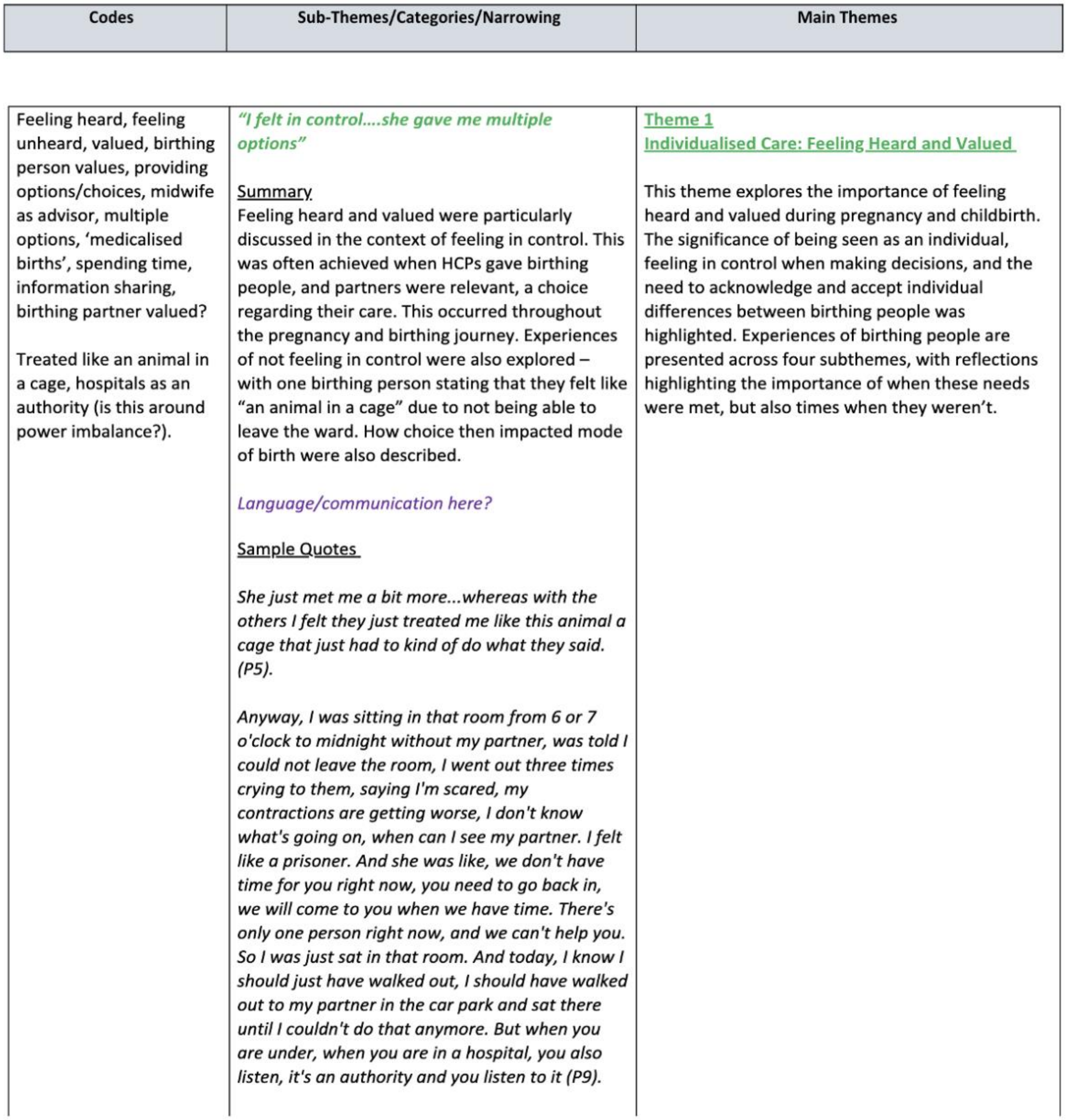
P: She just met me a bit more, like she sat down on the bed and talked to me and listened to me, she looked me in the eye like a human being,

Appendix O: Candidate Inductive Thematic Map



Note – Purple indicates areas/subthemes requiring consideration regarding where they fit with the data narrative.

