The Journey through Childbirth Pain: The Experiences of Indian and Vietnamese Women living in Australia

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This thesis to dedicated to the memory of my parents, Noel and Edwina Orrock. Thank you for instilling in me the value of learning, a love of exploring and self-belief. I know you would have been very proud of my achievement.

Abstract

Title: The Journey through Childbirth Pain: The Experiences of Indian and Vietnamese women living in Australia.

Background: Pain associated with childbirth is severe and women from culturally and linguistically diverse (CALD) backgrounds tend to have less than optimal access to pain management during this period. This lack of access is a concern, as in Victoria, Australia, one in three pregnant women has been born overseas. Many are from India or Vietnam and speak languages other than English. At the same time, there is little research in Australia considering childbirth pain from the perspectives of immigrant women.

Aims: The aim of this study was to explore the experiences of childbirth pain (including during pregnancy, birth and the postpartum) from the perspective of Indian and Vietnamese women living in Australia.

Design: A qualitative approach, using interpretative phenomenological analysis (IPA), was employed to explore participants' pain experiences. IPA was chosen because it moves beyond pure description to explore the deeper meaning of experiences.

Methods: Twenty-four pregnant women born in India or Vietnam participated in two in-depth interviews (prenatal and the postpartum).

Findings: Two core themes, a culture in transition and universal experiences, emerged through the trajectory of pregnancy, birth and the postpartum. Cultural factors influenced participants' information seeking, responses to labour pain, and decision making about pain relief. Similar factors shaped the postpartum experiences, with participants deciding whether to follow cultural customs that were aimed at preventing pain in later life. Ultimately,

decisions about childbirth pain were informed by a fusion of personal choice and cultural customs within the background of a new environment.

The second theme indicated that women, regardless of ethnicity and culture, had similar experiences. All desired reassurance as the birth approached. Women who had positive psychosocial support during birth and were satisfied with their experience of pain felt empowered. When women felt inadequately supported and fearful, they made decisions which later led to regret, disappointment and dissatisfaction with their experience of childbirth.

Conclusion: Overall, this study has provided new insights into the experience of childbirth pain. Specifically, women from India and Vietnam experienced a transition in culture whilst preparing for and managing childbirth pain. It is anticipated that the knowledge gained from this study will enrich our understanding of this experience and generate better awareness of pregnant Indian and Vietnamese women's needs related to childbirth pain. This thesis provides foundational information to support healthcare professionals to understand the dynamic landscape in which women from CALD backgrounds prepare for and manage childbirth pain. This understanding will inform future decisions. Ultimately, this information may help to inform care and to provide meaningful support for immigrant women.

Declaration of Authority

Victoria University

Doctor of Philosophy (Integrated)

"I, Davina Taylor, declare that the PhD thesis entitled, *The Journey through Childbirth Pain: The Experiences of Indian and Vietnamese Women living in Australia*, is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature  Date 20th February 2020

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Glossary

Anaesthetist: a medical doctor trained to provide specialty medical care including performing procedures with the aim to relieve pain.

Analgesia: pharmacological pain relief

Assisted birth: type of childbirth involving the use of an instrument, usually forceps or vacuum assisted birth.

Birth: used to describe second stage labour or the birth type.

Birth type: used to describe the process of birth: normal, forceps, vacuum or caesarean section.

Caesarean section/lower uterine segment caesarean section: a surgical procedure involving an abdominal incision for the purpose of birth of an infant. Can be planned or an emergency.

Childbirth: Is an all-encompassing term used to describe a woman's experience of the time period where they shift from pregnancy to motherhood. This process may occur with or without labour.

Clinician/s: an individual employed to provide health related care to another, including a midwife, a nurse, an anaesthetist or an obstetrician. Interchangeable with healthcare professional

Complication/s: refers to an unexpected medical event that resulted in an adverse outcome.

Cord prolapse: a birth complication related to the umbilical cord delivered before the baby.

Culture: a socially constructed phenomenon that is created from an individual's engagement with the social world.

Culturally and linguistically diverse (CALD): used to describe an individual who was born oversea, with a diverse culture and is non-English speaking.

Epidural top-up: this usually occurs when an epidural has been placed during labour for the purpose of pain relief but is also used for anaesthesia if a woman requires a caesarean section. In such a circumstance, anaesthesia doses of local anaesthetic and opioids are administered into the epidural catheter.

Episiotomy: an incision of a woman's perineum and vagina to aid in birth of a child.

Ethnic: used to describe an individual in terms of their culture, which is a socially constructed phenomenon; and race, which is related to an individual's biological and physiological properties.

First/ 1st degree tear: a tear in the skin of the perineum, the least severe of the tears.

Forceps birth: A type of assisted birth. The birth of the infant was aided with an instrument known as forceps.

Gestation: is the period of time between conception to birth and is measured in weeks.

Healthcare professional: an individual employed to provide health related care to another; including a midwife, a nurse, an anaesthetist or an obstetrician. Interchangeable with clinician.

Hypotension: low blood pressure

Immigrant: used to describe an individual who has relocated from one country to another.

Labour: used to describe the period from onset of labour associated pain to the birth of a baby. In this study, the term labour refers to first and/or second stage labour. In the first stage, the cervix dilates and the uterus contracts, causing pain. In the second stage of labour, pain originates from the distention of the vagina, perineum and pelvic floor from the pressure of the baby's head at the time of birth (Labor & Maguire, 2008).

Manual removal of placenta (MROP): refers to the manual removal of the placenta.

Midwife: A trained healthcare professional specialising in the care of women during pregnancy, birth and postnatally.

Minor tear: reported as minor tear, likely 1st degree tear.

Motor block: reduced or absent muscle movement.

Normal birth: the spontaneous birth of an infant between 38 and 42 weeks' gestation.

Obstetrician: a medical doctor trained to provide specialty medical care for women during pregnancy, birth and the postpartum.

Operative birth: another term for caesarean section

Opioid/s: a class of medications that act on the central nervous system to provide analgesia, including morphine, pethidine, and fentanyl.

Perineum: the anatomical position between the vulva and the anus.

Postpartum: the period of time after the birth of the baby.

Postpartum haemorrhage (PPH): bleeding after birth of more than the expected volume.

Prenatal: during pregnancy

Regional anaesthetic procedure: used to refer to a spinal anaesthetic. A procedure that involves application of local anaesthetic and opioid insertion, via a needle, into the subarachnoid space with the aim to provide anaesthesia for surgery.

Second/ 2nd degree tear: a tear involving the skin and the muscle of the perineum.

Spinal anaesthetic: also termed regional anaesthetic procedure.

Third/ 3rd degree tear: a tear that involves the muscles of the perineum and the rectum.

Urinary incontinence: the inability to control the bladder.

Urinary retention: the inability to empty the bladder.

Uterine tear: a spontaneous tear in the uterine wall.

Vacuum birth: a type of assisted birth. The birth of the infant was aided with an instrument known as a vacuum.

