Obstetric Violence Experiences of Birth Givers in Germany: A Thematic Analysis of Birth Stories

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Abstract

The current study is concerned with obstetric violence (OV) which refers to the mistreatment of birth givers during birth. The first aim of this study was to gain insight into which types of OV birth givers perceive to be present in Germany. Second, it was investigated what cultural tropes birth givers perceive to affect how they are treated by healthcare staff during birth. Third, the perceived impact of OV on birth givers was assessed. Fourth, birth givers' suggestions for improvement of birth-related care were investigated. To answer all four research questions 20 stories about OV experiences from birth givers in Germany were explored via thematic analysis. The different types of OV clustered into the main themes of unresponsiveness, plain mistreatment, withholding information and contact, violating boundaries, and systemic issues. Three cultural tropes that birth givers perceived to influence OV were identified: the 'overly emotional woman trope', the 'mother-over-human trope', and the 'untouchable doctor trope'. Birth givers perceived OV to impact them in the following domains: decreased functionality, continued loss of life quality, identity damage, and the desire to become active against OV. Suggestions for improvement of birth care were to be treated respectfully, be involved in the birth, for systemic issues to change, to receive appropriate care including aftercare, and for awareness about OV to increase. Conclusively, this study contributed to understanding the perspective of birth givers on OV types and OV impact in Germany. It highlights that birth givers perceive cultural tropes about birth and birth givers to be present in the OV context. If these tropes are confirmed by further studies, they could become a relevant aspect in future interventions against OV. Based on the birth givers' suggestions for improvements towards respectful maternity care, recommendations for possible changes on a systemic research level are portrayed. These recommendations might benefit further research about OV and future interventions against OV in Germany.

Keywords: obstetric violence, respectful maternity care, thematic analysis, underlying beliefs, birth stories, Germany.

Introduction

While many birth givers describe giving birth to their child as one of the happiest and most fulfilling events they ever faced (Callister, 2004) others experience giving birth negatively. In fact, for some birth givers the so-called 'miracle of birth' is not a miracle at all but rather a traumatising event as is reflected in the following experiences of birth givers:

I felt every single stitch he delivered into me. My legs began to quiver. I complained of the painful job he was performing on me. His answer was, 'You had a top up of the epidural. You shouldn't be able to feel a thing'. I said,'I know what I can feel and it hurts! I never got anything else for the pain. (Beck, 2018, p.99)

The most terrifying part of whole ordeal was being held down by 4 people and my genitals being touched and probed repeatedly without permission and no say in the matter, this is called rape, except when you are giving birth. My daughter's birth was more sexually traumatising than the childhood abuse I'd experienced. (Reed et al., 2017, p.7)

[...]she grabbed my cervix and pinched it. She would not let go until I consented to letting her break my water. I was in tears from the pain, screaming, begging, and sobbing for her to let go and get her hand out of my vagina. She would not let go until I consented, which I finally did. (Reed et al., 2017, p.6)

These birth givers were subject to a phenomenon that is known as obstetric violence (OV). OV can be defined as a form of gender-based, systemic, normalized violence that is directed towards birth givers and manifests itself in mistreatment, coercion, and bullying through medical staff during birth (Diaz-Tello, 2016; Freedman & Kruk, 2014; Mena-Tudela et al., 2020; Murray De Lopez, 2018). Although OV is labelled a violation of human rights by health institutions and researchers, it is present all around the globe (Diaz-Tello, 2016; Glas, 2013; Jewkes & Penn-Kekana, 2015; Khosla et al., 2016; Miller & Lalonde, 2015; Perrotte et al., 2020; Sadler et al., 2016; Shakibazadeh et al., 2018). Nevertheless, some studies show that how OV manifests can vary between countries (Bohren et al., 2015). Additionally, some studies emphasize how attributions of what constitutes OV can vary based on culture and local context (Freedman et al., 2014). Qualitative studies about OV have mostly been conducted in low- and middle-income countries, while high-income countries, such as

Germany, have seldomly been investigated (Murray De Lopez, 2018; Smith-Oka et al., 2021). Although OV appears to be understudied in Germany, the existence of various German self-help groups for OV shows that there is a need for research to address this topic further (Gerechte Geburt, 2014). Moreover, when focusing on such a geographical area where few studies have been conducted, unique or novel types of OV might emerge. Conclusively, qualitative studies with a focus on Germany are needed.

There exist different types of OV. For example, for their international meta-review of 65 studies, Bohren and colleagues (2015) created the following typology of OV behaviours: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints. In Germany, such different types of OV exist as well. These can range from overt OV behaviours such as fixating birth givers to more subtle forms of OV such as humiliating the birth giver with snide comments (Limmer et al., 2021). However, no final statements regarding the specific types of OV in Germany can be made yet since there is still too little research on the topic. Although the quantitative study by Limmer and colleagues (2021) shows that certain OV types appear to be present in Germany, qualitative studies about OV types are still scarce, which hinders the full understanding of the OV phenomenon. In this context, the most relevant German work is a book by Mundlos (2015). This book shows a collection of birth stories that illustrate what behaviours birth givers in Germany might perceive as obstetric violence. However, no systematic qualitative study has been conducted based on such birth stories to determine which types of OV birth givers perceive to be present in Germany.

In prior research, the causes for OV have been partially assigned to structural issues. Specifically, Bohren and colleagues (2015) emphasize that staff that performs OV does not necessarily have malicious intentions. Instead, OV can be the outcome of straining work conditions, since the high systematic demands in the medical field can damage medical professionals' working ability (Bernburg et al., 2016; Perrotte et al., 2020). Such strain is present in the German healthcare system as well which reflects in several changes that took place during the last 20 years. For example, structural changes in form of shutdowns of delivery facilities, midwife shortages, and an increase in technical interventions during birth (Jung, 2017; Krüger-Kirn & Wolf, 2018). Therefrom resulting overload in the obstetric and gynecological sector manifests in stressful work conditions that can foster low work satisfaction and emotional burnout (Driller et al., 2011; Fehr et al., 2014; Linsmayer & Braus, 2020; Schulz et al., 2021; Seelbach-Göbel, 2018). Explanations of why OV occurs often focus

on such systemic issues in healthcare institutions (Sadler et al. 2016). However, a different kind of structural aspect for why OV might occur has largely been overlooked in research: cultural tropes about birth and birth givers. A cultural trope refers to the reduction of a complex subject into a simplified representation that becomes a collective cultural understanding which might shape individual perception and behaviour (Florian, 2018; Sackmann, 1989; Townsley, 2001). Therefore, cultural tropes about birth and birth givers could potentially shape how and if OV occurs. For example, the clockwork narrative of Chadwick (2018) describes internalized standardized beliefs on which steps a 'good' birth should follow which presses individual births into the same set of medicalized norms. This particular trope might foster OV because it builds pressure to conform to the ideal of a clockwork birth for birth givers and birth helpers. Thus, this specific trope could result in disregarding the birth givers' individual needs in favour of compliance with the standardized medicalized ideal of the clockwork birth. This might be perceived as OV by birth givers. Such underlying cultural tropes have only once been explicitly investigated in the context of OV in a Mexican study (Murray De Lopez, 2018). In countries other than Germany significantly more research about cultural tropes has been conducted. For example, Pinos and colleagues (2016) describe the south American concept of marianismo which entails the belief that women are passive, submissive, and sacrifice themselves for motherhood. Applied to the birth context this stereotype might partially explain the occurrence of OV in South America (Castro, 2019). In Germany, however, such explicit stereotypes and tropes have not been found. Nevertheless, implicit gender stereotypes about expectations for women to be compliant followers were found (Braun et al., 2017). Thus, it is essential to understand which cultural tropes birth givers might perceive to contribute to their OV experiences in Germany.

Regardless of the underlying cultural tropes, OV experiences can have a severe impact on people. For example, prior studies have shown that experiencing OV is correlated with the emergence of postnatal depression and trauma, damaged family relationships, and a decrease in the number of children people want to have (Elmir et al., 2010; Gottvall, 2002; James, 2015; Miller & Lalonde, 2015; Muzik et al., 2017; Reed et al., 2017; Silveira et al., 2019). However, most of these listed prior studies explore the impact of OV in countries other than Germany and are of quantitative nature. Furthermore, these prior studies tend to investigate one specific possible impact factor rather than creating a full picture of the impact that the birth givers themselves perceive OV to have. Thus, to inform further research in Germany, qualitative studies about birth givers' first-hand experiences are needed to explore their perceived impact of OV.

Notably, the World Health Organization recognizes the negative impact of OV and therefore acknowledges that all birth givers have the right to respectful maternity care (WHO, 2014). To move towards more respectful maternity care, it must be investigated what exact requirements make up respectful maternity care for birth givers. This would enable individual caretakers and the healthcare system to adjust to these requirements. Of course, extreme OV behaviours such as hitting a birth giver are clearly identifiable as OV for everyone. For less clearly identifiable OV behaviours such as subtle informal coercion described by Oelhafen and colleagues (2021), this might not be the case. To elaborate, a study by Freedman and colleagues (2014) showed that birth givers and medical staff can have diverging definitions of what constitutes respectful treatment. Specifically, this issue can come into play when actions that might have become normalized in an overloaded obstetric healthcare system such as rough language or examination without prior information are considered a violation by birth givers (Castro & Erviti, 2003; De Aguiar et al., 2013; Freedman et al., 2014; Savage & Castro, 2017; Schulz et al., 2021). Because of such normalization, it might be difficult for medical institutions and medical professionals to grasp which exact structures and behaviours must be changed to reduce OV. Thus, it is important to determine what suggestions birth givers have to improve birth-related care.

Overall, this study intends to gain a deeper understanding of OV by investigating stories of birth givers who experienced OV in Germany. Specifically, it aims to explore which types of OV birth givers perceive to be present in Germany and which German cultural tropes these birth givers might perceive to contribute to their OV experiences. Moreover, this study aims to portray what impact the birth givers perceive OV to have and aims to show the birth givers' suggestions for respectful maternity care. It thereby adds to the scientific knowledge foundation that might help to reduce OV in the future. Thus, the specific research questions that this study aims to answer are:

1. What types of OV do birth givers perceive to be present in Germany?
2. What cultural tropes do birth givers perceive to contribute to their OV experiences in Germany?
3. What impact do birth givers perceive OV to have in Germany?
4. What suggestions for improvement of birth-related care do birth givers have for Germany?

Methods

Design

A qualitative approach in form of thematic analysis was employed with the data of 20 birth stories from birth givers who experienced OV in Germany. It was decided to analyse birth stories because they provide a detailed insight into the subjective perception of the birth givers which was crucial to adequately answer the research questions. The term 'birth story' refers to stories in which birth givers describe how they gave birth to their children.

Procedure and Participants

First, the study was approved by the Behavioural Ethics Committee of the University of Twente. Next, the developed Qualtrics questionnaire was published on various social media sites to obtain birth stories and suggestions for birth care improvements. Specifically, it was published on Twitter, Instagram, Facebook, and Reddit. Moreover, participants were recruited by contacting self-help group leaders via mail, who then shared the questionnaire with their members via their preferred channels. Furthermore, birth givers were recruited via convenience sampling and snowball sampling by contacting birth givers in the proximity of the researchers and by encouraging each participant to forward the questionnaire to friends and family members that would like to participate as well. Overall, data collection lasted from the 19th of April to the 1st of July. Participants were allowed to contribute a birth story if they met the criteria of being at least 18 years old, having experienced OV one year or longer ago, and not being currently pregnant.

When starting the survey participants received a trigger warning due to the sensitive topic of the study. After participants had agreed to the informed consent, they were directed to the questionnaire that contained a few multiple-choice questions and an open-ended text field to place their stories in (see below for details). Last, participants were asked to allow the usage of their information once more to offer them the opportunity for consent withdrawal. Overall, 20 birth stories were collected. Notably, solely 12 birth givers provided their birth stories via the questionnaire. Therefore, eight additional birth stories about OV experiences were selected randomly from the publicly accessible database of the biggest initiative against OV in Germany (Roses Revolution, n.d.). These additional stories were randomly chosen from the pool of most recent reports of 2021 via straw draw. Solely stories that were written from a first-person perspective above the length of 250 words were considered.

Materials

The approximate duration of the questionnaire varied based on the respective participant. However, since the participants were encouraged to prepare their answers before taking the questionnaire, the approximate length of the questionnaire itself was five to ten minutes. The questionnaire was solely available in German and is portrayed in the appendix in full length (Appendix A). Participants received detailed information on how to write the birth story. Namely, they were asked to write it from their first-person perspective and keep the length between 250 and 750 words. They were asked to write down everything that they perceived as violent during their births. Requirements for the stories were to name the location and environment of the birth experience (e.g. hospital, delivery room, home birth, etc.), to name the persons involved (e.g. midwife, doctor, partner, etc.), to name events (e.g. what violent acts, what happened exactly in what order, etc.), to describe own feelings about the situation and about specific actions, and to write about what suggestions for improvement they would have for the birth staff (e.g. doctor, midwife, nurse, etc.) if they saw them again today.

Within the instructions for the birth report, participants were provided with information about counselling offers. This information was meant to help participants in case they had to drop out of the study due to reactivated trauma or discomfort. Participants could also interrupt their participation to make sure that they could write their birth story at a pace that felt comfortable for them. After finalizing the birth story participants were presented with the following general demographic questions: ‘What is your nationality?’, ‘What is your ethnicity?’, ‘How old are you?’, ‘What gender do you identify as?’, ‘How many births did you have?’, ‘When did your violent birth experience take place?’ and ‘During which types of births did you experience violence?’. For the last question about types of births, the answer options were: ‘birth in a conventional medical facility (e.g. hospital, clinic, maternity unit, etc.)’, ‘birth that did not take place in a conventional medical facility (e.g., home birth)’, ‘planned caesarean section’, ‘unplanned caesarean section’, and ‘vaginal birth’. Participants could also specify if they experienced OV during another type of birth in an open text field. Last, the participants were thanked for their participation.