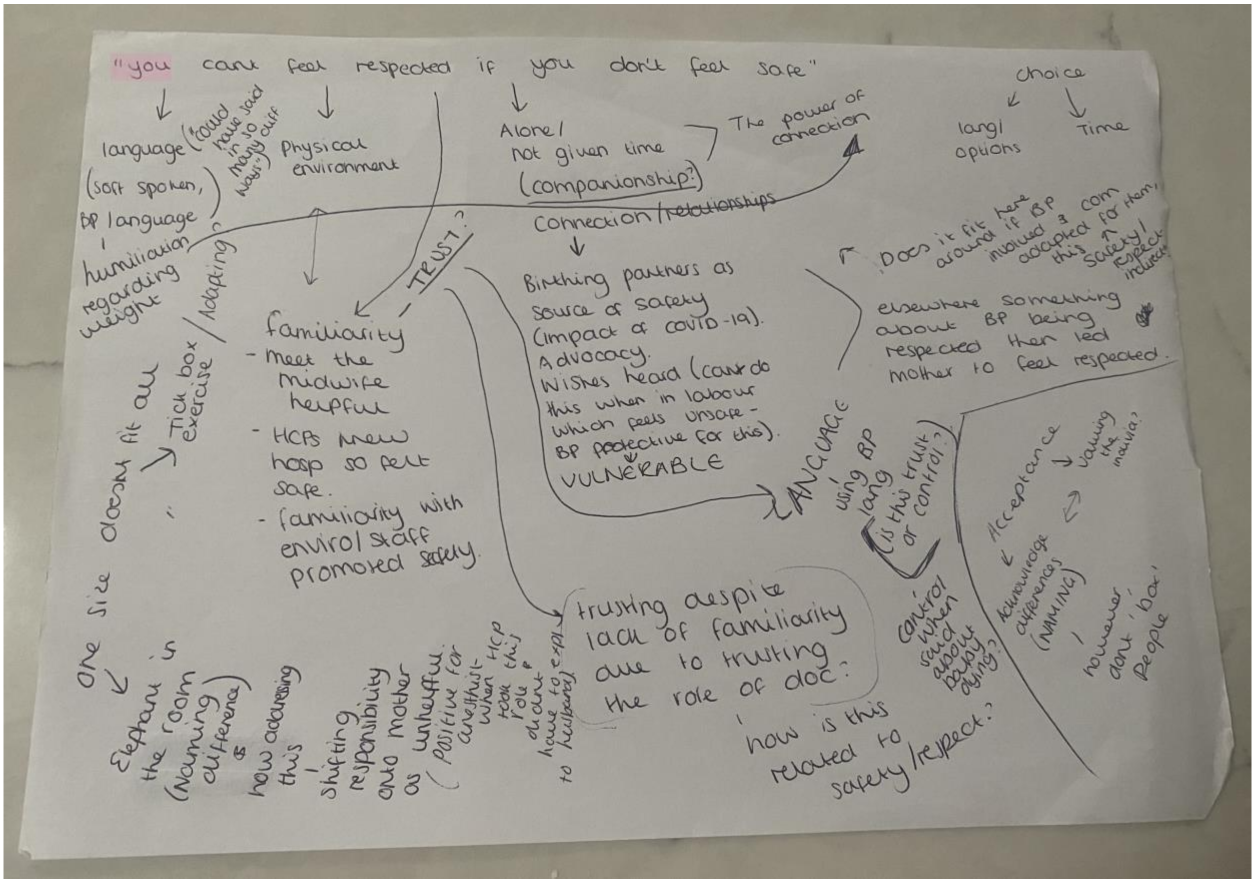
Appendix P: Example of Approach to Inductive Theme Development



Codes	Sub-Themes/Categories/Narrowing	Main Themes
Feeling heard, feeling unheard, valued, birthing person values, providing options/choices, midwife as advisor, multiple options, 'medicalised births', spending time, information sharing, birthing partner valued? Treated like an animal in a cage, hospitals as an authority (is this around power imbalance?).	*"I felt in control….she gave me multiple options"* Summary Feeling heard and valued were particularly discussed in the context of feeling in control. This was often achieved when HCPs gave birthing people, and partners were relevant, a choice regarding their care. This occurred throughout the pregnancy and birthing journey. Experiences of not feeling in control were also explored – with one birthing person stating that they felt like "an animal in a cage" due to not being able to leave the ward. How choice then impacted mode of birth were also described. *Language/communication here?* Sample Quotes *She just met me a bit more...whereas with the others I felt they just treated me like this animal a cage that just had to kind of do what they said. (P5).* *Anyway, I was sitting in that room from 6 or 7 o'clock to midnight without my partner, was told I could not leave the room, I went out three times crying to them, saying I'm scared, my contractions are getting worse, I don't know what's going on, when can I see my partner. I felt like a prisoner. And she was like, we don't have time for you right now, you need to go back in, we will come to you when we have time. There's only one person right now, and we can't help you. So I was just sat in that room. And today, I know I should just have walked out, I should have walked out to my partner in the car park and sat there until I couldn't do that anymore. But when you are under, when you are in a hospital, you also listen, it's an authority and you listen to it (P9).*	Theme 1 Individualised Care: Feeling Heard and Valued This theme explores the importance of feeling heard and valued during pregnancy and childbirth. The significance of being seen as an individual, feeling in control when making decisions, and the need to acknowledge and accept individual differences between birthing people was highlighted. Experiences of birthing people are presented across four subthemes, with reflections highlighting the importance of when these needs were met, but also times when they weren't.