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Chapter One: Introduction

The pain associated with childbirth is often described as the most severe pain experienced by a woman. For first-time mothers, this belief understandably creates apprehension and fear. In Australia, many women preparing for childbirth are from culturally and linguistically diverse (CALD) backgrounds. These women, living far away from family and friends, may feel isolated from important familiar supports and environments. Additional challenges arise for women with a first language other than English as they may also experience difficulties communicating their needs and comprehending advice on childbirth pain management.

1.1 Background and problem

The motivation for this research study originated in clinical practice. As a clinical nurse specialist in pain management, I provide information and care for women managing childbirth pain. The hospital where I work is situated in one of the most multicultural communities in Melbourne, Australia. Women from CALD backgrounds represent over half of those presenting for childbirth care. More than one-third speak languages other than English at home. Over the last decade, particularly, I have become increasingly aware of the challenges that exist for this group of women. Many have limited understanding of birth pain. They are uncertain about pain relief options and often appear fearful and apprehensive. In my professional experience, providing useful information to women from CALD backgrounds while they were already in labour was extraordinarily difficult. I wondered how we could help the women to be better prepared. Feedback from the anaesthetic team and the midwives who were also providing care confirmed my intuition that women from CALD backgrounds had little preparation for pain management in labour. This situation set in motion a journey to better understand the experience of childbirth pain from the perspectives of women from CALD backgrounds.

The first stage of this journey involved exploring the existing evidence about women from CALD backgrounds and preparation for labour and birth pain. From my own reading and my clinical experience, I understood that being prepared and well informed about managing birth pain leads to a positive childbirth experience. Similar views appear in the literature (Karlsdottir, Halldorsdottir, & Lundgren, 2014; Klomp, Manniën, de Jonge, Hutton, & Lagro-Janssen, 2014). Furthermore, I learned that preparedness for birth pain has an impact on the long-term health of the mother. In particular, poorly managed birth pain is associated with an increased likelihood of developing chronic pain (Kainu, Sarvela, Tiippana, Halmesmäki, & Korttila, 2010; American College of Obstetricians and Gynecologists, 2018) and postpartum depression (Eisenach et al., 2008; Kwok, Moo, Sia, Razak, & Sng, 2015). Thus, it seemed that being well prepared to manage the pain of childbirth was crucial and not only influenced the experience of childbirth but also the ongoing wellbeing of the new mother and child.

In Australia, childbirth information is often provided in prenatal education classes, which aim to help women and their partners prepare for birth (Barimani, Forslund Frykedal, Rosander, & Berlin, 2018; Nolan, 2012; Nolan, 2017). Nonetheless, participation in prenatal education classes is declining in Australia and globally, possibly related to the increasing demand on a family's time from work and home commitments, decreased availability of free classes and greater access to information through the internet (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013; Morton & Hsu, 2007; Tighe, 2010). Research also indicates that women from CALD backgrounds are less likely to attend prenatal education classes (Baron et al., 2015; Owens, Dandy, & Hancock, 2016). This information inspired me to undertake a Master's degree in which I conducted a preliminary quantitative study examining attendance at prenatal education classes in my current workplace. The findings concurred with international research and indicated that women from CALD backgrounds were less likely to attend prenatal education

classes than local women (65.5% vs 34.5%, *p*=.002). It also demonstrated that the main groups of women from CALD backgrounds who presented for childbirth care at my workplace were from India or Vietnam.

This discovery led me to further searches for studies of childbirth pain, including any pain related to parturition, from the perspectives of Indian and Vietnamese women living in Australia. My searches yielded very few results. The only Australian studies that investigated the experiences of immigrant women centred on other aspects of pregnancy and childbirth care, such as prenatal education (Owens et al., 2016) and breastfeeding (Maharaj & Bandyopadhyay, 2013). I concluded that there was no recent research exploring the experience of childbirth pain from the perspective of Indian or Vietnamese women living in Australia. This knowledge gap was the starting point of my PhD journey, and the focus for the current study.

1.2 Research question and aims

1.2.1 Research question

How do first-time mothers from India and Vietnam who are living in Australia understand their experiences of childbirth pain, during pregnancy and up to 8 weeks postpartum?

1.2.2 Aims

The aim of this study was to explore the experiences of pain during pregnancy, birth and the postpartum for women living in Australia, whose cultural background was from India or Vietnam, and who presented for childbirth care at a large Melbourne metropolitan hospital. Women in this study were first-time mothers and had been living in Australia for time periods ranging from six months to thirty years. A few women (n=3) had immigrated to Australia during infancy, with their family, and had been educated in Australia.

The remainder were more recent immigrants and had relocated to Australia in more recent years for study or professional opportunity.

1.3 Definition of terms

1.3.1 Childbirth

In this study, the term *childbirth* was used to explore a woman's experience from the moment that she considered herself to be in labour until after the baby was born. It was used interchangeably with *mode of birth* and with the term *birth*. The reason for this broad use was that definitions of childbirth and labour are not entirely precise medically and ambiguities relate to the onset of labour. For participants in this study, the onset of labour and childbirth began at the point where the woman believed that she had started labour. Medical definitions of labour and childbirth involve accurate diagnosis of first and second stage labour (World Health Organization, 2018a). These medical definitions are not used to delineate labour in this thesis, but they are discussed in greater detail in the following chapter. Because participants in this study were not expected to diagnosis their childbirth and labour medically, the decision was made to accept and appreciate their individual definitions of childbirth and labour. Furthermore, the definitions are true to the research methodology, which is founded on participants' perspectives.

1.3.2 Childbirth pain

The term childbirth pain was used as an overarching term to signify any pain experience associated with childbirth, including pain that occurred during pregnancy, birth and the postpartum.

1.3.3 Culture

In general, the terms *culture*, *ethnicity* and *race* are often used interchangeably, although they are, in fact, conceptually different. The term *culture* is applied frequently in this study and specifically refers to the behaviours and attitudes that have been shaped as a result of belonging to a community (Campbell & Edwards, 2012). With the exception of race, culture embraces all other characteristics of ethnicity, such as shared values, traditions, social constructs and religions.

Ethnicity is an all-encompassing term used to describe an individual or group of people with diverse languages who share common values, traditions, food, social constructs, ethnic backgrounds and religions (Australian Bureau of Statistics [ABS], 2011a). Unravelling that definition, the term *ethnicity* embraces culture, which is a socially constructed phenomenon, and race, which is traditionally referred to when describing biological and physiological properties of an individual (Teslow, 2014). More recently, social discussions have replaced the term *race* with *ethnicity*. However, the cultural meaning of ethnicity has often been overlooked in discussions pertaining to ethnicity, and the term ethnicity has recently been used almost exclusively to describe an individual's heritage and racial characteristics (Bhopal, 2014). Despite these social ambiguities, the fact remains that a discussion related to ethnicity includes culture, whereas a discussion of culture does not necessarily include ethnicity. Ethnicity and culture are complex concepts that continue to evolve over time with dynamic socially constructed meanings. For this reason, it is important to articulate the focus and meanings that will be referred to in this study. Culture is a socially constructed phenomenon that is created from an individual's engagement with the social world. Thus, whilst ethnicity is important, exploring the influence of culture on experience of childbirth pain is more consistent with the approach used in this research. Statements in this discussion, for example, *women from India*, are used to describe a women's ethnic

background, which encompass race and culture, and aim to provide the reader with contextual information regarding the country of birth and the cultural setting of the women.