Data Analysis

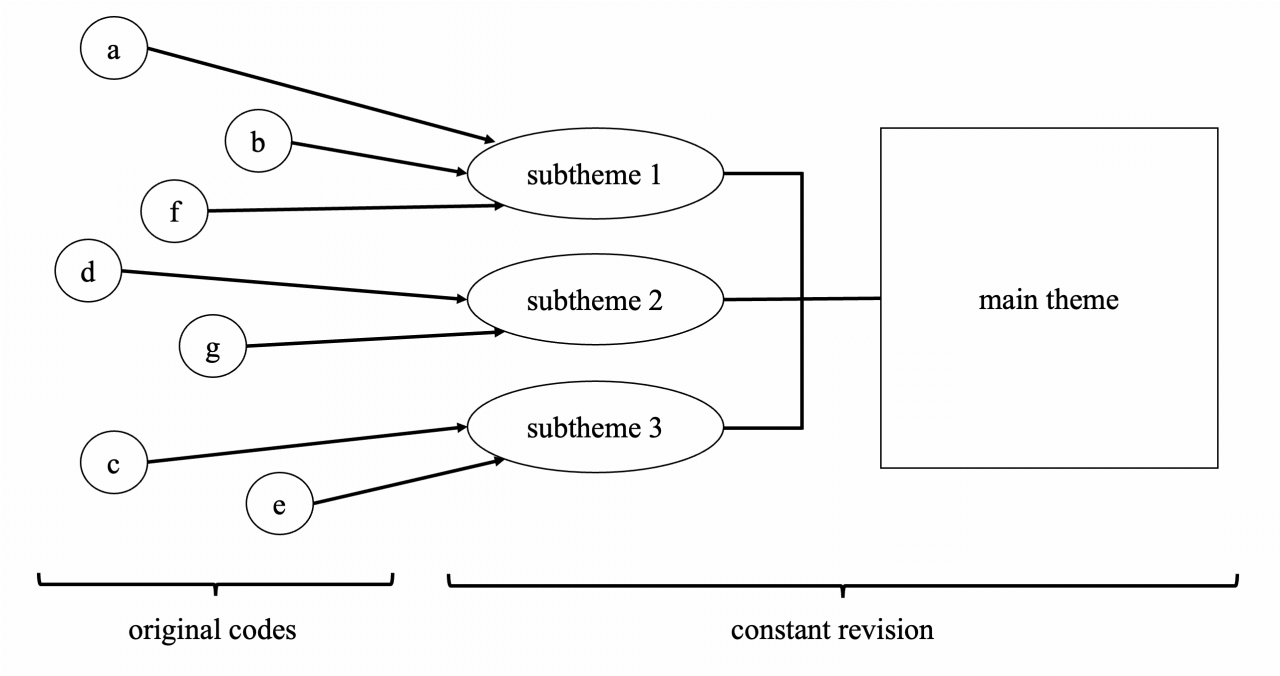
The measure of thematic analysis was chosen to identify themes within the stories. A theme is defined as an abstract entity in form of a meaning or a pattern that is drawn from the interpretation and integration of the data (Braun & Clarke, 2006; Kiger & Varpio, 2020; Nowell et al., 2017). Thematic analysis was chosen because it is a method that is fitting to understand the cognitions, actions, and experiences of the actors in stories (Kiger & Varpio,

2020). Furthermore, the researchers Braun and Clarke (2006) describe that thematic analysis is deemed useful to reduce many pages of stories down to their essence without losing meaningfulness and remaining accessible to further research. For this study, inductive thematic analysis was conducted. Epistemologically, the current study aimed to summarize and portray the birth givers' view of the OV situation in Germany. Therefore, the outcomes of this study are to be understood as looking at the OV situation in Germany through a window that is coloured by the subjective perceptions of the birth givers.

Specifically, established steps for thematic analysis were followed to ensure a systematic approach (Braun & Clarke, 2006). First, while de-identifying the birth stories to protect birth givers' identities, the coder familiarized themselves with the data and created a preliminary codebook with initial codes. The anonymized stories were then uploaded into atlas.ti to be able to assign these codes. Second, the stories were analysed in detail and the initial codes were revised, merged, and clustered into subthemes. These subthemes were then clustered into main themes once more. To illustrate, one participant described that she began to have severe depression due to her OV experience. Her original text fragment was therefore assigned the initial code of 'postnatal depression', which then formed the subtheme of psychological damage together with other initial codes. The subtheme of psychological damage described the perception that OV had damaged the overall mental well-being of the birth giver. The subtheme of 'psychological damage' was then once again clustered into the main theme of 'decreased functionality' together with two other subthemes. These subthemes were clustered together because all their underlying meanings centered around the feeling of being less functional in everyday life than before the OV experience. The initial codes were coded semantically in the sense that they were close to the explicit meaning of the data. On the other hand, subthemes and themes were created by clustering and interpreting semantic original codes based on shared underlying meaning. Therefore, no clear line can be drawn between semantic and interpretive levels as both were present within this thematic analysis. All themes were repeatedly reviewed, evaluated, and discussed with the supervisors to make sure that they accurately represented the data. An overview of complete code trees is presented in the appendix (Appendix B-E). A process description is presented in the following figure (Figure 1).

Figure 1

Graphic Depiction of the Inductive Thematic Analysis Process



Results

For the additional eight birth stories that were drawn randomly from the public online database, no demographic information was known. Nevertheless, the demographic information of the remaining twelve birth givers who had participated via the questionnaire was analyzed. Birth givers of various ages participated (mean= 41,17 years, SD = 11.89, range: 23-58 years). All twelve questionnaire participants had given birth to at least one child (mean= 1,5 births, SD = 0,80, range: 1-3 births). Although the twenty analyzed stories varied in length (mean= 880,5 words, SD = 537.32, range: 236-2060) most writers described their experiences in great detail. More extensive variable overviews are portrayed in table form (Table 1). Most participants were of German nationality, and all twelve questionnaire participants were Caucasian and identified as female. All twenty OV experiences took place in conventional hospitals and the actors that were mostly perceived as perpetrators were doctors. OV occurred mostly for unplanned caesarean sections, second most for vaginal births, and fewest during planned caesarean sections.

Table 1

Variable Overview in Relation to Prevalence (n) and Percent (%)

Characteristic	n	%
nationality		
German	11	91,67
Dutch	1	8,33
type of birth		
unplanned caesarean	6	50
vaginal birth	5	41,67
planned caesarean	1	8,33
year of OV experience		
1996	1	5
2000	1	5
2006	1	5
2017	1	5
2018	2	10
2019	1	5
2020	3	15
2021	6	30
No date	4	20
perceived perpetrators		
doctors	23	58,97
midwifes	13	33,33
midwife students	2	5,13
medical students	1	2,56

Note. The year of OV experience shows the year in which OV took place for each of the 20 birth stories. Perceived perpetrators shows the number of times different actors of these groups were mentioned as perpetrators in all stories. The remaining variables are related solely to the twelve birth story writers that participated via the questionnaire.

Types of OV

The birth givers described a variety of behaviours that they perceived as OV. These behaviours constitute the different types of OV that are perceived to be present in Germany. The established OV-type subthemes were clustered into five different main themes. An overview of the description of main themes and subthemes in relation to the number of stories they occurred in, and data examples are portrayed in the following table (Table 2).

Table 2

Themes about Types of OV with Corresponding Data Examples and Sample Prevalence (n)

Themes	Description	Data Example	n
unresponsiveness	A general dismissive and disregarding attitude and/or behaviour towards the birth givers and their needs.		**17**
ignoring*	Passively disregarding the birth giver as an individual and failing to acknowledge information, needs and requirements that the birth giver states.	"That I could not bear it anymore was answered with 'that doesn't matter'".	14
denying needs	Actively refusing to respond to birth givers' explicitly stated needs without providing a reasonable explanation.	"I expressed the wish that I would rather have a caesarean section now – all this under heavy contractions. The senior doctor […] said something like "We're not in the self-service shop here" and refused a caesarean section."	9
atmosphere	Stressful, negative, and non-welcoming atmosphere in the birth environment.	"I didn't find it particularly bad that we were almost alone, because I found everyone to be very unfriendly and stressed."	7
trivialization	Treating serious OV-related situations and connected demands of the birth giver as unimportant or irrelevant.	"My pain was not addressed as if it had not been accepted."	4
unprofession-alism	Staff acting and communicating in an unprofessional manner.	*NQ (no quote, since the two affected participants did not give consent to be quoted verbally)*	*2*
plain mistreatment	The most unambiguously identifiable mistreatment which was clearly labelled as such by birth givers.		***17***
verbal mis-treatment	Harming the birth giver with words, via yelling, mocking, scolding, blaming, or using condescending language.	"The nurses were always saying that I should not make such a fuss."	*15*
physical mis-treatment	Using physical force against the birth giver and/or inflicting physical injury or pain on the birth giver.	"I had to feel everything, nobody cared. This experience was indescribable […] the worst of all in terms of pain. I would rather have died than feel this pain."	*9*

Table 2 (continued)

withholding information and contact	Deprivation of resources (in form of information and contact) that birth givers perceive as essential for a self-determined, positive, successful birth experience.		**15**
withholding information	Not providing information about the birth process, upcoming medical measures and purpose of these measures.	"I had multiple gynecological exams without knowing by whom and why."	10
withdrawing	Withdrawing child and/or birth-companion against birth givers' wishes.	"That means I lay without my child, it was at the pediatricians next door, with my legs open in front of everyone."	10
violating boundaries	Crossing birth givers' personal boundaries and disrespecting their limits.		***14***
disrespecting consent	Acting without the permission of the birth giver and/or against the will of the birth giver.	"That the midwife, unprepared, hurts me insensitively and painfully on the fly, even though I'm screaming for her to stop."	13
privacy violation	Failure of staff to protect the birth givers physical privacy.	"Suddenly 20 students and the senior doctor were surrounding me"	3
systemic issues	Constraints or problems in the hospital and healthcare systems that birth givers perceived to contribute to OV.	"The mobile CTG didn't work, so I couldn't move as I wanted."	**8**

*NOTE. *=the code ignoring is similar to "denying needs". However "denying needs" describes actively denying needs while "ignoring"describes more of a passive dismissiveness.*

Unresponsiveness

First, OV was present mostly in the form of the main theme of *unresponsiveness*. This theme described general dismissive and disregarding behaviour and attitude towards birth givers and their needs. Within the context of this main theme, the birth givers perceived it as a violation when healthcare staff was *ignoring* them and their requirements by passively disregarding them as individuals or failing to acknowledge them. For example, this manifested in extensive waiting times, treating the birth giver like an object rather than like a person, ignoring health information about the special needs of impaired birth givers, or ignoring wishes that were explicitly stated in the birth plan. Another relevant unresponsiveness subtheme that was found

was *denying needs* of birth givers by actively choosing to not respond to the birth givers' needs. This included denying medication and pain medication, not providing care when birth givers articulated needs, not providing necessities such as food or water, and not believing the mothers when they stated needs. *("I expressed the wish that I would rather have a caesarean section now – all this under heavy contractions. The senior doctor […] said something like "We're not in the self-service shop here" and refused a caesarean section."*). The birth givers described a stressful *atmosphere* in which they felt unwelcome and like an annoyance as an aspect of their traumatic birth experiences. Another aspect that became apparent within the main theme of unresponsiveness was the violation of birth givers via *trivialization* by which birth givers' serious demands and OV situations were treated as unimportant or invalid by staff. Examples that were present for this theme were staff downplaying, denying, or normalizing the birth givers' pain or the performed OV itself. Moreover, *unprofessionalism* was present when medical staff communicated about private matters or played games on smartphones while surgery was conducted on the birth givers.

Plain Mistreatment

Second, OV manifested itself in the main theme of *plain mistreatment* which described the most active acts of violation that could be most clearly and unambiguously labelled as such. The most common plain mistreatment form in the sample was *verbal mistreatment* which described mistreatment via words. Specifically, this entailed the behaviour of using rough language, yelling, mocking, scolding, and making condescending comments towards the birth givers. Additionally, some birth givers were verbally blamed for natural bodily functions such as bleeding. On the other hand, the subtheme p*hysical mistreatment* described the use of physical force and inflicting physical injury or pain on the birth givers. For the birth givers, this manifested itself mainly in repeated rough physical examinations, performing fixation on the women, forcing legs open to conduct examinations despite the birth givers' objections, continuing treatment despite failing pain medication, and conducting painful examinations and surgical measures without waiting for pain medication to unfold its effect. (*"The necessary caesarean section was extremely painful. I said that over and over again during the surgery. It wasn't taken seriously. They said this was normal. Only afterward I realized that the epidural hadn't worked and that I was in excruciating pain.").*

Withholding Information and Contact

This main theme described the tendency of staff to withhold resources that the birth givers perceived as important for having a positive, self-determined birth experience and successful birth. *Withholding Information* from the birth giver was a corresponding subtheme that described instances when the medical staff did not offer information about the birth process and upcoming procedures to the birth givers. This was especially linked to situations in which examinations or procedures were performed on birth givers without educating them on what was going to happen first, and which purpose these procedures had. W*ithdrawing* of close others occurred when staff withdrew either the child against the birth giver's wish or withdrew the birth support person by denying them access to the birth giver.