Continuity of carer – forming a relationship, feeling cared for – existing relationships with HCPs, HCP had positive relationship with doula, vulnerability in trusting HCPs, distrust of professionals, birthing partner as source of safety.	**Establishing trust and safety – the impact of relationships** Summary Continuous support from trusted individuals (e.g., birthing partners/HCPs – most commonly midwives) were discussed in the context of feeling safe. However, participants also discussed how interactions and relationships with some professionals had led to a lack of trust for the service which continued throughout the pregnancy and birthing journey. *Query does advocacy fit here?* Sample Quotes *No, just the one thing I was thinking about that could maybe, what they did at the (name) hospital, which I found really good, was meet the midwife. It's an evening where you can go and meet all the midwives so that you have met everyone. So you know, you come in and you meet all the midwives, so whenever you go into Labour, you would have met that person before. I think it made it a little bit less, like it made it a little bit more be on the same level, like we are on the same page.* *But I can't help but feel really privileged that I gave birth in a hospital that I knew the staff. And I didn't know all the staff. Like there's been millions of midwives since I've left, so I didn't know all the midwives that came into me, especially post birth, but having (midwife name who had previously worked with) there on that day, and then having her come back in the morning once I'd given birth, that was just really lovely.* *So. So yeah, and then I did feel better as soon as he was back, I like clung on to him and was just like, don't go because again I need you.*	**Theme 3 – Continuity of Care/Carers: Pregnancy, Birth and Beyond**

Appendix Q: Example of Refining Themes - Mind Map



Appendix R: Example of Deductive Analysis Process with Illustrative Quotes

Deductive code	Summary	Exemplar quotes
Dignity and respect	In line with the overarching inductive theme of “one size doesn’t fit all”, examples of dignity and respect were identified across the data. Many described the importance of being seen and accepted as an individual. However, the consistency of being treated with dignity and respect differed across accounts, as highlighted through the inductive analysis. **Researcher note - this code felt very broad and often overlapped with other deductive codes.*	*Then she said to me, you have too much fat on your belly, so I can't. I can't measure your child's heartbeat. You need to have an electrode on the head, and I was just lying there naked on that bed, feeling so humiliated that she just told me that I was too fat for them to measure my baby's heartbeat, like she could have said it in so many different ways.(Jamie).* *I was going to say, the bit I didn’t feel respected in, so baby was put on me, grunting away and looking a little bit blue, and I was going to (obstetrics doctors name), I think his APGARS are 6 and 8, I don’t think they are 10 and 10. And he basically went “yes dear”, and wrote down 10 and 10. And I was like that is absolutely not cool, and not his APGARS, like he’s blue and he’s grunting, so yeah, that I felt abit put out by. (Maya).*
Privacy and confidentiality	Compared to previous literature, the concepts of privacy and confidentiality were not main features in participant accounts when exploring RMC, with minimal references to these concepts. Privacy was discussed in the context of birth progression and how having multiple people in the room negatively impacted this and made the birthing process feeling more medicalised, whilst others shared that they felt less impacted by privacy than they expected. Instead of confidentiality, sharing of	*Like I stopped caring about people seeing my bits after like three hours of being in the birthing thing. I was like like yeah, it’s free game now. I never realised I’d feel that way, even after seeing all of it and seeing other people, I just thought because I’m quite prudish, well previously anyway, and I was literally like there is no privacy to this whatsoever and it’s fine, I don’t really care and I'm really surprised I felt that way actually. (Maya).* *And I was like, I'm not progressing because you got me in the middle of a room with all the lights on, you've got 20 people walking in and out and around, and I'm not in a situation where I'm relaxed enough for my body to let go and say, come on, let's do this. (Alex).*

	information regarding birthing people's preferences appeared more important for establishing safe and respectful care. Incidents of confidentiality not being maintained were not evidenced in the dataset.	
Freedom from harm and mistreatment/ill treatment	In alignment with practice recommendations (Oladapo et al., 2018; WHO et al., 2018) harmful or abusive care was rarely experienced. One incident reported occurred outside of a maternity setting (in the emergency department), whilst another birthing person felt mistreated when they were humiliated for being overweight, which overlapped with the deductive code of 'dignity and respect' (see above).	*I was losing so much of me, I was having PTSD attacks four times a day, and so I started to plan to take my own life. And then one night I had made a plan, and I thought I can't keep myself safe, I can't keep my baby safe, and I called an ambulance. I went to A&E, unfortunately I had a really bad experience there. I was there for twenty hours and I wasn't given any food or drink, I was waiting for the crisis team. I was spoken to really poorly by doctors – they said to me "why would you think about taking your own life when you've got a baby, don't you love your baby?". And they just said really horrific things to me, and I was shamed a lot for being pregnant. Yeah, it was a really awful experience and I remember thinking I'm being shamed. And at one point I was in the room thinking should I just try and take my life here, I'm being shamed, the baby, I shouldn't be a mother. It was a really awful time. (Robin).*
Informed choice/consent, information, respect for choices and preferences	In keeping with previous literature, these domains related to the concept of control, which birth plans appeared to influence. Time given to make choices and share information, whilst allowing birthing people to voice their preferences during decision-making were reported. However, choices and preferences	*I still felt like they were trying to take the choice out of my hands in terms of what my birth looked like, and that all of these regulations and protocols and things that I had to jump through, for me to have the birth that I wanted to have. (Charlie).* *And I think for me, I prepared for everything that could have happened, and within my birth plan, I felt as though I had a pathway for anything and everything. And although things did go differently to what I envisaged*