For the purpose of this study, the term culturally and linguistically diverse (CALD) is used to describe individuals residing in a country that differs in culture and language from the country where they were born. The term CALD is used to highlight the context of an individual's environment and is closely aligned with the term immigrant. However, in this study, the term immigrant is used specifically to describe an individual who has relocated from one country to another. Thus, not all immigrants are from CALD backgrounds.

1.4 Significance of study

Australia is a multicultural country, with increasing numbers of new immigrants (Phillips & Simon-Davies, 2017), many of whom come from CALD backgrounds. Women from CALD backgrounds face many uncertainties during childbirth, often related to pain. At the same time, they are less likely to attend prenatal education classes and thus may miss the opportunity to receive birth pain information. Possibly for that reason, in the researcher's practice setting, pregnant women from CALD backgrounds are presenting for childbirth care with limited preparation for labour pain. Many of these women are from India or Vietnam, with these being the principal CALD groups in this study's setting. Currently, it is difficult to develop a better understanding of their experience of childbirth pain and support better pain management practices because of the lack of recent research exploring the experience of childbirth pain from these women's perspectives. This study is designed to address the current lack of research and specifically explore the experiences of childbirth pain from the perspective of Indian and Vietnamese women. The significance of this study rests in the opportunity it provides to increase our understanding of these women's experiences.

This study differs from earlier research because it explores women's experiences along the entire continuum of childbirth from pregnancy to the postpartum. New insights uncovered in this study will potentially highlight the challenges that women from CALD backgrounds face related to preparing for birth pain and also provide understanding of the experience of labour pain and management from these women's perspectives. This study will provide opportunities to uncover knowledge about the experience of postpartum pain, an area of interest not recently explored. For the researcher, it is anticipated that the study will create much needed new knowledge, generate stimulating discussion and open avenues for possible future exploration. Ultimately, new information uncovered in this study may lead to strategies that may contribute to a better experience of childbirth pain for Indian and Vietnamese women giving birth in Australia.

1.5 Structure of thesis

This thesis consists of ten chapters. In the first chapter, the concept of childbirth pain is introduced and the research question and aims are specified. Chapter two provides a review of literature and is separated into parts A and B. In part A, the phenomenon of pain and specifically birth pain is considered. Part B discusses the psychosocial factors that influence the experience of childbirth pain. Chapter three describes the methodology and the rationale for choosing an interpretative phenomenological approach (IPA). Chapter four presents this study's methods. In chapter five, an overview of the findings is presented. Chapters six, seven and eight explore the developing themes along the childbirth continuum: pregnancy, birth, to the postpartum. In the discussion chapter, chapter nine, the emergent themes are brought together and presented in relation to the aims of this study. The final chapter, chapter ten, concludes this thesis by addressing the strengths and limitations, the study's significance and suggestions for future research.

Chapter Two: Pain and Childbirth

2.1 Introduction

Chapter two is divided into two parts. Part A provides background into the complex phenomenon of pain, a pivotal concept in this study. Information is presented about the nature and experience of pain in general, and then more specifically about childbirth pain. A brief overview of the history and a detailed description of the contemporary perspectives of birth pain is presented, along with an overview of managing pain in childbirth. Subsequently, other pain conditions associated with childbirth are presented and the consequences of poorly controlled birth pain are discussed. In part B, the link between the experience of childbirth pain and psychosocial influences is explored. The effect of attitudes, confidence and fear, on the experience of childbirth pain is also discussed. Lastly, the influence of culture on the experience of childbirth pain is discussed generally and more particularly for women from CALD backgrounds.

Part A

2.2 Explaining pain

Pain is a complex phenomenon that has captured the attention of philosophers, scientists and researchers for centuries. Because of its complex nature, it is challenging to present this information holistically. Thus, for the purpose of this thesis, in part A I will discuss the phenomenon of pain on a foundational level to provide the reader with a clear and general understanding and to introduce the concept of birth pain.

2.2.1 The nature and experience of pain

Traditionally, pain has been described as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Anand & Craig, 1996, p. 3). More recent advances in pain science have led to a new definition, which is still under consideration. This definition, “an aversive sensory and emotional experience typically caused by, or resembling that caused by, actual or potential tissue injury” is yet to be fully endorsed by International Association for the Study of Pain (2019). Despite these efforts, defining pain remains complicated because of the factors that influence the perception of pain, and the experience of pain as a subjective entity (Cohen, Quintner, & van Rysewyk, 2018). Addressing this complexity in a single definition is challenging, which is why definitions continue to be debated.

Pain classification

Pain is considered to be multifaceted and can be classified differently depending on the circumstance in which it is experienced. In a temporal sense, pain may be classified in relation to the expected duration of the pain condition (Kennedy & Abd-Elsayed, 2019), such as acute or chronic, and also in terms of the pathophysiology of the pain stimuli, such as nociceptive or neuropathic pain (Table 1: Terms used to classify pain, p. 23). Pain may be described in different ways depending on its nature and origin. For example, an aching pain, such as when a person over-exercises, can be described as acute or short-lived; nociceptive, meaning that injury has resulted from damage to non-nerve tissue; and somatic, identifying that the pain originates from muscle. Another example is the pain of burning a finger in a flame. In this situation, the pain is more complex, because once the finger is removed from the flame, the pain persists. Nerves are damaged, thus the pain is termed neuropathic, and may be acute or chronic depending on the severity

of damage and the response of the nerves (Devor, 2013). A summary of the terms generally used to classify pain is provided in Table 1 (p. 23). Classifications of pain are based on the nature of pain, however, the manner in which an individual perceives, interprets and expresses pain is much more complex.

Pain physiology and psychology

The experience of pain is subjective (International Association for the Study of Pain, 2017) and every pain encounter is unique. Even after a consistent stimulus, individual reports of pain intensity vary considerably (Stroman, Ioachim, Powers, Staud, & Pukall, 2018). In this way, one person's pain experience may be vastly different to another's and therefore pain is best described by the individual who experiences it. Variations in pain experiences have been studied and current theory suggests that regulation occurs as pain signals travel from the point of origin to the spinal cord, brain stem and cerebral cortex (Stroman et al., 2018; Tracey & Mantyh, 2007). Simply, there are two understood theories of pain stimulus regulation, *gate control theory* and *pain matrix*.