Violating Boundaries

The main theme of *violating boundaries* concerned instances in which medical staff crossed birth givers' boundaries and disrespected their limits. This is reflected in the subthemes of disrespecting consent and privacy violation. It became apparent, that medical staff was *disrespecting consent* of the birth givers which meant acting without the permission of the birth giver or against the will of the birth giver. For example, consent was disrespected passively by coercing birth givers into giving consent to interventions or actively when healthcare staff continued to conduct examinations against the birth givers' explicitly stated dissent. Disrespecting consent was also present in active form by blackmailing birth givers by making false promises, threatening with the babies' health, or by threatening to omit help if they do not agree to what the medical staff demanded. (*"In the meantime, the senior doctor also made a comment in the sense of "If you don't participate properly here now, you have to look for another place to give birth!". This was at a time when labor was every minute and the cervix was almost fully dilated!").* Last, birth givers experienced *privacy violations* when their physical privacy was not protected by staff. For example, when multiple staff members viewed them in vulnerable positions without asking for consent first.

Systemic Issues

Systemic issues meant constraints or problems in the hospital and healthcare systems that birth givers perceived to contribute to OV. This included dysfunctional equipment which led to impaired care. The birth givers also described dysfunctional pain medication as a prominent systemic aspect of their OV experience. Staff shortages and constant staff changes as well as staff being insufficiently prepared for the birth were named as further systemic issues.

Perceived Cultural Tropes in the OV Context

Within the stories, several cultural tropes that might play a contributing role in why OV occurs were identified: 'the overly emotional woman trope', 'the mother-over-human trope', and 'the untouchable doctor trope', which are elaborated on in the following table (Table 3).

Table 3

Themes about Cultural Tropes with Corresponding Data Examples and Sample Prevalence (n)

Themes	Description	Data Example	*n*
overly emotional woman	The trope that birth givers are hysterical, overly emotional, or too sensitive when they react rationally and adequately to mistreatment.	"Maybe that's normal and my hormones just make me so sensitive to it."	7
mother>human	The 'mother-over-human' trope entails that mothers must endure suffering by compromising on their own basic human needs to always meet all the assumed needs of the child. Only if all the baby's needs are met birth givers are allowed to attend to own needs.	"Far too many interventions are carried out under the guise of "the main thing is that the child is fine" without the mother's information or consent."	5
untouchable doctor	The trope that no one may speak up against or correct the highest ranking professional in the room even if someone else has more thorough insight into the situation.	"Meanwhile, the midwife quietly told us that she was sure that our child could not be born the "normal way" [...] We should insist that a cesarean section be done. But she probably shouldn't say that officially or in front of the senior doctor."	3

First, the most occurring *overly emotional woman* trope described the perceived collective belief that birth givers were simply too emotional, hysterical, or sensitive if they reacted proportionately and rationally to OV. From the birth givers' point of view, the trope manifested in specific behaviours of the medical staff. For example, in condescending comments and trivialization of the birth givers' pain. However, sometimes this trope was also perceived to shape individual beliefs of the birth givers themselves in response to such trivialization. Specifically, this was the case when trivialization led to the birth givers beginning to doubt their own judgement, assuming the OV as normal, and attributing their discomfort and trauma to being too sensitive, emotional, or hormonal.

Second, the *mother-over-human* trope was present in situations in which the child's assumed needs were weighted against the mother's needs. In this context, writers perceived to be forced into a mother role by being forced to hold and breastfeed their child while they were not yet physically or mentally capable to do so. Additionally, this trope entailed that the birth givers perceived that their role as 'mother' was used against them to disrespect their consent. For example, by blackmailing them with the baby's health. For birth givers, this became problematic when they were asked to compromise on their own basic human needs to take care of their child like a 'good' mother would.

Last, the trope of *the untouchable doctor* became apparent, which describes the perception of birth givers that there is a strict hierarchy system in place that does undermine a functional speaking-up culture in the birth clinics. This way, the highest-ranking staff member is put at the top of the chain and cannot be spoken up against because their opinion is worth more. Thus, speaking up was perceived to be inhibited for birth givers and lower-ranking staff members even if they were more informed than the doctor about a specific birth.

Perceived Impact of OV

Birth givers perceived OV to have a variety of impacts. The different impact subthemes were clustered into four distinct main themes. The corresponding names and descriptions of themes with specific data examples and prevalence are portrayed in the following table (table 4).

Table 4

Themes about Impact of OV with Corresponding Data Examples and Sample Prevalence (n)

Themes	Description	Data Example	n
decreased functionality	OV experience harming the everyday functionality of the birth giver in the long-term.		**7**
psychological damage	OV experience harming the mental health of a birth giver.	"I cried in the shower for six weeks every night, because I could not grasp what had happened"	4
physical damage	OV experience harming the body and physical functionality of the birth giver.	NQ	1
work life	OV experience harming birth givers working ability.	NQ	1

Table 4 (continued)

loss of life quality	A perceived decrease of the overall standard of comfort and happiness in life for birth givers individually and for their social systems.		**4**
personal life	A perceived negative effect of OV on individual aspects in the birth giver's personal life.	"Another child would never be an option again. I can't repeat this feeling of really dying from this pain during and after the birth."	4
trauma of others	OV eliciting trauma in people close to the birth giver.	"My son has suffered a severe birth shock"	3
Identity Damage	OV harming the sense of self and way of being in a negative way long-term.		**2**
shadow of myself	Feeling like having lost one's true integer self and becoming a weaker version of who one formerly was.	"I do not recognize myself on the pictures [taken after the birth]. Now I know why my husband did not want to take a photo of me at first. Why he misses his old [partner]. I was a shadow of myself.".	2
activism	A desire to become active against OV.		**2**
protecting others	Desire to protect others from experiencing OV as well.	„Now I have processed [my experience] and am trying to professionally empower women for childbirth!"	2

Note. *NQ=no quote can be given due to participants wishes to not be quoted.*

First, the main theme of *decreased functionality* described how birth givers perceived the OV experience to damage their everyday functionality. This main theme contained several subthemes: psychological, damage, physical damage, and work life. Birth givers described that they took *psychological damage* from their experience when the OV harmed their mental health *("I cried in the shower for six weeks every night, because I could not grasp what had happened"*). For long-term psychological effects, birth givers described flashbacks and nightmares connected to the OV situations, as well as panic attacks, obsessive thoughts, and postnatal depression. One participant described that she became suicidal in response to her OV birth experience.

Additionally, the subtheme *physical damage* described when birth givers perceived the OV experience to have harmed their bodies and physical functionality. For example, for one birth giver, the OV experience created lasting physical pain which restricted them from

conducting daily tasks. Last, for one birth giver, the theme of *work-life* was established which entailed the notion that birth givers felt their functionality at work decrease after the OV experience. Specifically, this birth giver reported that the psychological damage that she suffered due to OV permanently reduced her workforce.

The second main theme was *loss of life quality.* This theme meant that birth givers perceived the OV experience to decrease their overall standard of comfort and happiness. This loss of life quality was perceived to affect them individually as well as their families surrounding them. In this context, the subtheme *personal life* described that the birth givers perceived OV to harm life aspects that were not solely functionality oriented. Specifically, for some birth givers, the OV experience decreased their wish to have further children, isolated them socially, and negatively affected family life. Furthermore, birth givers named the long-term *trauma of others* that their child and partners experienced during the birth as an additional negative effect that contributed to the families' loss of life quality.

The main theme of *identity damage* described that some birth givers felt like their OV experience harmed their sense of self. Within this main theme, the subtheme of *shadow of myself* was described. This subtheme meant that birth givers felt like they lost the person that they were before the OV experience and had become a different weaker person than they usually were. For some birth givers, this feeling of having lost oneself remained present for up to two years which was interpreted as a disruption of the regular 'way of being' and therefore constitutes identity damage. Last, for some birth givers, their OV experience sparked the desire to engage in *activism* to advocate for birth givers' rights and to *protect others* from becoming subject to OV as well *(„Now I have processed [my experience] and am trying to professionally empower women for childbirth!").*

Birth givers' suggestions on how to improve birth-related care in the future

The birth givers expressed a variety of suggestions for the improvement of birth-related care. Interestingly the suggestions were often formulated as wishes for the future and were, therefore, less focused on concrete action advice for individual caregivers than originally assumed. A table with descriptions of themes in relation to corresponding data examples is shown in the following table (Table 5).

Table 5

Themes about Suggestions of Birth Givers with Data Examples and Sample Prevalence (n)

Themes	Description	Data Example	n
respectful treatment	The wish to be treated on an eye-to-eye level by the medical staff and for them to show consideration for the birth giver as a person including not only physical health but also mental health aspects and social needs.	"You should at least introduce yourself before touching someone between the legs."	7
involvement	The wish to be treated as an active participant in own birth who is allowed to and trusted to make self-determined choices.	"Today I would just wish to be included in my own birth."	3
systemic changes	Suggestion to change systemic structures that were perceived to contribute to OV to enable a more positive birth experience for the birth givers.	"Here [in the childbirth preparation course] a realistic picture of a birth, the postpartum period, should be conveyed."	3
appropriate care	Wish for more individual, timely, and extensive care while giving birth.	„That the midwife is often present to ask questions or get help. That she can take 5 minutes and not just open the door, look in and leave.“	3
acknowledge needs, pain, and feelings	Wish to take birth givers seriously by acknowledging and being responsive to their needs, pain, and feelings.	"To acknowledge my pain would have been the most important thing."	3
aftercare	Wish for support after the birth ended to be able to adjust to new life situation and to handle potential birth trauma.	"A questionnaire regarding postpartum depression should be completed with every mother during postpartum care. Information on help centers should be provided preventively.“	3
awareness	The wish for more societal awareness about OV to improve the situation for future birth givers.	NQ	1

Note. *n=prevalence of the theme in the stories, NQ=no quote can be given due to participants wishes to not be quoted.*

The most prevalent theme regarded the suggestion for *respectful treatment*. This main theme described that birth givers wanted to be treated on an eye-to-eye level by the medical staff and for them to show consideration for the birth giver as a person including not only physical

health but also mental health aspects and social needs. For the birth givers, the respectful treatment theme manifested in further specific wishes such as the wish to be taken seriously. Additionally, they wished for medical staff to respect their consent and to communicate with them politely. The theme of respectful treatment was also characterized by a wish for less scaremongering and the wish for a trusting interaction between staff and themselves. Moreover, they considered the right to fulfill their social need of having a support person present as an important part of respectful treatment. The main theme of *involvement* for the birth givers referred to wanting to be treated as active participants in their own birth process. Specifically, the birth givers wanted to participate in deciding what happens to themselves and their children. In this context, they also wished for the staff to trust in their abilities to make self-determined choices and allow them to make such choices.

The main theme *systemic changes* described the suggestion to change systemic standards in the hospital and healthcare structures that were perceived to contribute to OV. In this context, general wishes were to have functioning equipment available, to have supervision throughout the birth process to ensure respectful treatment, and to set more realistic expectations on how births are handled in hospitals. Furthermore, some participants had very specific suggestions for systemic changes. For example, one birth giver suggested the creation of a positive mistake culture because she felt that staff could not be honest about mistakes they made, due to fear of potential repercussions. Additionally, one birth giver expressed the wish for a less medicalized birth with fewer interventions. Furthermore, the main theme of *appropriate care* described the birth givers' desire to receive more individual, timely care and for health care staff to have more time to engage with them. *(“Except for the student, everything felt like the purest mass processing, not saying a word, just doing everything quickly so that the next one can come.”).*

Last, birth givers wished for the caretakers to take them seriously by *acknowledging their needs, pain, and feelings* by responsively interacting with them instead of behaving dismissively. Moreover, birth givers asked to improve *aftercare* which meant their desire to be provided support to reprocess birth and deal with its aftermath. *(“The questionnaire regarding postpartum depression should be completed with every mother during postpartum care. Information on help centers should be provided preventively.“).* Another wish was to create more *awareness* about the topic of OV within society to improve the OV situation for future birth givers.

Discussion

Types of OV

The first aim of the current study was to determine what types of OV birth givers perceive to be present in Germany. Overall, they perceived OV types they suffered from to be: general unresponsiveness towards birth givers, plain verbal and physical mistreatment, withholding information and contact with close others, violating boundaries regarding consent and privacy, and systemic issues. The most prevalent theme of unresponsiveness shows that a central point in whether birth givers feel violated during birth might depend on whether staff shows dismissive attitudes and behaviours towards birth givers. This unresponsiveness theme is of special interest for this study since being more responsive to birth givers could potentially influence the other types of OV. For example, sometimes unresponsiveness manifested in the trivialization of the birth giver's pain. Such trivialization could potentially lead to violating boundaries in form of continuing painful procedures because the medical staff thinks the birth giver is dramatizing. The finding of the unresponsiveness theme is not entirely surprising. Namely, a prior study concluded that unresponsiveness to needs might be a crucial aspect within OV that can be due to individual misconduct and systemic overload, which was the case in the current theme as well (Maya et al., 2018; Morison & Mavuso, 2022). This current theme of unresponsiveness relates to prior documented themes of neglect that describe a more passive dismissiveness towards the birth giver (Bohren et al. 2015). Contrastingly, in the current study, the unresponsiveness theme did not solely entail passive unresponsiveness but also active unresponsiveness. This manifested in active actions such as denying explicitly stated face-to-face requests for need fulfillment, necessities, care, and pain medication. Additionally, some former studies show a more limited view of unresponsiveness that is solely reflected in being unresponsive to birth givers' needs (Maya et al., 2018). Contrastingly, in the current study, this unresponsiveness appeared to be more multifaceted as it concerned many aspects besides direct need-related unresponsiveness such as a negative birth atmosphere, trivialization of OV itself, and unprofessionalism.