	weren’t always acknowledged, with hospital regulations acting as a barrier. This overlaps with theme two in which respect was established through promoting control. One example of a procedure not feeling consensual was shared in relation to a sweep.	*and wanted; it was still within my remit of my choice. (Robin).* *The stretch and sweep that I had on the Tuesday night that I only agreed to because I'd refused an induction. That now, in hindsight, feels very much like I didn't consent to that really. Like I did because I felt like I had to, which isn't really consent. And it was, you know, my cervix was completely like, there was nothing she could do, like it was just really painful for no reason. And then obviously when you actually agree to an induction that involves more people shoving things in places. So yeah, there's quite a lot of things like that where I just feel like I agreed to these things because I was sort of informed that I needed them. (Jamie).*
Non-discrimination, equality and equitable care	Individuals most often spoke about equality relating to acceptance of individual needs. Mapping theme three, minority groups spoke about the need for greater recognition of different birthing outcomes from HCPs and tailored resources which would enhance non-discrimination and promote equality. Equitable care was impacted by a lack of diversity in the maternity workforce.	*I think the number one thing and I have touched on this already, so sorry, but it is treating people like individuals because there are these cohorts of people that they deal with and they think in cohorts (Alex).* *It often felt like I needed to comply in some way in order to get a little bit of what I wanted rather than just, I don't know….I think when you’re working-class you just expect that people won’t listen to you or value your opinion. (Aubrey).* *The one time I would say, was probably when that first midwife was so dismissive of me. And I just thought this doesn't feel right to me because she's obviously a midwife. She's in a caring profession, So I was really surprised when I sort of felt that she was combative with me, and disrespectful of me. And I remember thinking afterwards, there was just as little part of me that went, is it for that reason? (talking about ethnicity). (Alex).*

Timely healthcare and to the highest attainable level of health	This domain was most often discussed in relation to staff presence and staff being attentive to the needs of birthing people. Some individuals discussed waiting for significant periods of time for epidurals and procedures to be implemented, which left them in pain. Delays in beds and space for birthing people during labour were also discussed, overlapping with the inductive theme one in which several individuals had to remain in corridors. Some individuals spoke about the pressures of time on birth and how this influence them being offered interventions that not all birthing people wanted to have. Therefore, whilst timely, this did not necessarily align with birthing people feeling this was to the highest attainable level. Highest attainable level of health wasn't achieved for some due to a lack of regard for their mental well-being during the intrapartum period, aligning with theme three.	*And then it's must have been like lunchtime ish, like 11 or 12 o'clock, but it very much felt like you were on a time limit, so it was like you need to be at this stage by this point, otherwise we're gonna do more things basically. (Casey).* *And I kept saying can I have that epidural, please? That was at like for 4pm, so it wasn't until midnight that finally someone came in to me. (Jo).*
Continuous support during labour and childbirth	In accordance with theme one, the importance of support during labour and childbirth was highlighted,	*And in this whole thing, the midwife hadn't really checked me, she had just been like sitting at her laptop. (Aubrey).*