Mid-last century, Melzack and Wall (1965) proposed the *gate control theory* and neuroscience continues to advance the intricacies of this theory. The key concept is based on physiological regulation. This theory describes the process that occurs when a stimulus travels from the point of origin to the spinal cord, where it is interpreted and regulated and then sent to the brain for higher level processing (Moayedi & Davis, 2012). In *gate control theory*, the existence of a *physiological* regulator of a pain impulse is described, which regulates the impulse at the level of the spinal cord, subject to competing impulses, such as pain, pressure, vibration, heat or cold, heat and pressure (Mendell, 2014).

Table 1: Terms used to classify pain

TERM	DEFINITION		EXPLANATION	EXAMPLES
Acute pain	Pain that last less than 6 months		Pain can be nociceptive (injury to non-nerve tissue) and/or neuropathic (injury to nerve tissue)	Bone fracture, muscle tear, surgical incision
Chronic or persistent pain	Pain that persists for longer than 6 months in duration		Usually the result of neuropathic pain	Persistent postpartum pain, sciatica, phantom limb pain
Nociceptive pain	Arises from actual or possible damage to non-nerve tissue and includes somatic and visceral pain	Somatic pain	Stimulus originates from the skin, tissue or muscle and often described as sharp and localised	Surgical incision, skin cut, muscle tear
		Visceral pain	Stimulus originates from an organ and is often more difficult to locate, more generalised and often involves sensations such as aching, stretching and tightening	Uterine pain during and after childbirth, ischemic heart pain
Neuropathic pain	Results from stimulation of the nerve fibres		Can be short lived or can result in prolonged pain	Sciatica, phantom limb pain

References: International Association for the Study of Pain (2017), Macintyre and Schug (2014), Devor (2013).

Psychosocial factors can influence the interpretation of stimuli in the brain and the theory that describes this process is termed the *pain matrix*. This sophisticated process was initial described by Melzack (1990) as the “Neuromatrix” and later re-named. In it, pain modulation occurs in the brain, which regulates and transforms the pain signal into a conscious sensation, thus creating an awareness of pain (Morton, Sandhu, & Jones, 2016). The *pain matrix* is useful for explaining the unique perception of pain experienced by an individual (Wiech, 2016). In acute pain, pain modulation can be influenced by various factors, including anxiety, fear, previous experience, and culture (Campbell, Edwards, & Fillingim, 2005; Fillingim, 2017) (discussed further later in this chapter). It is important to note that the influences of such factors, for example previous experiences, can be significantly more complex in the circumstance of chronic pain, when the *pain matrix* is subject to constant stimulation (Meyer, Karl, & Flor, 2015). Pain is also complex to observe.

Pain is both subjective to an individual and powerfully engaging to observers. When pain is experienced by an individual, their expression can be observed although the observer cannot see pain. The expression of pain may take the form of facial grimaces and verbal expressions such as “ouch”. The signal that results in an individual’s expression of pain can also be observed by examining the neural pathway with magnetic resonance imaging (MRI) (Morton et al., 2016). It is interesting that if we see a painful event, like a person stubbing their toe on a chair and we observe a pain response in this person, our response is one of empathy for the person experiencing the painful event. This can also be seen on the MRI of the observer, as similar neural pathways are stimulated by the observation of the pain encounter (Morton et al., 2016). This observer pain phenomenon results from a complex neurostimulation process termed *mirror neurons* (Schott, 2015). The mirror neuron phenomenon is more complex in a situation where the observer is a nurse or midwife, whose

daily activity involves observing individuals in pain. A nurse/midwife in this situation can seem to have reduced empathy, although controversy exists as to whether observing an individual in pain repetitively results in diminished mirror neuron response, or the nurse/midwife consciously self-regulates their behaviour for emotional protection (Ferrari & Coude, 2018).

One of the main purposes of pain is to warn the individual of imminent danger, to change the course of events or protect from ongoing harm (Whitburn, Jones, Davey, & Small, 2014). In the case of exercise, an aching or strained muscle during or after exercise is a warning to take more care, not to extend beyond the muscle's capacity. With the finger in the flame example, the pain results in removing the finger from the flame. This is not the case with birth pain, which is quite unusual in that there is no related tissue damage despite significant pain. The physiological and psychosocial complexity of the experience of pain has long fascinated researchers and pain perception can be determined by and transformed through life experiences. The pain that a woman experiences in birth results from a union of physiological factors (as described in section 2.2.2) and psychological factors (as described in section 2.3). The experience of childbirth pain has all the features of complex pain but at the same time co-exists with one of life's most important events, the birth of a baby (Bleidorn, Hopwood, & Lucas, 2018).

2.2.2 The nature and experience of childbirth pain

Pain during childbirth is the result of physiological changes taking place during the first and second stages of labour. In the first stage, the cervix dilates and the uterus contracts, both events simultaneously sending neurotransmitter signals to the spinal cord at the thoracic vertebras 11 to 12 and then to the brain, to process the pain stimuli (Kafshdooz, Kahroba, Kafshdooz, Sheervalilou, & Pourfathi, 2019). Uterine contractions during this stage also stimulate the beta-endorphin hormone that has been reported to aid in relieving pain (Buckley, 2015; Jain, Mishra, Shakkarpude, & Lakhani, 2019). In the second stage of labour, pain originates from the distention of the vagina, perineum and pelvic floor from the pressure of the baby's head (Meyer et al., 2017). This process stimulates pain signals that are transmitted along the pudendal nerves (the sacral spinal region) and then travel to the brain for processing. Labour pain is characterised by both visceral pain caused by uterine contractions and cervical stretching and somatic pain as a result of vaginal distention (Jones et al., 2012; Kafshdooz et al., 2019). Because of its duration, birth pain is classified as an acute pain, but it may result in persistent pain for some, and involves both nociceptive and neuropathic pain. Thus, birth pain is the consequence of multiple pain stimuli stemming from various sites, and at different time intervals during labour. For this reason and many other reasons yet to be discussed, the experience of childbirth pain is complex.

Historically, birth pain was shrouded in secrecy and considered a taboo subject. Before the 19th century, it was not publicly discussed or studied even by women. The last century, however, has given rise to social changes and research has helped to shed light on birth pain from the perspectives of women. The following discussion describes the increasing visibility of women's perspectives of childbirth pain.

In the beginning: a woman's perspective of childbirth pain

A woman's voice in the narratives of childbirth was virtually unheard of before the 1930s. Publications on childbirth were from the perspective of husbands, independent observers or medical clinicians (Cosslett, 1994). Mothers' voices in the childbirth literature began to appear in the 1930s, such as in the book *The Squire* by Enid Bagnold in 1938. It was daring for its time, and Bagnold (1938/1987) weaved the account of the birth of her fifth child into the narrative of the novel. Bagnold described her birth pain experience as a collection of sensations, some painful and others not, all of which completely engaged her body and mind until the birth of her child. Bagnold's writing paved the way for women in the English speaking world to discuss birth pain more openly and just over a decade later, in the mid-20th century, Fernand Lamaze (1891–1957) encouraged women to publish narratives of their birth experience (Al-Gailani, 2017; Michaels, 2010). These writings helped open up this once clandestine subject and provided evidence for the advancement of birth pain management, education and research.