Cultural Tropes

The current study identified three cultural tropes that contribute to OV in the eyes of the birth givers. Since the ‘untouchable doctor trope’ describes hierarchy processes in hospitals it is assumed to be more limited to hospital culture. Meanwhile, the ‘overly emotional woman trope’ and the ‘mother-over-human trope’ are not limited to the hospital culture and therefore might be of special interest to discuss further. The theme of the ‘overly emotional woman’

entailed framing birth givers as overly sensitive when they reacted rationally to obstetric mistreatment and pain. A similar generalized societal belief about women exaggerating their emotions has been documented by a prior study (Hutson-Comeaux & Kelly, 2002). Some researchers link this belief to the notion that women are wrongfully believed to be naturally more able to handle pain due to their child-birthing ability (Hoffmann & Tarzian, 2001; Prego-Jimenez et al., 2022). Furthermore, a literature review from Samulowitz and colleagues (2018) about gender bias in health care also describes how women who suffer from pain, as is the case during birth, might be more likely to be framed as overly hysterical and emotional. The current study is the first to link this 'overly emotional woman trope' to the OV setting. Furthermore, it infers that behaviours resulting from this cultural trope might play a crucial role in whether birth givers' perceive their treatment as respectful. As a novel element, the current study, also documented that not solely medical staff but also birth givers themselves might be subject to this trope when they start to self-doubt their judgement of the OV situation. This phenomenon of blaming the impact of a violating event on oneself has been observed in harassment research before (Veletsianos et al., 2018). This might explain why the birth givers who suffer from this trope still can become drawn into it themselves in the OV context.

Moreover, the 'mother-over-human trope' describes the perceived generalized belief that mothers must suffer by compromising on their own basic human needs to always meet the assumed needs of the child. Thus, the importance of the child appears to be elevated above the birth givers' importance. Interestingly, this trope shows parallels to the south American concept of marianismo which describes the societal belief that mothers must sacrifice themselves for motherhood (Pinos et al., 2016). The current study is the first to determine this intercultural similarity. Notably, the perceived presence of both tropes implies that although explicit stereotypical tropes might not be as present in German birth care, implicit stereotypical tropes could potentially still harm birth givers nowadays (Carlana, 2019; Greenwald & Krieger, 2006; Régner et al., 2019). Overall, the current study shows that these cultural tropes might contribute to the occurrence of OV. Specifically, they could be used as pseudo-legitimisation for insufficient care and violating boundaries. Furthermore, these tropes might undermine birth givers' determination to stand up against mistreatment during birth.

Impact of OV

Overall, the current study described multiple impacts that birth givers perceived OV to have. Notably, few birth givers described how OV damaged their identity in the long-term, which

has been observed by prior studies about traumatic birth (Beck, 2009). Additionally, some birth givers engaged in activism to protect future birth givers from experiencing OV, which might show some parallels to activism due to posttraumatic growth in sexual assault victims (Swanson & Szymanski, 2020). However, the most prevalent themes of decrease in functionality and loss of life quality might be of most interest to elaborate on as they mark the most severe impact for a majority of the investigated birth givers. Notably, prior studies have documented how OV might decrease the functionality of individuals. For example, OV can harm the mental health and physical health of birth givers (Reed et al., 2017; Scandurra et al., 2021; Silveira et al., 2019). This was the case in the current decrease in functionality theme as well and manifested in elements such as physical impairment and pain, flashbacks, panic attacks, postnatal depression, and for some suicidal intentions. Additionally, a novel element regarding functionality was that an OV experience might impair the birth giver in such a way that they lose their ability to work and therefore their existential foundation. However, the current study went beyond simply stating these potential consequences. Namely, it was established that birth givers perceived OV to cause long-term harm to their everyday functioning. This adds a novel meaning dimension to the prior found singular impacts as it sets into perspective what this impact means for birth givers on a personal level.

Furthermore, it was determined that birth givers perceive OV to lead to a loss of life quality as it decreased their overall standard of happiness and comfort in life. This applied not solely to the birth givers themselves but also to the social systems surrounding them. Although this meaning-making aspect is novel in the current study specific categories that made up the current theme of loss of life quality were found by prior studies. For example, the negative influence on family life and the decrease of wishes birth givers formerly had for further children (Gottvall, 2002; Muzik et al., 2017; Taghizadeh et al., 2021; Vischer et al., 2020). The current study adds to prior research that an OV experience is sometimes perceived to lead to social isolation which decreases perceived life quality as well. Overall, both aspects of perceived negative impact on own functionality and life quality show that OV is perceived to have a severe impact on the birth givers' life and support system. Notably, prior research has not explicitly linked OV to a decrease in functionality and loss of life quality. However, prior studies speak about these aspects as a result of PTSD after a traumatic birth (Beck, 2004, 2006; Webb et al., 2008). The current study shows that some birth givers perceive OV to be a relevant aspect for the emergence of such impact and PTSD itself. This would be in line with prior research that links OV to the emergence of PTSD (Martinez-Vázquez et al., 2021).

Implications following from the suggestions of birth givers

The birth givers' suggestions for improvement are ground for several implications of the current study. Notably, the birth givers' specific recommendations were not simply repeated in this section. Instead, new recommendations were formulated that still contained the gist of the original suggestion themes. The reformulation was performed to create concrete advice for researchers and future interventions, which was assumed to increase scientific research value. A summary of key recommendations can be found in the table (Table 6).

Table 6

Recommendations for Improvement of Birth Care and Reduction of OV

Nr.	Implication	Connected Theme
1.	Establish a standard operating procedure for consent during birth to allow birth givers to make more active, informed, and self-determined choices.	involvement
2.	Establish interprofessional training for birth helpers on how to interact with birth givers in ways that take into consideration their wishes for respectful maternity care. *	respectful treatment + acknowledgement of needs, pain and feelings
3.	Create birth preparation courses that portray a realistic picture of birth that does not sugar-coat but instead shows the full picture with worst-case scenarios and procedures.	systemic changes
4.	Create and take measures to reduce structural pressure on the birth care sector to enable individual, timely, and extensive care.	appropriate care
5.	Educate birth givers about support contact points that provide post-stationary help for birth givers' mental health, physical health, and new life situation.	aftercare
6.	Connect with specialist societies to advocate for more research about OV in Germany.	awareness

Note. *main criteria for respectful maternity care = interacting on an eye-to-eye level, using civil language, showing concern for mental and physical health of birth giver, taking birth givers seriously by acknowledging their pain, feelings and needs.

Notably, the first two recommendations require more extensive elaboration. Since birth givers' consent was disrespected during birth in this sample a solution on how to optimize the consent procedure might be useful. For this, a standard operating procedure (SOP) for consent during birth could be established. For example, in form of a high-quality checklist on what steps of consent must be requested at which time points for birth givers to have the best

possible active self-determination. This way birth givers could always be informed of measures and the purpose of measures performed on them. Notably, in other healthcare sectors, such SOPs have increased positive patient outcomes and healthcare staff compliance with the standard regulations (Chen et al., 2016; Simons et al., 2014). The SOP for consent should also be trained in interprofessional training for birth helpers on how to interact with birth givers. This is especially relevant since it is not enough if SOPs are present, but the medical staff must also be trained on how to perform these SOPs adequately (Valente et al., 2022). Notably, simply checking all boxes on such an SOP would not be sufficient to reduce the chance of birth givers experiencing OV during birth. Therefore, further key aspects of such interprofessional training topics according to this study could be: how to interact with birth givers on an eye-to-eye level, how to maintain civil language in stressful situations, how to signal concern for the mental and physical health of birth givers, how to show birth givers that they are taken seriously and that their pain, feelings, and needs are acknowledged.

Notably, the current implications correspond to prior research about respectful maternity care. For example, birth givers' need for autonomy and self-determined choices has been documented as a crucial aspect of positive birth experiences and improved treatment satisfaction by prior studies (Baker et al., 2005; Shay & Lafata, 2015; Vedam et al., 2017). When comparing the themes that underlie the recommendations to a recent international literature review of Jolivet and colleagues (2021) it becomes apparent that many foundations of the current recommendations are explicitly named and implied by this former review already. However, in comparison, the current study adds novel theme-related suggestions of the need for realistic preparation, the need for aftercare, and the need for creating more research awareness for OV in Germany. Moreover, the current study states specific recommendations for intervention designers and researchers, while former literature tends to focus on advice for individual caretakers (Baker et al., 2005; Jolivet et al., 2021; Shay & Lafata, 2015; Vedam et al. 2017). Thus, in contrast to prior research, the recommendations in the current study show that comparatively many changes must be achieved on a systemic level first. From these systemic changes, individual change can arise to achieve the respectful maternity care that birth givers wish for.

Strengths, Limitations, and Future Research

To be able to adequately frame the conclusions of this study, strengths and limitations must be considered. First, one strength of this study lies in its qualitative nature by which OV is investigated on the experiential level. Therefore, it enriches prior research by reflecting on

important aspects of OV which cannot be grasped by quantitative research. This study was supervised by two experts who specialized in qualitative analysis to ensure the best possible objectivity and correct procedure. Although three birth stories took place more than 5 years ago the majority of stories concerned recent birth experiences. This adds to the relevance of this study. Furthermore, due to the chosen method of thematic analysis, the results of this study are made accessible to laypeople who do not have specific scientific training. Last, a strength of this research lies in directly addressing and questioning affected individuals on what requirements they set for respectful maternity care. Therefore, this study possesses the unique quality of concrete advice that might appeal to individual birth-care staff, healthcare institutions, intervention designers, and other researchers.

Nevertheless, this study has severe limitations. Namely, no inter-coder-reliability could be established since only one coder was present. Therefore, the results of this study need to be treated with great caution. Although the main coder received training in conducting qualitative research and coding, this was the coder's first time conducting a thematic analysis. The coder remained objective to her best ability while evaluating the stories. Although no explicit biases are known to the coder, it cannot be ruled out that subconscious biases might have influenced the analysis. Results might be coloured by the Covid-19 pandemic which affected the healthcare sector (Reingold et al., 2020). Last, although the agreed sample size of 20 birth stories was reached, the data never achieved full saturation, since new codes kept emerging occasionally. Therefore, future studies should replicate the current study with bigger sample size. This way confidence in the established themes could be increased.

After future research has increased confidence in the current recommendations via extensive revision and investigation further steps become possible. For example, to translate such revised recommendations into practice, concepts for interventions on how to achieve change on a systemic and individual level could be developed and executed. If future research supports the current findings, such interventions could make sure to consider the cultural tropes that are perceived to contribute to OV to achieve long-lasting change. Since the current sample consisted exclusively of Caucasian people research on diverse samples is needed to fully reflect the OV situation in Germany. This is especially relevant as discrimination based on ethnicity can influence how much OV people face (Chalmers & Omer-Hashi, 2002; Small et al., 2002). Moreover, during the inductive analysis, another category of birth givers' strategies against OV was identified but fell outside of the intended scope of the current study. Therefore, other studies could explore whether different acting strategies of birth givers during OV have different outcomes.

Conclusion

Conclusively, the current study shows the perspective of birth givers on OV types and their impact in Germany. The perceived OV types in the sample were mostly characterized by unresponsiveness towards birth givers but also by plain mistreatment forms, withholding information and contact, and violating boundaries. Furthermore, systemic issues appear to contribute to OV not only in the eyes of prior research but also in the eyes of birth givers. OV is perceived to have long-term negative consequences regarding everyday functionality, life quality, and personal identity. Besides its negative effects, for some OV elicits positive impulses of becoming active against OV to protect future birth givers. This might be labelled a form of posttraumatic growth. Moreover, the birth givers perceive cultural tropes about birth and birth givers to negatively impact how they are treated during birth: 'the overly emotional woman trope', 'the mother-over-human trope', and the 'untouchable doctor trope'. This study is the first to find an intercultural similarity between the 'mother-over-human trope' and the south American concept of marianismo. All tropes could be investigated further to be confirmed and then addressed by future interventions that aim to reduce OV in Germany. Before planning interventions, exact change goals that must be met to eliminate OV should be determined and evaluated from all relevant perspectives. The current study showed the perspective of birth givers on which birth-care aspects should change. Further, it provides concrete recommendations for further research to draw from and contributes to the knowledge about OV in Germany. Thus, the current findings might assist future researchers and intervention-makers who aim to achieve the reduction of OV and the emergence of respectful maternity care for birth givers.

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Appendix A

Questionnaire (translated version)

Incentive Text

Thank you for considering participating in my study despite the sensitivity of the topic. Your suggestions on how obstetrics can be improved in Germany are required. The following is only basic information about the study, which you must confirm for ethical reasons. Then you go directly to the information for your personal birth story. Thank you for your trust and your effort!

Informed Consent

PROJECT TITLE: Obstetric violence experiences of birth givers in Germany – An analysis of birth stories.

INVESTIGATORS: This study is carried out as part of Marie Luise Reuther's master's thesis (M.Sc. psychology student). This is supervised by Dr. Stans Drossaert at the Faculty of Behavior Management and Social Sciences at the University of Twente in the Netherlands.

TRIGGER ALERT: This study deals with the mistreatment of birth givers during childbirth. This means that you will be asked to write down your own experiences of psychological and physical violence during childbirth. If you are not comfortable with this, feel free to not participate in this study.