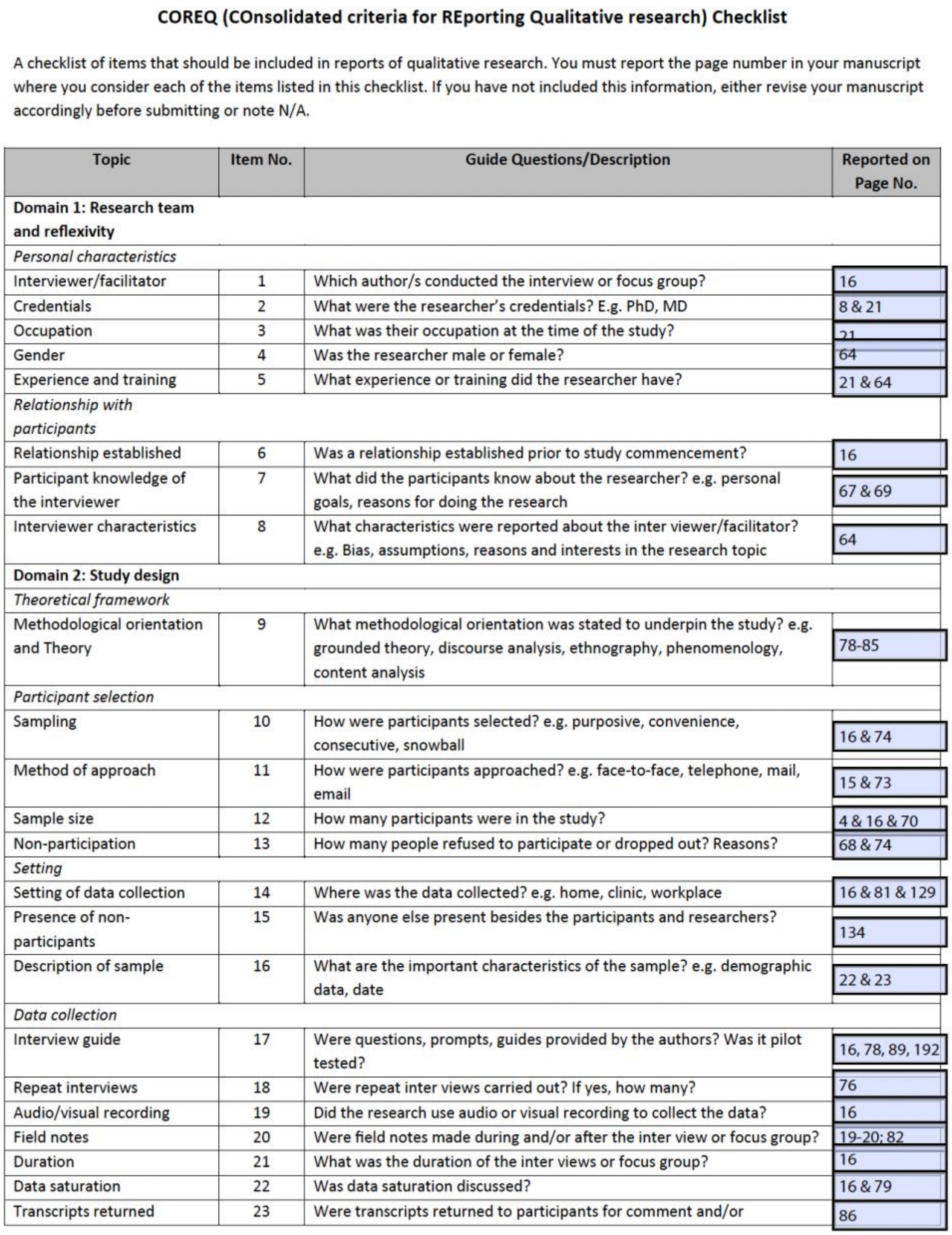
	with positive reports when continuous support was available during labour and childbirth from HCPs. Further, some individuals noted a preference to have their own space and did not feel that continuous support from HCPs was needed. **Researcher note: overlap with deductive domain of ‘companion of choice’ and ‘continuity of care’.*	*I had a midwife there pretty much constantly and so as soon as I was moved onto the labour ward, it was just really lush. They were just so supportive and so lovely. (Blake).* *I’d asked for them to be quite stepped back, so they would come in every so often to check on me, but it wasn’t constant which is what I wanted. (Dani).*
Effective communication	The language used by HCPs appeared particularly important for communicating advice and during times of decision-making. When effective, this maps with theme 2 and existing guidelines, with effective communication described as the HCP being calm and using accessible language. Effective communication with birthing partners was also key for establishing RMC, overlapping with theme four.	*And I think every step felt like it was explained really well - and I suppose they explained it to me as they would another doctor, I suppose. But also they explained it to (husband name) properly, they didn't expect me to then explain that to (husbands name). So that was quite nice because I didn't have to then you know, like paraphrase for (husbands name) in kind of laypersons speak. I could be like they could explain it to me and then they'd say like what that actually means is...and they would do that for him. (Sam).* *He didn't talk down to me. He knew that I, it had obviously got back to him like he knew that I'd looked at all the studies and that I was quite well educated on it. And I think he adapted his communication style with me based on that, and I think that's really important for anyone to, and it's a skill right to be able to adapt your communication style based on where that person is at. (Jordan).* *Whether it was my triggers, that I didn’t want this done, or doctors coming in and said they’d all read my birth plan and used the language I wanted and needed to be heard. So I think that just made everything seem a*

		lot smoother and I just felt a lot more supported. (Robin).
Companion of choice	Aligning with inductive themes one and four, having a companion of choice was often discussed and promoted safety and respect. Whilst not considered in existing recommendations due to the COVID-19 pandemic occurring after their publications, lack of flexibility for the inclusion of a companion of choice during this time prevented individuals feeling respected throughout the intrapartum period.	*I had to like leave to go and see my husband. So like he could only visit for two hours a day, but I could leave at any point and just walk around the hospital. And so I was in quite a lot of pain at this point, just like and yeah, forcing myself to go on walks and it was ridiculous because the COVID restriction was my husband couldn't come on the ward with me, but it was fine for me to be sat in a corridor, labouring effectively, which just has no logic to it basically. (Jamie).* *I had to go alone for my 20-week scan, which obviously was quiet scary. It was in a new country and it was my first pregnancy and I don't know, I felt, yeah, it was not nice. I did ask if we could FaceTime, if I could have my partner on FaceTime, but they didn't want me to do that. (Aubrey).* *It was encouraged (partners/companions) throughout. He couldn't come to all of the midwife visits because of work, but that was okay. And they where really good about like letting me record heartbeats for him, you know when you're hearing the doppler or whatever, so that was quite nice. (Maya).*
Continuity of care; ensuring continuous access to family and community support.	Mapping with inductive theme one, continuity of carer related to a sense of familiarity which allowed birthing people to feel safe. However, the deductive code of continuous access to family and community support recommended was limited in the data, and similarly to findings which led to this domain being suggested (i.e., Shakibazadeh et al.,	*And that was because I was telling her that they were sending me home after doing certain things but that I still felt like something was wrong. And she did call and say, and I think people I had someone like that in my corner, when you go to like emergency wards for pregnancies, I can't remember what they are called, but it's always different people because it's different shifts. Whereas your midwife in that team always sees the same people, so you always form more relationships with those sorts of people. (Jordan).*