Over the next half century, women's perspectives of childbirth contributed significantly to academic literature and changed the way in which birth pain was viewed. This research disputed the idea that the experiences of pain during birth were all the same and that birth pain should be endured silently and stoically. Currently, evidence suggests that each pain experience during childbirth is significantly and intensely unique (Whitburn, Jones, Davey, & McDonald, 2019).

Contemporary perspectives of childbirth pain

Today, literature exploring the experiences of childbirth pain are richer than ever before. In most cases, when women are requested to describe the experience of childbirth pain, descriptions relate to their emotions (Whitburn et al., 2014) or the severity of pain (Nur Rachmawati, 2012; Aziato et al., 2017), rather than how pain felt physically. For example, one participant in the study by Nur Rachmawati (2012) described birth pain in the following way: “I feel the pain has reached my feet. It is very painful, very intense. It is getting more painful. It is the most painful….my God” (p. 264–265). In contrast, Taghizdeh, Ebadi, Dehghani, Gharacheh, and Yadollahi (2017) reported that women described labour pain more positively, for example a participant stated, “I did not have any negative feelings about that day….Every day that passes, I enjoy it more. I am very happy about it” (p. 493).

There is a wealth of childbirth literature exploring women’s childbirth pain with a focus on the meaning of pain (Taghizdeh et al., 2017; Whitburn, Jones, Davey, & Small, 2017; Reed, Barnes, & Rowe, 2016). For many women, the experience of childbirth pain involves a complex interchange of physical changes, emotional sensations, social constructs and mental functionality. Thus, a women’s perceptions of birth pain and the meaning assigned to it are variable. Some women indicate that pain during childbirth is powerfully linked to inner maturity and conquering the pain gives rise to a unique sensation of personal achievement (Reed, Barnes, & Rowe, 2016; Taghizdeh et al., 2017). In some cultures, it is considered essential for a woman to experience the pain associated with childbirth, which is considered a rite of passage into motherhood (Reed et al., 2016). In other research, women perceived birth pain as a means of testing motherhood, and women who were unable to self-manage birth pain were considered not yet ready for motherhood (Benza & Liamputtong, 2014; Reed, Callister, Kavaefiafi, Corbett, & Edmunds, 2017).

Many women describe the experience of childbirth as a paradox (Van der Gucht & Lewis, 2015). On the one hand, pain during childbirth is seen as incapacitating and disabling, while on the other hand there is an overwhelming sense of happiness and completeness with the birth of a new life. Other studies have found similar perceptions. For example, in a qualitative study in the UK that explored women's (n=10) birth pain experiences, one woman expressed feelings that she was not able to manage her pain, which was so intense that she had grave concerns for her life. But then when she saw her baby, the pain disappeared, it was just her and her baby (Leap, Sandall, Buckland, & Huber, 2010). This *bitter sweet paradox* is commonly expressed and, for some women, the experience of childbirth pain is a voyage of discovery, because they believe that only through suffering can true fulfilment be understood (Bassey Etowa, 2012).

Only a few studies have succeeded in articulating descriptions of childbirth pain. In one such study, the birth pain experience of Ghanaian women in Africa (n=14) was explored, and a participant stated, "it is like you are being torn apart" (Aziato, Acheampong, & Umoar, 2017, p. 3). Sensations have been described by women giving birth, including tightening, pulling, stretching, aching, stabbing, and burning; sometimes the pain is reported to be sharp and at other times, dull (Mestrović, Bilić, Loncar, Micković, & Loncar, 2015; Schug, Palmer, Scott, Halliwell, & Trinca, 2015). In childbirth, a woman is likely to experience all or most of these sensations and possibly because of these complexities, a woman's description of birth pain can be ambiguous.

2.2.3 Childbirth pain management

Managing the pain of childbirth is complicated and there is no one right way suitable for all women. Most approaches to pain management stem from longstanding custom. In the following discussion, the history of pain relief for birth is described briefly followed by the options that are currently available to women giving birth in Australia.

A brief history of childbirth pain management

The history of birth pain management is replete with interwoven concepts, ideas and beliefs, along with the use of pharmacological and non-pharmacological interventions. One of the first references to birth pain management is from the 1st century BC by the Greek physician Soranus of Ephesus (Laale, 2011). He encouraged carers to ease the pain of labour by placing warm cloths soaked in oils over the abdomen and genital area. From the 4th century AD, beliefs about women were heavily influenced by the Church and birth pain was commonly considered a penance for original sin (Corretti & Desai, 2018). Original sin refers to the Christian belief that humanity exists in a state of sin and women were expected to endure the pain of childbirth. Caregivers of labouring women were generally discouraged from providing pain relief, because this conflicted with Church ideology and carers were often punished for providing pain relief in childbirth. Childbirth was both feared and misunderstood and midwives were sometimes considered witches (Ehrenreich, 2010; Kristóf, 2017). The influence of the Church continued into the middle ages, when labouring women were encouraged to pray to Saint Margaret, the patron saint of childbirth, to ease labour pains and to petition for a safe delivery (Alberts, 2016). The dominance of religious ideology in birth pain management in Europe lessened following the Renaissance period and with the onset of scientific exploration (Henry, 2010). In the 16th, 17th and 18th century,

herbal formulations for management of pain became increasingly popular, including the use of poppy and hemp plants.

Historically, childbirth occurred in the home and the woman was supported by her midwife (Donnison, 1988). The midwife's role during labour focused on facilitating labour, managing pain by employing techniques such as repositioning and emotional support (Arney & Neill, 1982; Thompson & Burst, 2015). Midwives were considered to be the woman's voice during labour and were seen as steadfast advocates during birth (Green, 1989). It was during this time, in the 17th century, that midwifery was first challenged by medical influences. Nonetheless, pioneering midwives, like Jane Sharpe, established a strong foundation of knowledge sharing through the development of the first widely accepted academic midwifery text (Wear, 2002). In this era, pain during labour was viewed as an inevitable and healthy process.

In the 19th century, the spotlight turned to pharmacological means of managing birth pain. Ether and chloroform were introduced and in 1853, Queen Victoria was the third woman in history to use chloroform for birth pain management (Gibson, 2017). With the acclaimed testimony of the second user of chloroform, Charles Darwin's wife Emma Darwin (Snow, 2005), chloroform became a popular choice of pain relief in labour for affluent women. Late in the 19th century, nitrous oxide and opioids were introduced for managing labour pain and continue to be widely used. Today in Australia, over half of all women giving birth use nitrous oxide, and one in five uses opioids to help manage the pain of childbirth (Australian Institute of Health and Welfare, 2015).

During the 19th and early 20th centuries, medicalisation of the childbirth process became more prevalent and accepted throughout the world (Arney & Neill, 1982). Women's understanding that pain was necessary during labour became challenged and coincided with the rise in medical and pharmacological options aimed at reducing labour pain (Ampofo, & Caine, 2015). Consequently, during the 20th century, women's perceptions of labour pain changed from an inevitable process to something that should be controlled.