CRITERIA FOR PARTICIPATION: We are looking for people who are at least 18 years old, are currently not pregnant, and whose violent birth experience was at least a year ago and took place in Germany. If you do not meet these criteria, please do not participate.

TARGET: The aim of this study is to examine individual birth reports to determine cultural narratives that may influence the occurrence and expression of obstetric violence. Furthermore, another aim of the study is to analyze different birth stories in relation to each other in order to examine similarities and differences between experiences of violence during childbirth. Specific suggestions on how obstetric care can be improved are also collected. You were asked to participate in this study because this study requires as many different birth experiences as possible.

PROCEDURE: If you agree to participate in this study, you will be asked to write a story about your own violent birth experience and are asked to make suggestions for improving birth care. After writing your birth story, you will be asked to provide demographic information about yourself (age, nationality, ethnicity, etc.). However, you are not obliged to provide us with this information and you can refuse to do so without giving any reason if you are uncomfortable with this. The length of your participation depends on how much time you want to invest in your birth story.

RIGHTS OF PARTICIPANTS: Your participation in this study is voluntary. You have the freedom to decline participation, to refuse to answer any question, and to withdraw from the study at any time without providing a reason.

BENEFITS: Your participation could make an important contribution to the scientific understanding of obstetric violence. This could also ensure that future measures to reduce and eliminate obstetric-safe violence in Germany can be designed effectively. And your suggestions for improving obstetrics could also appeal to obstetricians.

RISKS: You may feel uncomfortable about the subject of the study. In this case, you can skip questions that you do not want to answer. Also remember that your participation in this study is voluntary, which means that you are free to discontinue your participation at any time. If any traumatic memories are triggered or severe discomfort is felt during participation, please discontinue immediately and seek professional help if necessary. Below we provide you with information that can assist you in coping with recurring distressing thoughts or trauma.

24H GEWALTHILFE-HOTLINE: 08000 116 016
WEBSEITEN: https://www.gerechte-geburt.de/links/verarbeitung-von-schweren-geburten/

CONFIDENTIALITY: Confidentiality is maintained by completing the study anonymously. There is no way to link your direct personal information to the survey. Birth stories are anonymized so they cannot be linked to your direct personal information. Summary results of this study may be used in reports, presentations or publications, but your name will not be disclosed. Initially, only the research team consisting of Marie Luise Reuther and Dr. Stans Drossaert has access to the collected data, which is stored encrypted and password-protected in electronic databases or on encrypted password-protected computers. De-identified information collected about you during this study may be shared with other researchers or used for future research studies. We will not seek additional consent from you before sharing the anonymized data. If the results are published, the anonymized data may be shared with other researchers for verification purposes, but your identity will remain confidential as no directly identifiable information is collected. It is unlikely that other researchers who have access to the data will be able to identify you indirectly through a deductive approach. Demographic information (if you choose to provide it) is stored separately from birth histories during data analysis. In order to ensure confidentiality to the extent required by law, the following measures are also taken: the anonymization of the answers of the participants by the Qualtrics platform and the omission of the collection of directly identifying information.

ASK:
For more information about this study, you can contact Marie Luise Reuther via m.l.reuther@student.utwente.nl or Dr. Contact Stans Drossaert via c.h.c.drossaert@utwente.nl who are responsible for this study. If you would like to speak to someone other than those listed here to discuss any issues or concerns if the contacts listed here are unavailable, or to discuss your rights as a participant in this study, contact the University's Department of Behavioral Management and Social Sciences Ethics Committee Twente in the Netherlands at ethicscommittee-bms@utwente.nl.

CONSENT AND AUTHORIZATION:
In order for us to use your responses for this study, you must consent to the information described above by ticking all of the boxes below. Click on each box to tick it.

- I have read and understood the information given above.
- I understand that I can refuse to answer any questions and withdraw from the study at any time without giving a reason.
- I give my voluntary consent to participate in this study.

Birth Story

YOUR PERSONAL BIRTH STORY

After reading the instructions, you are welcome to start writing your birth story in the text box on the following page! If you want more time to write your birth story, here are the instructions for downloading your birth story again: Instructions (clickable pdf)

INSTRUCTIONS

Write your story about your violent birth experience. Write down everything that you experienced as violence. Both physical violence, psychological violence, verbal violence and anything else that you have experienced as violence are relevant here. The birth story should be written from your own first-person perspective and should be between a half and a page and a half long (between 250-750 words). You can formulate freely and colloquially. The following must be included in the birth history for us to use it in the study:

1. Location and environment of your birth experience (e.g. hospital, delivery room, home birth, etc.) It is not necessary to identify you here, just the type of environment.

2. Persons involved (e.g. midwife, doctor, partner, etc.). An exact naming of names is also not necessary here due to your anonymity protection!

3. Events (e.g. what violent acts, what happened exactly in what order, etc.).

4. Your own feelings about the situation in response to specific actions.

5. What improvements would you like to see made by birth helpers, if your obstetricians (e.g. doctor, midwife, nurse, etc.) stood in front of you again today?

You are free to cancel your participation at any time. For example, if you feel too uncomfortable, experience severe discomfort, or traumatic memories are evoked. The following offers of help can support you in coping with recurring stressful thoughts or trauma: Help line for difficult births (available Wednesdays 12:00-14:00 and Thursdays 19:00-21:00): 0228/92959970, violence help hotline (always available): 08000 116 016, and websites: https://www.gerechte-geburt.de/links/verarbeitung-von-schweren-geburten/

Please enter your birth story in the space below and then confirm that we can use it:

[Text Field]

CONSENT

Please indicate whether we may use your birth story for our study.
- Yes, you may use my anonymous birth story.
- No, you may not use my anonymized birth story (I wish to withdraw from the study).

Please indicate whether we may quote verbatim extracts from your birth history in our study.
- Yes, you may quote excerpts from my birth story verbatim.
- No, you may not quote verbatim excerpts from my birth story.

Demographic Information

Following we pose questions for demographic information that are very useful to us. You are free to decide whether you want to provide this information. If you do not want to answer the demographic questions, you can skip straight to the bottom question.

What is your nationality?
- Geman
- Other (specify if desired)
- I do not want to say

What is your ethnicity?
- Caucasian
- Black or African American
- Indigenous (America or Alaska)
- Asian
- Indigenous (Hawaii or Pacific Islands)
- Other (Specify if desired)

How old are you?
- Text field

What gender do you identify as?
- Female
- Male
- Diverse (specify if desired)
- I do not want to say

How many births did you have?
- 1
- 2
- 3
- 4
- 5
- 6
- 7 or more
- I do not want to say

During which type of births did you experience violence?
- Birth in a conventional medical facility (e.g. hospital, clinic, maternity unit, etc.)
- Birth that did not take place in a conventional medical facility (e.g., home birth)
- planned caesarean section
- unplanned caesarean section
- Vaginal birth
- Other (Specify if desired)

When did your OV experience take place? (please state the year)
- Text field

Please indicate whether we may use demographic information about you for our study.

- Yes, you may use my answers to the demographic questions.
- No, you may not use my answers to the demographic questions.
- I didn't give any answers.

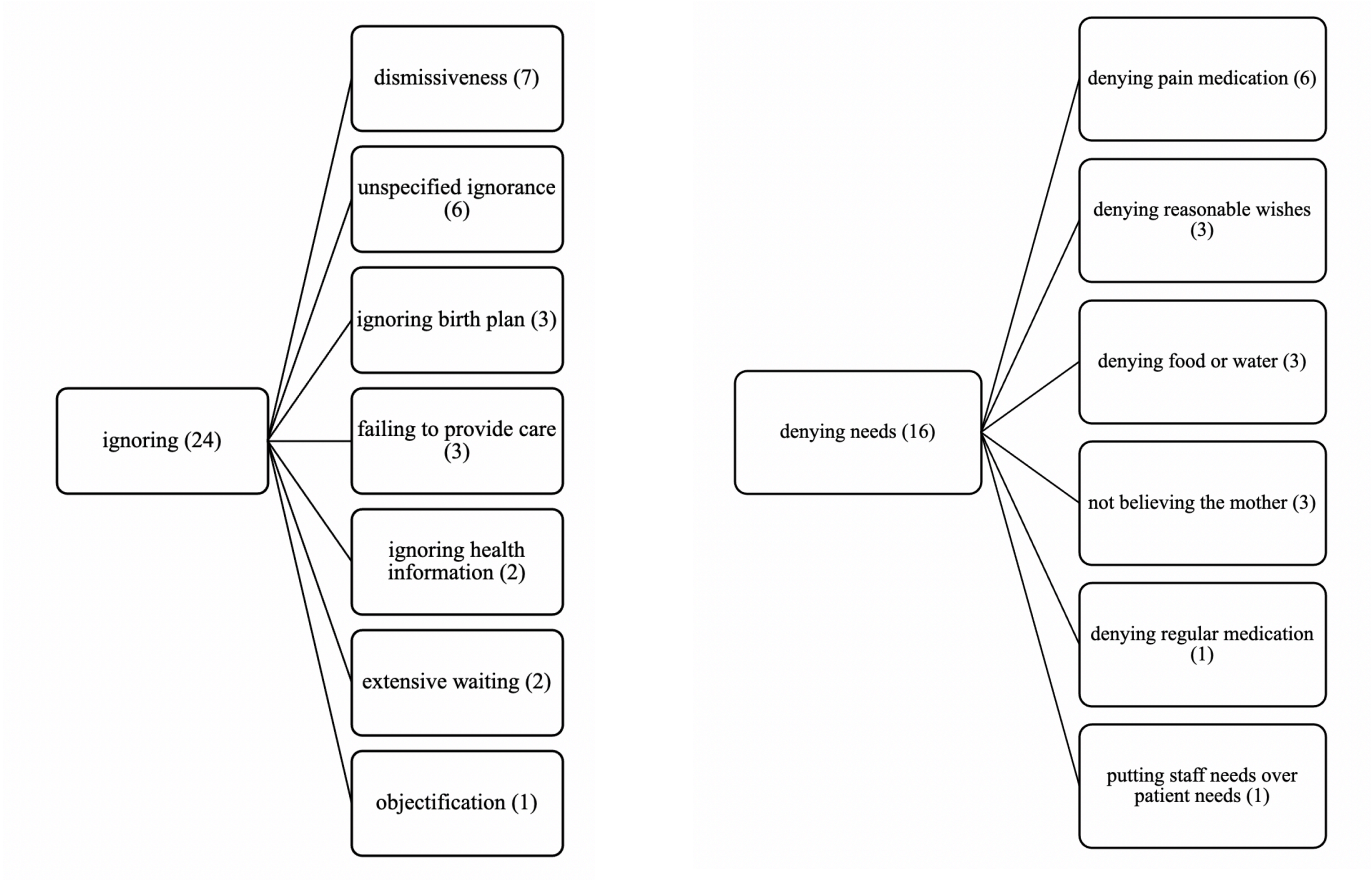
Closure

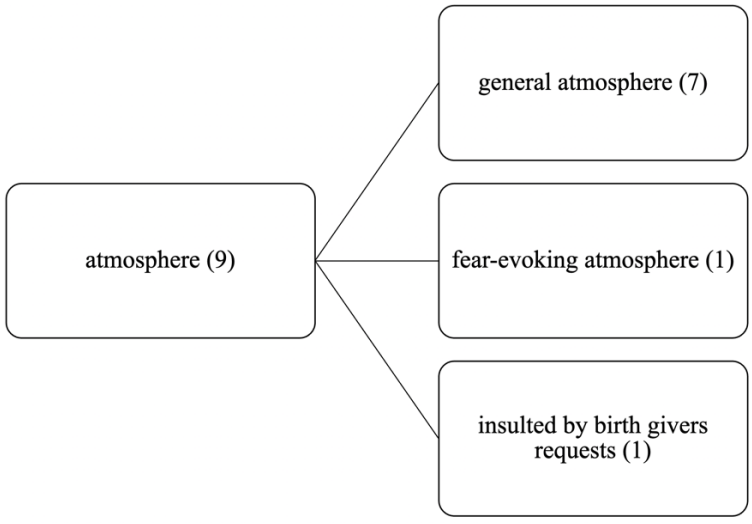
Thank you very much for your participation!