	2017), individuals spoke of disappointment with supportive provisions (e.g., for breast feeding and well-being).	*I do think that continuity of care, even though it may not be able to happen 24/7, if they are coming back on the next shift, having that same midwife if they are still there. (Casey).* *Also no one helped me with breastfeeding, no one told me what to do, and I did say I need help with breastfeeding because I have no idea. And I really wanted to breastfeed, it was like the biggest dream that I had. I really wanted to breastfeed. (Charlie).*
Right to liberty, autonomy, self-determination, and freedom from coercion	In line with theme two, examples of a lack of liberty and autonomy included a sense of having to ask for permission from HCPs to carry out their wishes. Hospital feeling like an authority prevented autonomy, which appeared particularly evident during COVID-19. Whilst coercion wasn't often discussed, some individuals post-birth gained further information regarding the decisions made and felt they had been given limited information which had guided their decisions in a particular direction. At times, it was not possible to establish distinctions between autonomy and the domains of 'informed choice' and 'respecting choices and preferences'.	*I did ask them why can't I go to maternity? And they were like no, because we are going to induce you. And I was like, I don't want to be induced and they said, but you have to, you have to be induced. And I'm like they didn't give me any options, because I know now that they could have given me antibiotics and I could have gone longer, even though the water was broken. (Aubrey).* *I think I just knew that I wouldn't do anything that I didn't want to do. I know a lot of people don't have that and I do feel for them, because some people don't have that. But naturally I'm just one of those people who is like – If I don't want to do it, I'm not going to do it. I just feel like I'm the one who is pregnant so I'm the one who has to deal with the issue. But I also know that a lot of people don't have that mentality, so that's a personal thing for me generally. Like if I don't feel comfortable and don't want to do something I won't, and I felt like that during my pregnancy and birth. And I think that comes across, so it was never like pushed upon me that I had to do anything. (Jordan).* *Anyway, I was sitting in that room from 6 or 7 o'clock to midnight without my partner, was told I could not leave the room, I went out three times crying to them, saying I'm*

		scared, my contractions are getting worse, I don't know what's going on, when can I see my partner. I felt like a prisoner. And she was like, we don't have time for you right now, you need to go back in, we will come to you when we have time. There's only one person right now, and we can't help you. So I was just sat in that room. And today, I know I should just have walked out, I should have walked out to my partner in the car park and sat there until I couldn't do that anymore. But when you are under, when you are in a hospital, you also listen, it's an authority and you listen to it. (Taylor).
Enhancing quality of physical environment and resources.	This domain particularly overlaps with inductive theme one, and particularly the sub-theme in which physical environments mirrored. Some experiences of positive physical environments and resources were highlighted; however this did not appear consistent, suggesting this domain was dependent on hospital location and funding.	*And then they said we don't have space for you, so you need to wait in the hall. So I was standing in the hall with like semi contractions for an hour, just walking around out there. And then I came in and they put me in this tiny little room because there were no beds on the other. So they put me in a tiny little room and they checked me. (Aubrey).* *And then it was just all very lovely cause hospital where I gave birth, well they've got a really lovely kind of labour ward and the birthing rooms are just calm. You can have music on it if you want to. It's just beautifully set up and so it was all really calming. (Blake).*

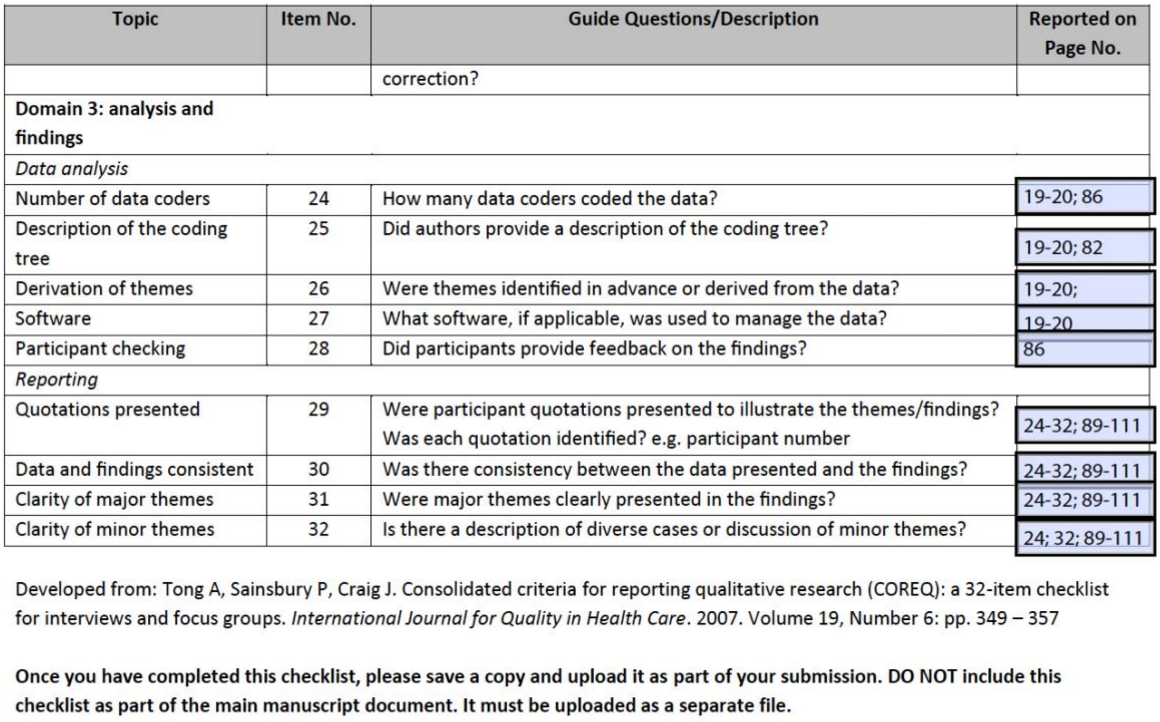
Appendix S: Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007)