In the early to mid-20th century, epidural analgesia was introduced. It is now widely used in childbirth and is growing in popularity. Figures show that in 1992, 17% of women giving birth in Australia used epidural analgesia (Anim-Somuah, Smyth, & Howell, 2005), compared with 27% in 2003 (Lain, Ford, Hadfield, Blyth, Giles, & Roberts, 2008), 31% in 2012, and 39% in 2013 (Australian Institute of Health and Welfare, 2014). This change illustrates a greater acceptance by pregnant women and healthcare professionals of using epidural analgesia during childbirth and probably reflects its greater availability.

Childbirth pain management options

In present day Australia, birth pain relief is routine and pain management is dominated by two ideologies, non-pharmacological and pharmacological pain relief. Available options vary between hospitals and other health care settings (Steel et al., 2015) but basic options, such as nitrous oxide and opioids, are universally available in hospitals. Except for nitrous oxide, not all options are available to every women and access depends on the resources of the setting. For example, a water birth is only possible if a bath and trained staff are available, usually at larger hospitals and specialist birth centres (Milosevic et al., 2019). In most cases, pain relief options can be used in combination. The initiation of one form of pain relief does not preclude another, except for pharmacological options and the use of water. For example,

it is not possible for a woman with an epidural to have a shower or bath. In general, women use more than one pain relief method during childbirth (Steel et al., 2015). In the following discussion, options that are available in most Australian hospitals are briefly described.

Non-pharmacological options

Non-pharmacological means of managing pain in labour have long existed (Benfield, Heitkemper, & Newton, 2018; Dong, Hu, Liang, & Zhang, 2015; Taavoni, Sheikhan, Abdolahian, & Ghavi, 2016) and the term non-pharmacological refers to therapies that are drug-free (Jones et al., 2012). Some common examples are water, massage, transcutaneous electrical nerve stimulation, aromatherapy and relaxation therapies (Sanders & Lamb, 2017).

Of the available non-pharmacological options, the use of water may have the longest history. Memoirs describe the custom of using water in childbirth for hundreds of years. For example, since antiquity, New Zealand Maori communities embarked on a journey from the hills to a sacred river so that a woman could give birth in the river (Schibeci, 2009). Similar approaches have been used in other cultures (Schwartz, 2018; Vecchio et al., 2016). In modern day Australia, most birth rooms have showers for women to use during labour to help with managing pain. Some birth suites also have a bath. The use of water in childbirth reduces pain and decreases the use of pharmacological pain relief (Cluett, Burns, & Cuthbert, 2018).

Other non-pharmacological options, such as relaxation and massage, have been shown to reduce anxiety, and consequently pain, during labour (Smith et al., 2018), although the design of studies has often led to difficulties with likely bias. In a review of trials that considered relaxation techniques in labour including yoga, mindfulness and music, Smith et

al. (2018) concluded that whilst outcomes showed reduced pain, studies were poor quality, particularly in relation to sample size. Many non-pharmacological options have been described as lacking scientific verification, nonetheless these options increase childbirth satisfaction by empowering women to engage in decision-making and encouraging partner participation (Levett, Smith, Bensoussan, & Dahlen, 2016; Thomson, Feeley, Moran, Downe, & Oladapo, 2019). Additionally, most non-pharmacological options are easily accessible, techniques are easily taught to women and few side-effects are reported (Schug et al., 2015) Thus, when women are considering options to aid in the management of birth pain, it is reasonable to start with non-pharmacological options before moving to pharmacological options, which pose a greater risk of side effects (Bonapace et al., 2018).

Pharmacological options

At present, pharmacological agents for managing labour pain are well accepted and have been widely studied. Nitrous oxide is a non-flammable, colourless gas (Brown & Sneyd, 2016; Collins, Starr, Bishop, & Baysinger, 2012) that aids the management of early labour pain and is safe for both mother and baby (Schug et al., 2015). In most Australian healthcare settings, nitrous oxide is available for a woman in labour to inhale through a mask or mouthpiece. Advantages of nitrous oxide are its rapid onset, non-invasive nature and the fact that it does not limit a woman's mobility during childbirth. Women also maintain a sense of control because they are able to self-administer the gas (Likis et al., 2014). While nitrous oxide is used by 54% of labouring women in Australia, its analgesic efficacy in severe labour pain is limited and studies have shown that women have better quality pain relief with epidural analgesia (Australian Institute of Health and Welfare, 2015; Feng et al., 2016; Schug et al., 2015).

The use of opioids for the management of labour pain by parental (subcutaneous or intramuscular) or intravenous injection is common worldwide. In Australia, the opioids pethidine, morphine and fentanyl are commonly used, with fentanyl now often preferred to pethidine because of better side-effect profiles for the mother (Fleet, Belan, Jones, Ullah, & Cyna, 2015). In an Australian randomised control trial, for example, Fleet et al. (2015) compared fentanyl with pethidine for its safety and efficiency in relieving pain in labour. They demonstrated that fentanyl was as effective as pethidine at managing birth pain. Overall, opioids, regardless of the type or route, are poor alleviators of severe pain and may cause side effects including nausea, vomiting, itch and drowsiness (Phillips, Fernando, & Girard, 2017).

Epidural analgesia is considered the *Gold Standard* in labour analgesia because it provides superior pain relief in labour compared with all other forms (Schug et al., 2015). Nonetheless, like other pharmacological options, epidural analgesia poses risks (Ashagrie, Fentie & Kassahun, 2020). The most common complications are maternal hypotension, fever, motor block and urinary retention (Anim-Somuah, Smyth, & Jones, 2011; Tan, Sultana, Han, Sia, & Sng, 2018). Birth related concerns including, increased risk of an instrumental birth (Adams, Frawley, Steel, Broom, & Sibbritt, 2015; Anim-Somuah et al., 2011; Wassen et al., 2015) and, a prolonged second stage of labour (Anim-Somuah et al., 2011) has been associated with epidural analgesia. Even with these known concerns, women's use of epidural analgesia continues to rise. This situation is likely related to the control that women feel during labour with epidural analgesia (George, Allen, & Habib, 2013). Overall, epidural analgesia reduces the need for other forms of pain relief in labour, but it does not increase maternal satisfaction when compared with nitrous oxide, pethidine, morphine or fentanyl (Anim-Somuah et al., 2011).

Pharmacological and non-pharmacological pain relief agents are primarily used for the management of pain in the first stage of labour, where much of the focus of pain management is concentrated. Other pain conditions may occur in second stage labour or result from childbirth, and those conditions are discussed in the following section.

2.2.4 Pain conditions associated with childbirth

Childbirth is associated with an array of pain conditions. Common pain conditions that are experienced during birth and often continue for a few days after birth include perineal pain, uterine pain and back pain.