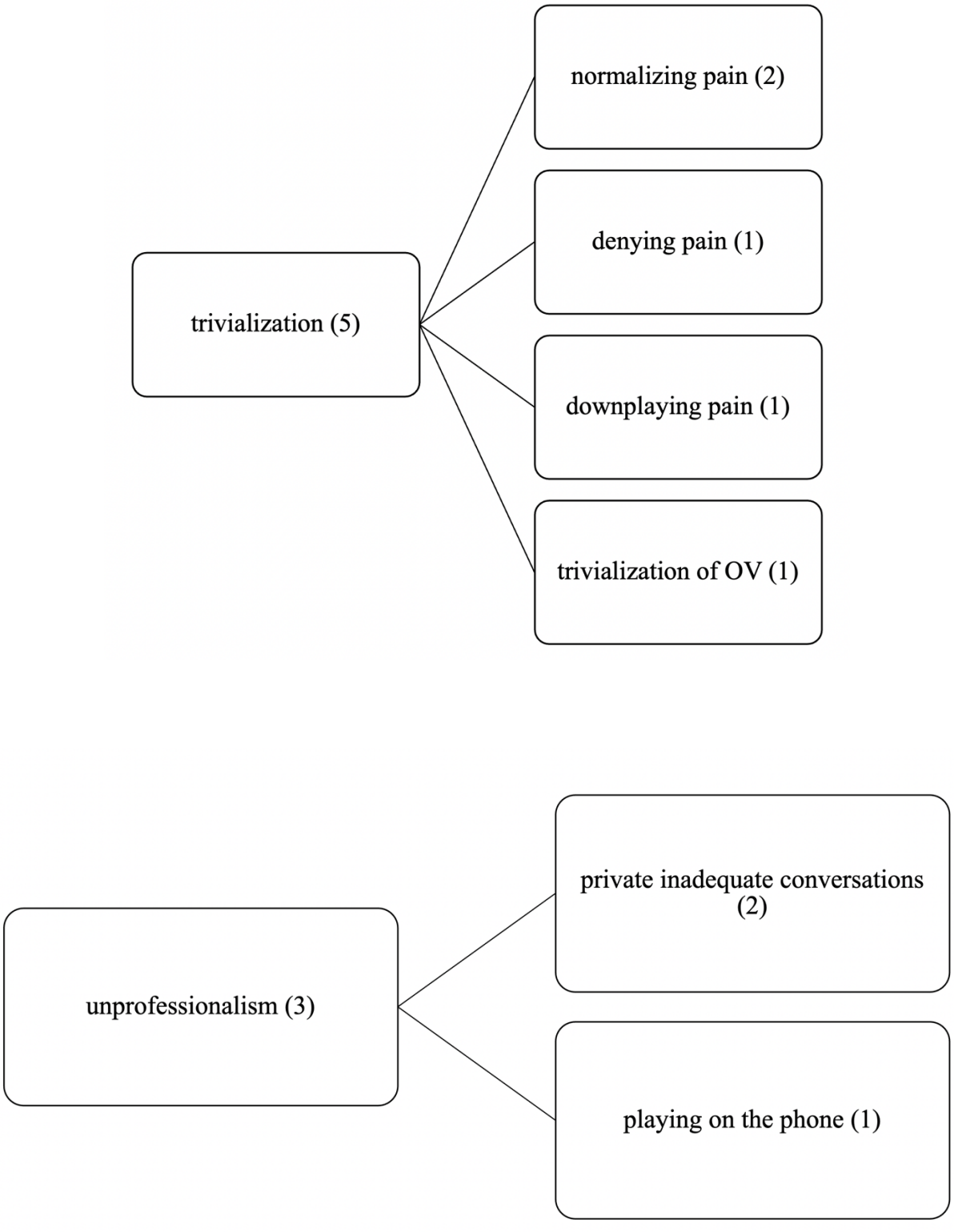
APPENDIX B

Code Trees for OV Types

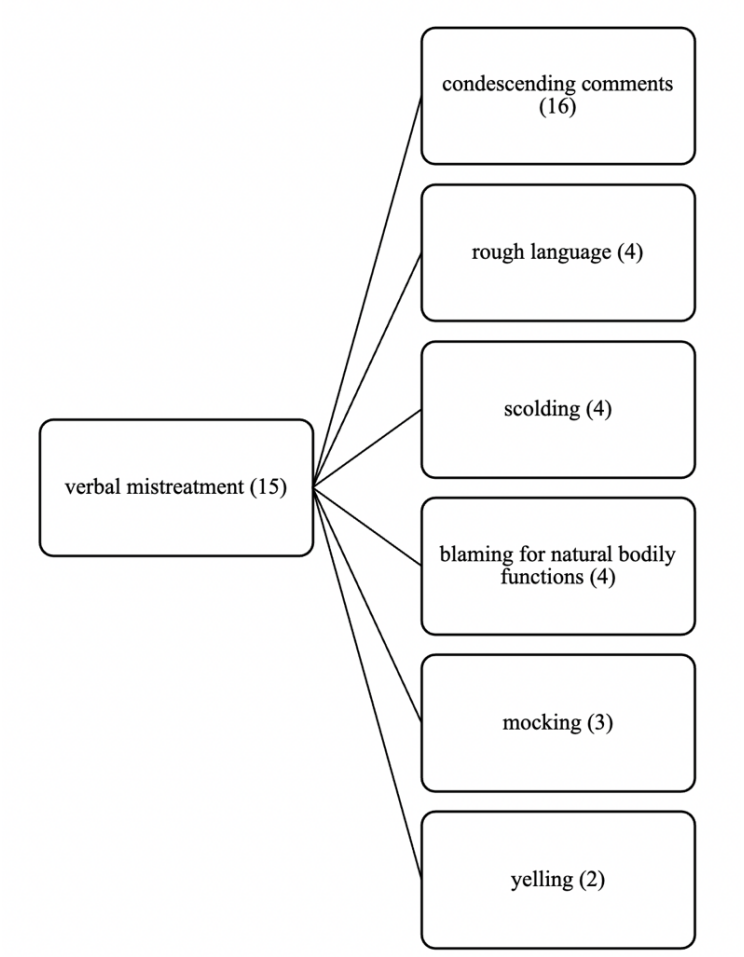
Unresponsiveness

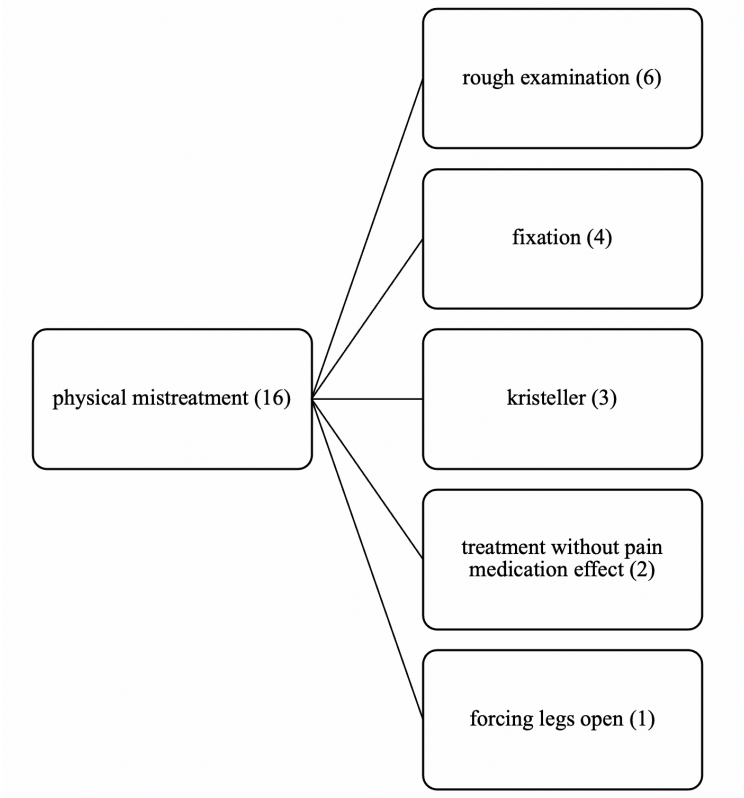




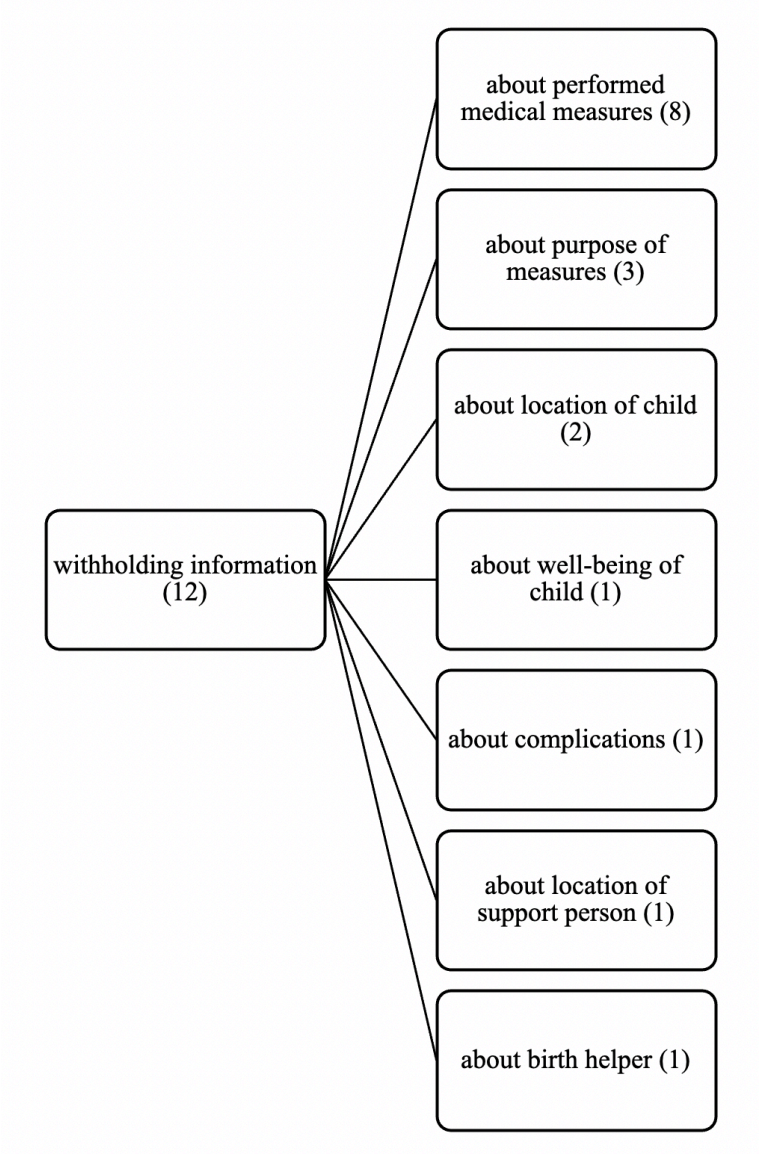

trivialization (5)
normalizing pain (2)
denying pain (1)
downplaying pain (1)
trivialization of OV (1)
unprofessionalism (3)
private inadequate conversations (2)
playing on the phone (1)