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	16
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	8 & 21
Occupation	3	What was their occupation at the time of the study?	21
Gender	4	Was the researcher male or female?	64
Experience and training	5	What experience or training did the researcher have?	21 & 64
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	16
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	67 & 69
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	64
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	78-85
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	16 & 74
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	15 & 73
Sample size	12	How many participants were in the study?	4 & 16 & 70
Non-participation	13	How many people refused to participate or dropped out? Reasons?	68 & 74
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	16 & 81 & 129
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	134
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	22 & 23
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	16, 78, 89, 192
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	76
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	16
Field notes	20	Were field notes made during and/or after the inter view or focus group?	19-20; 82
Duration	21	What was the duration of the inter views or focus group?	16
Data saturation	22	Was data saturation discussed?	16 & 79
Transcripts returned	23	Were transcripts returned to participants for comment and/or	86

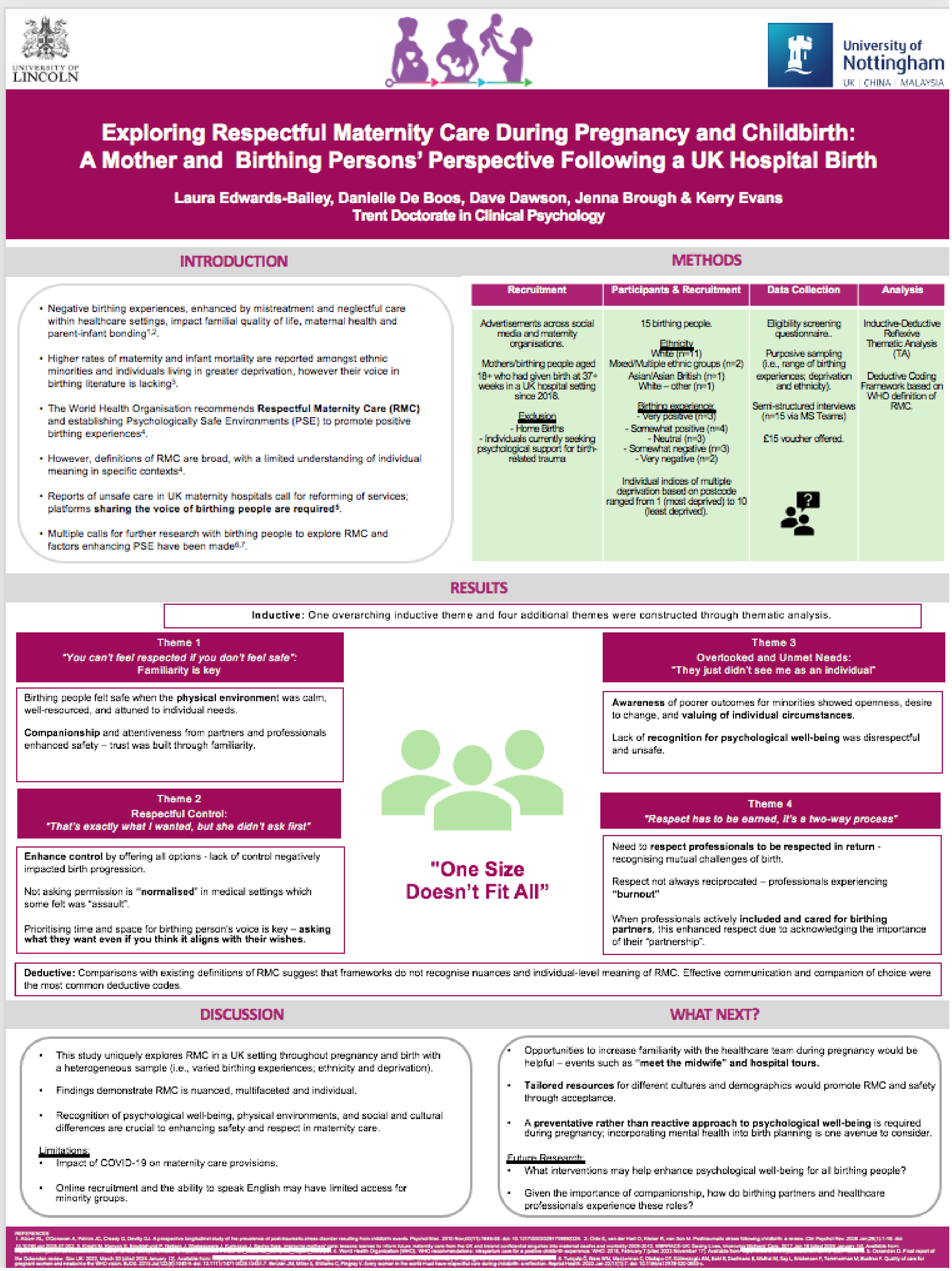


Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	19-20; 86
Description of the coding tree	25	Did authors provide a description of the coding tree?	19-20; 82
Derivation of themes	26	Were themes identified in advance or derived from the data?	19-20;
Software	27	What software, if applicable, was used to manage the data?	19-20
Participant checking	28	Did participants provide feedback on the findings?	86
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	24-32; 89-111
Data and findings consistent	30	Was there consistency between the data presented and the findings?	24-32; 89-111
Clarity of major themes	31	Were major themes clearly presented in the findings?	24-32; 89-111
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	24; 32; 89-111