Perineal pain

Perineal pain is a consequence of trauma during childbirth, and may result from perineal tearing, episiotomy, and assisted birth (vacuum or forceps birth) (Molakatalla, Shepherd, & Grivell, 2017). This pain condition is common. In a Melbourne study of 215 women interviewed within 72 hours of vaginal birth, 90% of participants had experienced perineal pain that affected activities such as sleeping, walking and sitting (East, Sherburn, Nagle, Said, & Forster, 2012). Thus, a painful perineum affects the quality of recovery after childbirth (Lindqvist, Persson, Nilsson, Uustal, & Lindberg, 2018). Additionally, perineal pain is also likely to have a negative influence on breastfeeding and general baby care (Cooklin et al., 2018) because the mother is unable to sit comfortably or move easily. In most cases, perineal pain will subside within weeks of childbirth but it can persist for many weeks or even months (Leeman, Rogers, Borders, Teaf, & Qualls, 2016).

Uterine pain

Uterine pain occurs during the first and second stages of labour, and immediately after birth. It occurs as a result of contractions stimulated by circulating oxytocin released from the posterior pituitary gland (Uvnäs-Moberg et al., 2019). Contractions generally start as mild and escalate to severe, causing lower abdominal and lower back pain (Lee, Kildea, & Stapleton, 2015). They are typically described as throbbing, cramping and aching (Schug et al., 2015). Anecdotally, women report that uterine pain continues for a few days after childbirth and can worsen during breastfeeding with after-birth pains (Wen, Hilton, & Carvalho, 2015). After-birth pains have been attributed to increased release of oxytocin during breastfeeding and can be worse in multiparous women (Wen et al., 2015).

Back pain

Back pain occurs during pregnancy, labour and after childbirth. The nerve fibres that innervate the uterus and cervix return to the spinal cord between the twelfth thoracic and the first lumbar vertebrae, resulting in referred pain to the lower back (Labor & Maguire, 2008). Back pain after childbirth is characterised by a dull aching pain in the lower back and is usually exacerbated by forward flexion posture of the spine (Bergström, Persson, & Mogren, 2014), for example, bending over when changing a baby's nappy and poor breastfeeding posture. Lower back can also be associated with pelvic girdle pain. Pelvic girdle pain is commonly reported by pregnant women and is due to the pressure placed on the pelvic and lumbar musculoskeletal regions during pregnancy (Gutke, Boissonnault Brook & Stuge, 2018; Stuge, Jenssen & Grotle, 2017). In most cases pelvic girdle pain resolves after birth but for one in five women, it may persist for years (Bergström, Persson & Mogren, 2014).

Back pain is the second most common pain condition reported by women within 3 months of birth (Gaudet, Wen, & Walker, 2013). For example, Melbourne researchers who examined pain conditions occurring within the first 8 weeks of birth among first-time mothers (n=229) found that approximately half of participants reported experiencing back pain, and 25% of women indicated that back pain continued for 2 weeks or more after the birth (Cooklin, Amir, Jarman, Cullinane, & Donath, 2015).

Overall, perineal, uterine and back pain are physiological pain conditions that occur because of childbirth, and which may occur during or immediately after the birth. If these pain conditions are not suitably managed, harmful consequences may result. In the next section, the consequences of poorly controlled childbirth pain are outlined.

2.2.5 The impact of poorly controlled childbirth pain

Acute severe birth pain may affect a new mother's health and wellbeing. Research indicates that poorly controlled pain may lead to physiological and psychological adversity including severe acute postpartum pain, persistent postpartum pain (PPP) and postpartum depression (PPD) (Eisenach et al., 2013; MacKinnon et al., 2017).

Postpartum pain

Pain after birth is not uncommon. In fact, 10% of women experience severe acute pain within the first 3 days after birth (Eisenach et al., 2008). Woolhouse, Gartland, Perlen, Donath, and Brown (2014) reported the most common health concerns of new mothers were pain related, specifically back, breast and perineal pain. Less commonly reported health concerns included haemorrhoids and constipation. Paradoxically, while postpartum pain is often unexpected by women, Woolhouse et al. (2014) identified as many as 15 general health

conditions in the immediate postpartum period. Over half of these concerns were pain related.

Research has focused on ways to decrease postpartum pain. For example, a randomised controlled trial (n=161) examined the effect of music therapy during labour on early postpartum pain and showed that music reduced pain not only during labour but also in the first 10 days postpartum (Simavli et al., 2014). In another study, Vaziri et al., (2017) considered the influence of aromatherapy, specifically lavender oil, on pain in the immediate postpartum period. They found that women (n=56) who received lavender therapy reported less perineal pain (p=.004, p<.001) and physical pain in general (p<.001) than women in the control group, 24 hours after birth (Vaziri et al., 2017). Both studies show promise in ways of managing postpartum pain, although the research is not robust at this stage.

Persistent postpartum pain (PPP)

Postpartum pain for up to 3 months after childbirth is common (Woolhouse et al., 2014) and, although less common, women may experience postpartum pain for 12 months and beyond (Eisenach et al., 2013; Kainu et al., 2010). According to pain classification (Table 1, p. 23), postpartum pain that persists for longer than 6 months is considered persistent pain. Back, perineal, breast (Woolhouse et al., 2014) and caesarean section incisional pain (Eisenach et al., 2013) have been reported by numerous women 6 months after childbirth.

Although severe acute postpartum pain contributes to the development of PPP (Eisenach et al., 2008; American College of Obstetricians and Gynecologists, 2018), studies have shown conflicting results regarding other factors that influence the development of PPP. Kainu et al. (2010), for example, reported that PPP was more likely to occur in women with a history of chronic disease or persistent pain (n=600), whilst Eisenach et al. (2013) found

no association between a history of persistent pain and the development of PPP (n=1228). Both studies had relatively large cohorts and similar designs, the former was a Finnish study and the latter an American study. It is unclear whether factors such as lifestyle differences between the countries may have had an influence on outcomes. In the same Finnish study, the influence of labour analgesia on the development of PPP was considered, and Kainu et al. (2010) reported that the likelihood of developing PPP after childbirth was not associated with epidural analgesia use in labour (n=600). Nonetheless, more research is needed to determine whether the type of pain relief provided in childbirth affects the development of PPP.

Postpartum depression (PPD)

Postpartum depression is recognised as a depression that occurs usually within the first 12 months postpartum but may commence during pregnancy (Dennis, Brown, & Morrell, 2016). It may affect as many as 25% of new mothers (Ding, Wang, Qu, Chen, & Zhu, 2014), and pain during childbirth and the postpartum appears to be linked to the development of PPD. This factor has been examined in a Melbourne study (n=1507) in which new mothers who reported five or more general health conditions, many of which were pain related, were six times more likely to report PPD symptoms in the 3 months after childbirth compared with women reporting under two health conditions (Adjusted OR=6.69, 95% CI=3.0–15.0) (Woolhouse et al., 2014). In another study, a secondary analysis of data from postpartum Canadian women (n=5,614) confirmed that pain was an important factor in the development of PPD (Gaudet et al., 2013). Thus, it is reasonable to consider that postpartum pain, especially ongoing postpartum pain, plays a role in the likelihood of developing PPD.