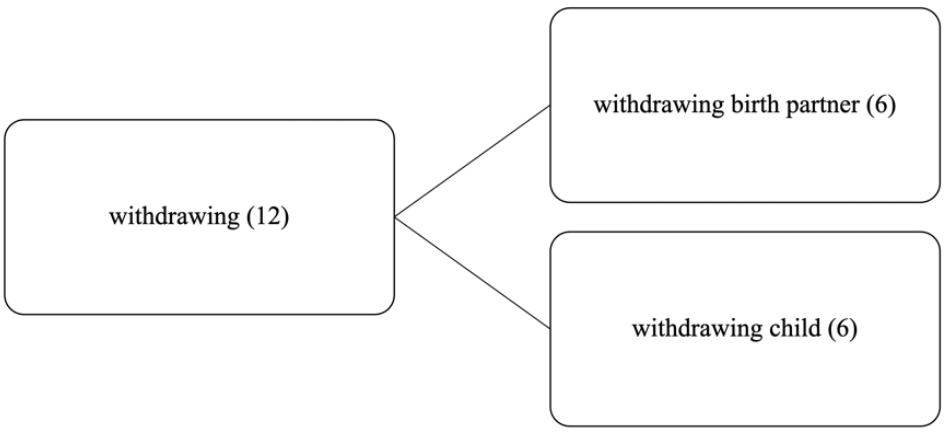
Plain Mistreatment



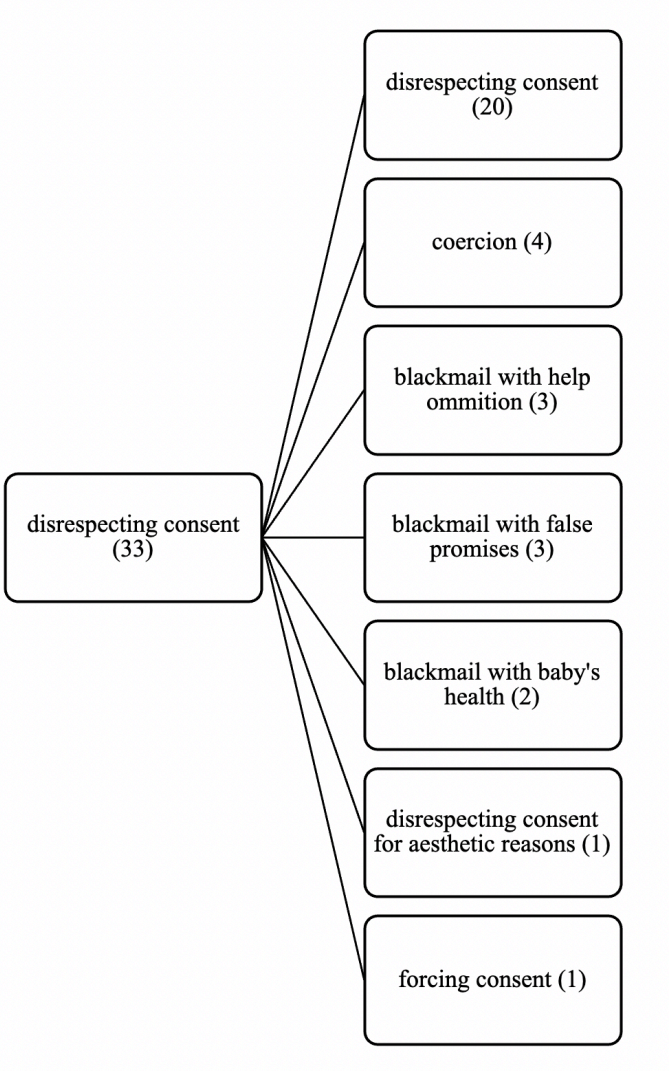


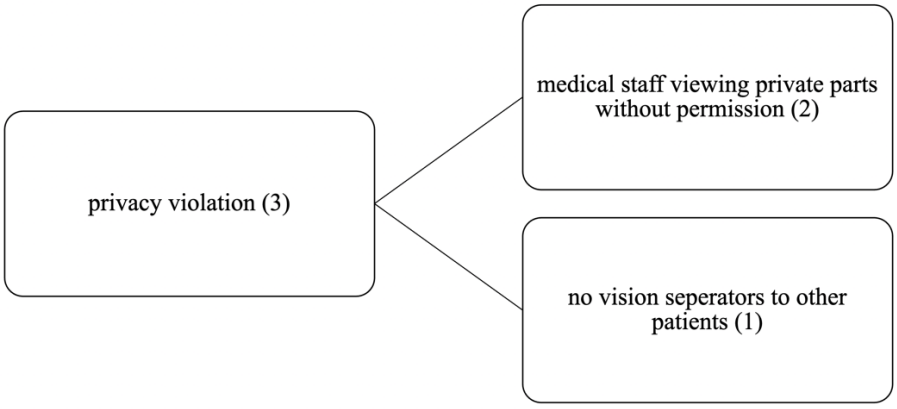
Withholding Information and Contact



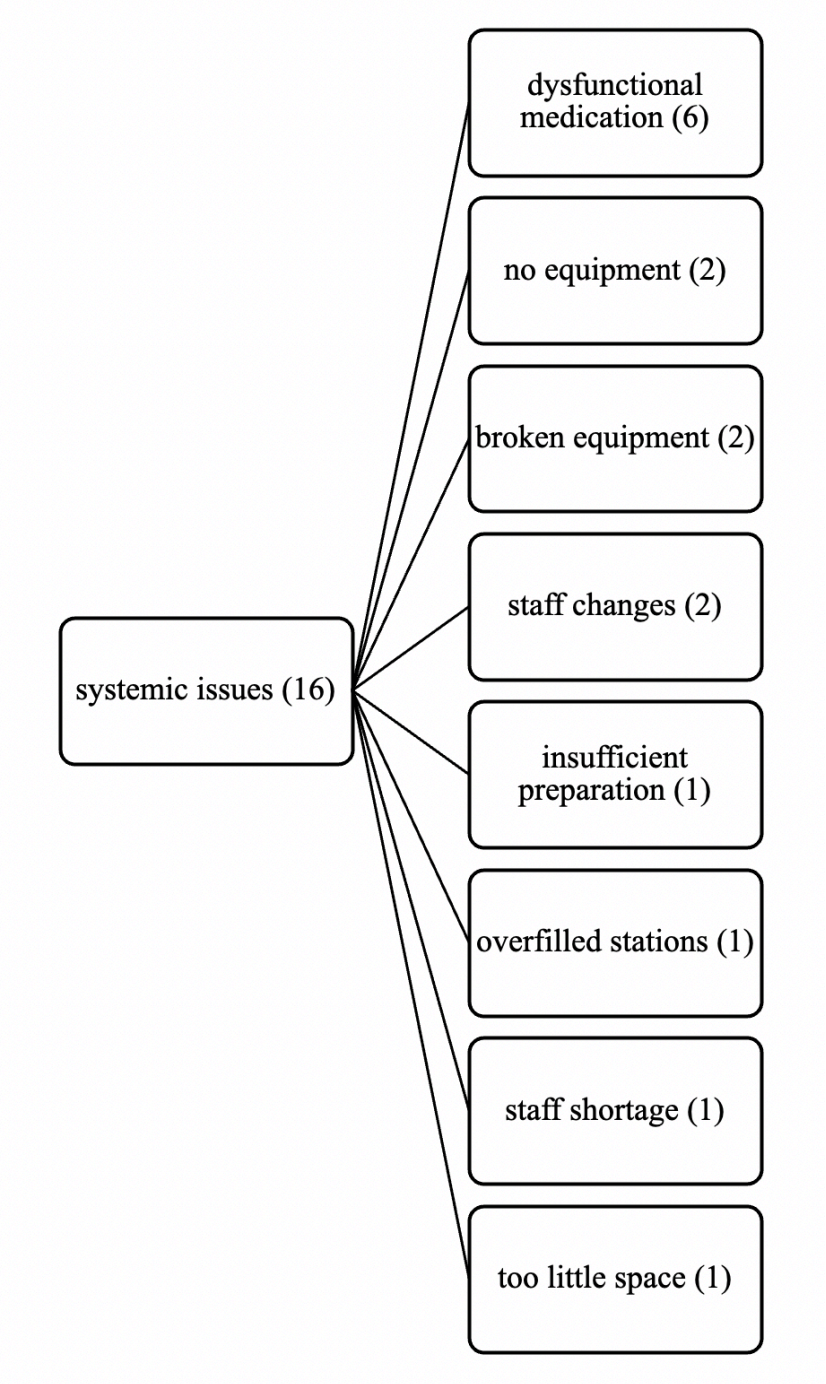


Violating Boundaries





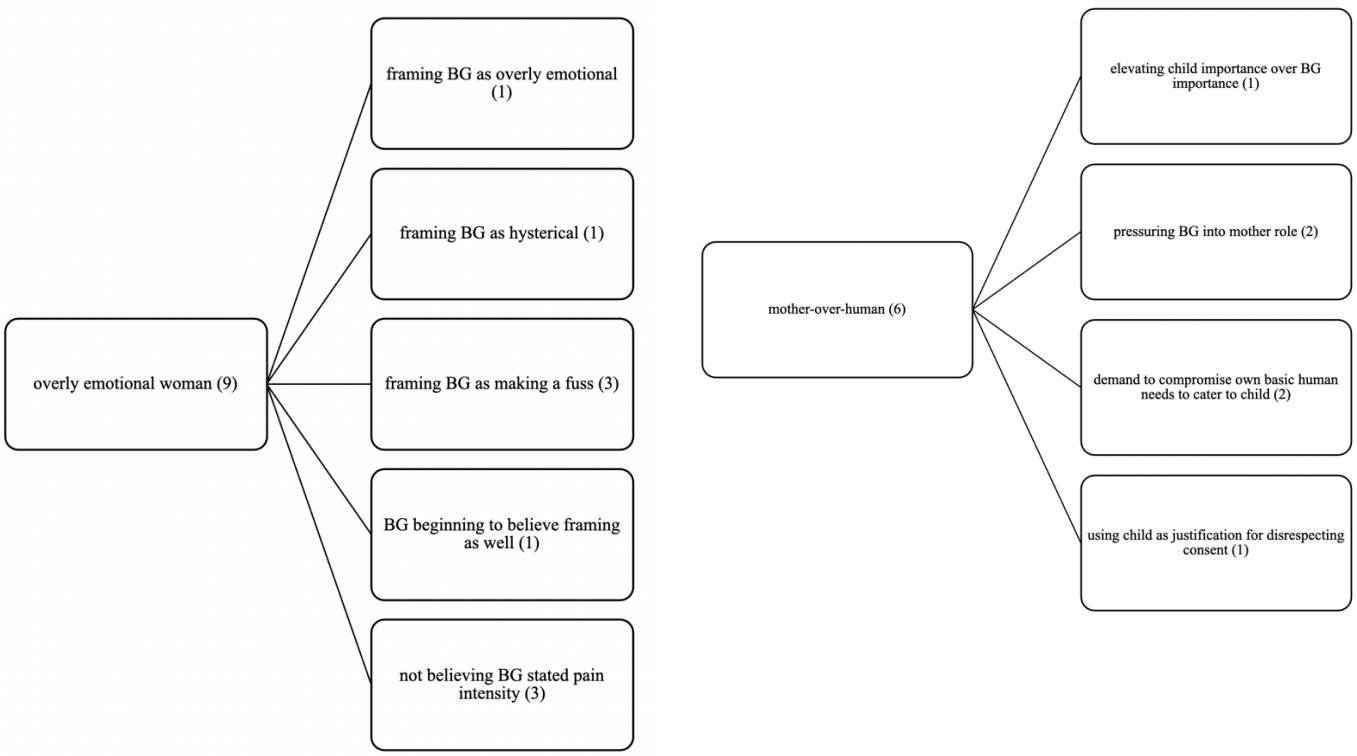
Systemic Issues

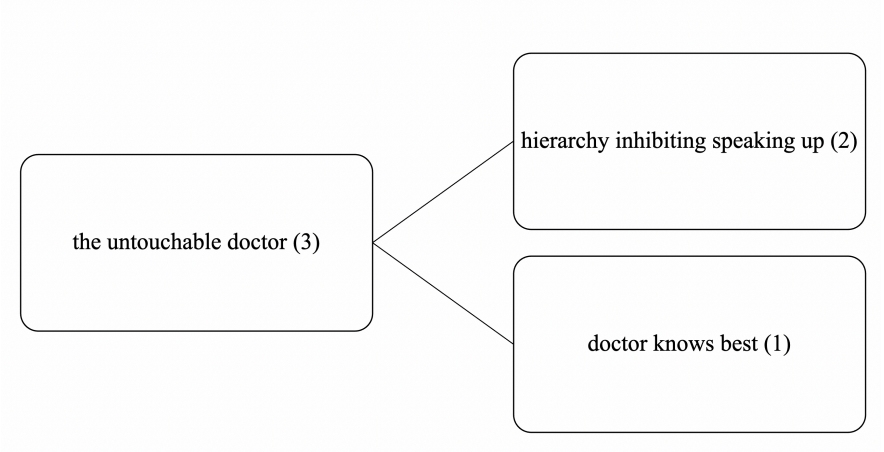


Note. The numbers stated behind the code tree elements show the total number of times the code emerged in the data.

Appendix C

Code Trees for Cultural Tropes



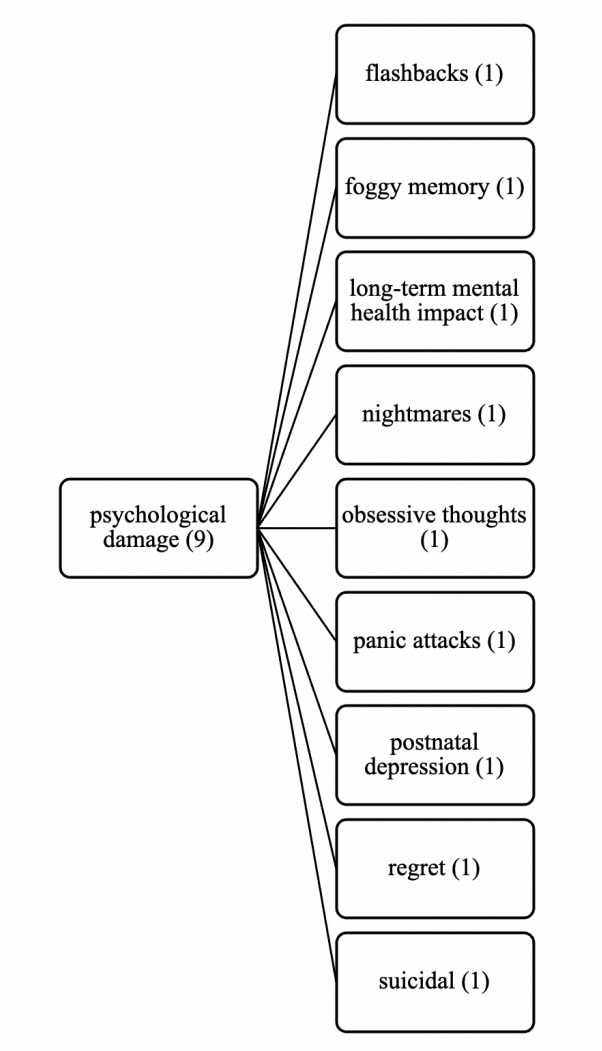


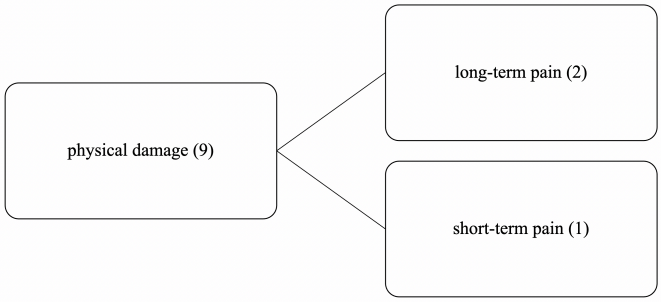
Note. The numbers stated behind the code tree elements show the total number of times the code emerged in the data.