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Poster



Exploring Respectful Maternity Care During Pregnancy and Childbirth: A Mother and Birthing Persons' Perspective Following a UK Hospital Birth

Laura Edwards-Bailey, Danielle De Boos, Dave Dawson, Jenna Brough & Kerry Evans
Trent Doctorate in Clinical Psychology

INTRODUCTION

- Negative birthing experiences, enhanced by mistreatment and neglectful care within healthcare settings, impact familial quality of life, maternal health and parent-infant bonding[1,2].
- Higher rates of maternity and infant mortality are reported amongst ethnic minorities and individuals living in greater deprivation, however their voice in birthing literature is lacking[3].
- The World Health Organisation recommends **Respectful Maternity Care (RMC)** and establishing Psychologically Safe Environments (PSE) to promote positive birthing experiences[4].
- However, definitions of RMC are broad, with a limited understanding of individual meaning in specific contexts[4].
- Reports of unsafe care in UK maternity hospitals call for reforming of services; platforms **sharing the voice of birthing people are required**[5].
- Multiple calls for further research with birthing people to explore RMC and factors enhancing PSE have been made[6,7].

METHODS

Recruitment	Participants & Recruitment	Data Collection	Analysis
Advertisements across social media and maternity organisations. Mothers/birthing people aged 18+ who had given birth at 37+ weeks in a UK hospital setting since 2018. Exclusion - Home Births - Individuals currently seeking psychological support for birth-related trauma	15 birthing people. Ethnicity White (n=11) Mixed/Multiple ethnic groups (n=2) Asian/Asian British (n=1) White – other (n=1) Birthing experience - Very positive (n=3) - Somewhat positive (n=4) - Neutral (n=3) - Somewhat negative (n=3) - Very negative (n=2) Individual indices of multiple deprivation based on postcode ranged from 1 (most deprived) to 10 (least deprived).	Eligibility screening questionnaire.. Purposive sampling (i.e., range of birthing experiences; deprivation and ethnicity). Semi-structured interviews (n=15 via MS Teams) £15 voucher offered.	Inductive-Deductive Reflexive Thematic Analysis (TA) Deductive Coding Framework based on WHO definition of RMC.

RESULTS

Inductive: One overarching inductive theme and four additional themes were constructed through thematic analysis.

Theme 1
"You can't feel respected if you don't feel safe":
Familiarity is key

Birthing people felt safe when the **physical environment** was calm, well-resourced, and attuned to individual needs.

Companionship and attentiveness from partners and professionals enhanced safety – trust was built through familiarity.

Theme 2
Respectful Control:
"That's exactly what I wanted, but she didn't ask first"

Enhance control by offering all options - lack of control negatively impacted birth progression.

Not asking permission is "**normalised**" in medical settings which some felt was "assault".

Prioritising time and space for birthing person's voice is key – **asking what they want even if you think it aligns with their wishes.**

"One Size Doesn't Fit All"

Theme 3
Overlooked and Unmet Needs:
"They just didn't see me as an individual"

Awareness of poorer outcomes for minorities showed openness, desire to change, and **valuing of individual circumstances**.

Lack of **recognition for psychological well-being** was disrespectful and unsafe.

Theme 4
"Respect has to be earned, it's a two-way process"

Need to **respect professionals to be respected in return** - recognising mutual challenges of birth.

Respect not always reciprocated – professionals experiencing **"burnout"**

When professionals actively **included and cared for birthing partners**, this enhanced respect due to acknowledging the importance of their "partnership".

Deductive: Comparisons with existing definitions of RMC suggest that frameworks do not recognise nuances and individual-level meaning of RMC. Effective communication and companion of choice were the most common deductive codes.

DISCUSSION

- This study uniquely explores RMC in a UK setting throughout pregnancy and birth with a heterogeneous sample (i.e., varied birthing experiences; ethnicity and deprivation).
- Findings demonstrate RMC is nuanced, multifaceted and individual.
- Recognition of psychological well-being, physical environments, and social and cultural differences are crucial to enhancing safety and respect in maternity care.

Limitations:

- Impact of COVID-19 on maternity care provisions.
- Online recruitment and the ability to speak English may have limited access for minority groups.

WHAT NEXT?

- Opportunities to increase familiarity with the healthcare team during pregnancy would be helpful – events such as "**meet the midwife" and hospital tours.**
- **Tailored resources** for different cultures and demographics would promote RMC and safety through acceptance.
- A **preventative rather than reactive approach to psychological well-being** is required during pregnancy; incorporating mental health into birth planning is one avenue to consider.

Future Research:

- What interventions may help enhance psychological well-being for all birthing people?
- Given the importance of companionship, how do birthing partners and healthcare professionals experience these roles?