Appendix D

Code Trees for Perceived Impact of OV

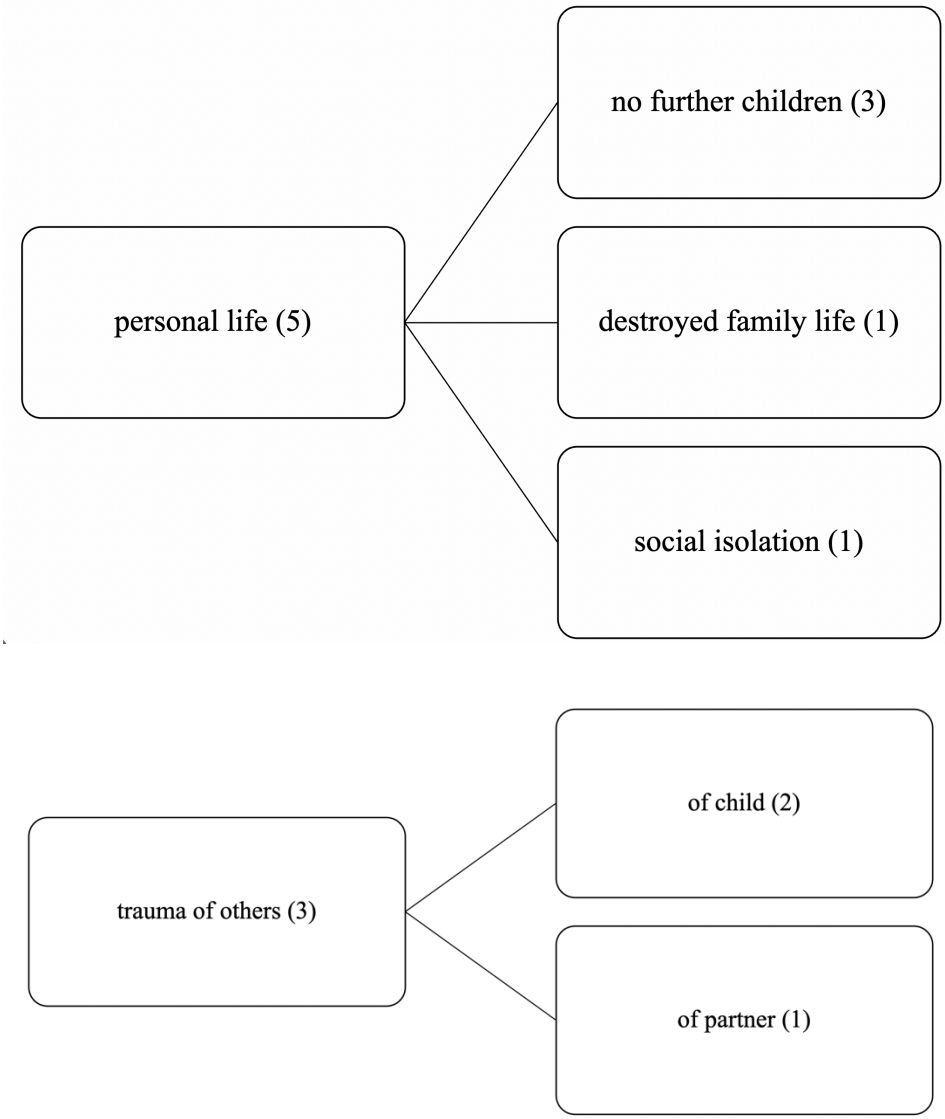
Decreased Functionality





Note. There is no code tree for work-life since this theme contained no sub-codes.

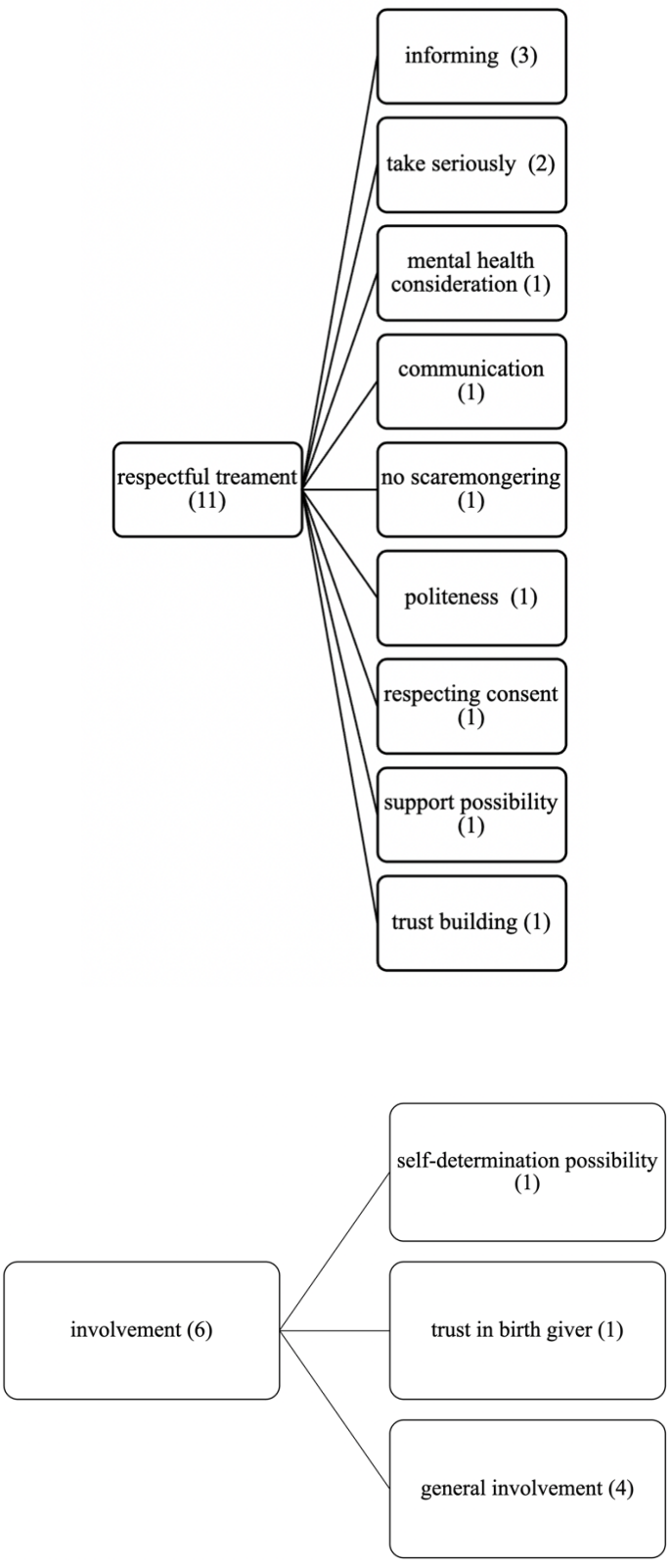
Loss of Life Quality

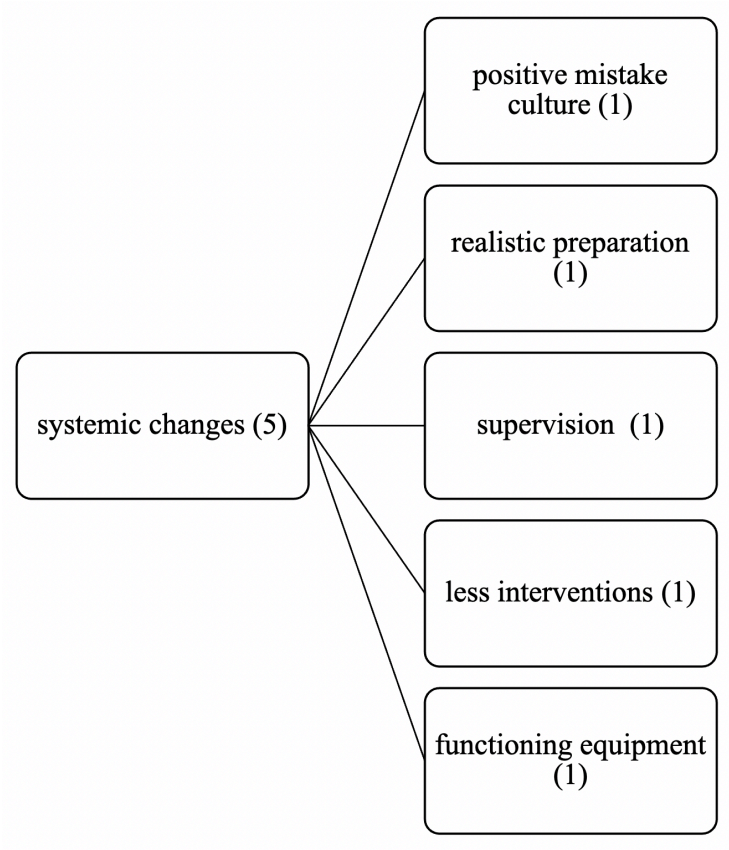


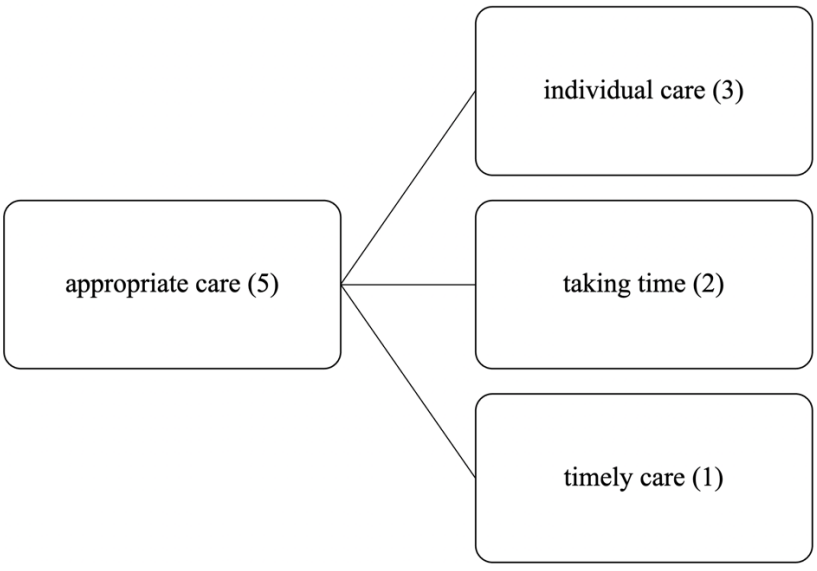
Note. There are no code trees for shadow of myself and protecting others since these themes contained no subcodes. The numbers stated behind elements show the total number of times the code emerged in the data.

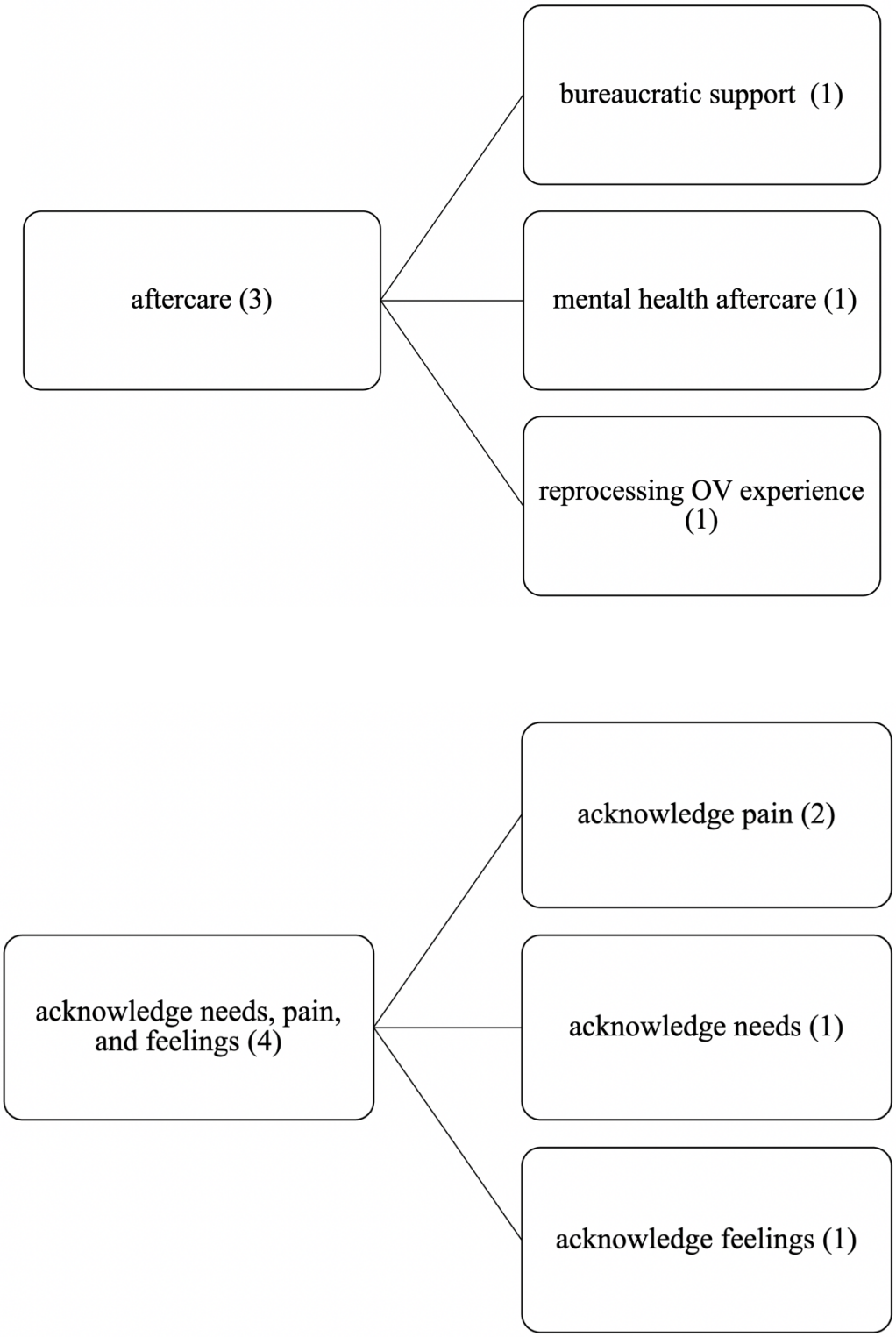
Appendix E

Suggestions of Birth Givers




systemic changes (5)
positive mistake culture (1)
realistic preparation (1)
supervision (1)
less interventions (1)
functioning equipment (1)


appropriate care (5)
individual care (3)
taking time (2)
timely care (1)



Note. There is no code tree for awareness since this theme contained no subcodes. The numbers stated behind elements show the total number of times the code emerged in the data.