Some researchers have considered the influence of specific pain relief techniques on the development of PPD. The relationship between epidural analgesia to manage birth pain and the development of postpartum depression (PPD) has been examined. In a secondary analysis of data from Canadian mothers (n=207), Nahirney, Metcalfe, and Chaput (2017) reported no statistical significance between epidural analgesia and a reduction in PPD. This contrasts with previous findings that epidural analgesia was associated with a decreased incidence of PPD. For example, Ding et al. (2014) found that women (n=214) who received epidural analgesia during birth were less likely to develop PPD than those who did not (OR=0.31, 95% CI 0.12–0.82, *p*=0.018). Other studies have had similar outcomes and the weight of evidence supports a decrease the incidence of PPD with epidural analgesia (Lim, Farrell, Facco, Gold, & Wasan, 2018; Suhitharan al., 2016; Wisner, Stika, & Clark, 2014).

Ding et al. (2014) have also suggested that women who were more prepared to manage their birth pain were less likely to develop PPD because of their level of engagement with pain management. This factor may explain the relationship between lower rates of PPD after epidural use. Considering this perspective in more detail, in another study Orbach-Zinger et al., (2018) examined the intention to use epidural analgesia and the development of PPD, but found no relationship between intention to use but not using epidural analgesia and PPD. However, in women who did not intend to use but did, in fact, use epidural analgesia during childbirth, there was an association with the development of PPD (Orbach-Zinger et al., 2018). Possibly, women who planned to use epidural analgesia but did not do so were empowered by their ability to manage the pain, while women who did not plan to use epidural analgesia were unprepared for the severity of pain. Thus, the expectations of a pregnant woman regarding pain in childbirth may have an influence on her wellbeing after birth.

In sum, Part A has highlighted that birth pain is both complex and unique and is powerfully linked to the experience of the woman giving birth. A woman's perception of birth pain may arise from numerous and possibly contrasting experiences. The factors that shape the experience of childbirth pain is the focus of the following section, part B.

Part B

2.3 Factors that influence the experience of childbirth pain

A woman's perception of childbirth pain can be influenced by a plethora of factors. Some influence the pain signal at the point of origin, such as baby's position, the duration of contraction, or pressure on bladder, bowel and pelvis (Ebirim, Buowari, & Ghosh, 2012). Psychosocial factors, such as a woman's attitude, confidence, fear, and culture (Karlsdottir, Sveinsdottir, & Olafsdottir, 2015), influence the pain signal within the *pain matrix* and shape the pain perceived during childbirth (Ebirim et al., 2012). In Chapter two, part B, these factors are described briefly together with the effects of attitude, confidence and fear, while the influence of culture on the experience of childbirth pain is explored in greater detail.

2.3.1 Attitude

There are various definitions of the term attitude, however for the purpose of this study, the term attitude refers to how an individual thinks and feels towards an event or situation (Maio, Haddock, & Verplanken, 2018). Recent evidence suggests that a woman's attitude to childbirth pain has a considerable impact on how she will experience it (Karlsdottir et al., 2015; Whitburn et al., 2014), and attitudes can be shaped at any time during a woman's life. From early teenage years, women are aware that childbirth is painful and most likely they learn this from stories relayed by mothers to daughters, and from other female relatives and acquaintances (Kay, Downe, Thomson, & Finlayson, 2017; Melender, 2002). Because of this practice, attitudes regarding birth pain may be developed long before pregnancy. An Australian study highlighted that women often developed opinions about birth pain based on others' mostly negative experiences (Fenwick, Toohill, Creedy, Smith, & Gamble, 2015).

These negative experiences can influence women's perceptions at any time but particularly during pregnancy. A woman's attitude towards birth pain has also been linked to her behaviours during pregnancy and childbirth. For example, a positive attitude can promote confidence, while uncertainty can generate fear (Dönmez, Kisa, & Özberk, 2016; Karlsdottir, Sveinsdottir, Kristjansdottir, Olafsdottir, & Aspelund, 2018; World Health Organization, 2018a). These contrasting behaviours are discussed in the following section specifically in relation to childbirth pain.

2.3.2 Confidence

Confidence to manage childbirth pain leads to a more positive experience in general (Karlsdottir et al., 2015; Leap et al., 2010), and can influence a women's control of pain and choice of pain relief during childbirth (Karlström, Nystedt, & Hildingsson, 2015; Spaich et al., 2013). For example, Karlström et al. (2015) explored factors contributing to positive experiences of childbirth and found that women (n=26) reported positive experiences when they also felt confident to manage birth pain. In another study, similarly, confidence in pain management was found to be associated with childbirth satisfaction (n=335) (Spaich et al., 2013).

The ways women cognitively process birth pain or engage in pain related information during pregnancy have been explored in other studies. Whitburn et al. (2014) found that a woman's (n=19) thoughts during pregnancy regarding birth pain influenced her experience. In that study, conducted in Australia, open and positively focused women who were engaged prior to childbirth reported a more positive childbirth experience than woman who were distracted and disengaged prior to childbirth. Similar findings were reported in a Dutch qualitative study in which Klomp et al. (2014) explored women's (n=15) expectations regarding birth pain

management. Women felt a need to be prepared, well supported, in control and to be a participant in decision making. In the same way, Jonsdottir et al. (2019) compared the experience of childbirth between distressed women and non-distressed women using measures for anxiety, depression and stress and found that distressed women used more pain relief during labour than non-distressed women. Those authors suggested that women who were distressed became more emotionally overwhelmed with the uncertainty of childbirth and had reduced ability to cope with labour pain.

Uncertainty during childbirth has also been explored and was linked to low confidence (Karlsdottir et al., 2015; Neerland, Avery, & Saftner, 2019). In a large Icelandic study (n=1100), the association between women's expectation of the intensity of pain in childbirth (EIPC) and their attitude to birth pain management was examined. Results indicated that the strongest predictors of a high EIPC score were negative attitude to the impending childbirth (OR=2.39), low sense of security (OR=1.80), and expecting to use pharmacological options to help manage birth pain (OR=1.63) (Karlsdottir et al., 2015). Thus, women who were not confident in their ability to manage birth pain and expected to use pharmacological pain relief had higher than normal levels of pain expectation. In support, Neerland et al. (2019) examined prenatal and birth confidence and indicated that confidence for birth was associated with the intention not to use analgesia in labour. Based on this literature, it seems likely that a woman's confidence in her ability to manage birth pain empowers her. Researchers have also explored the influence of low confidence on the development of severe fear of childbirth (Fenwick et al., 2015), discussed below.

2.3.3 Fear of childbirth

Fear of childbirth is not unexpected in pregnancy, and in fact it is considered usual to be fearful about an event of forthcoming pain (Handelzalts et al., 2015). Estimates indicate that one-quarter of pregnant women will experience childbirth fear (Toohill, Fenwick, Gamble, & Creedy, 2014). A pathological fear of childbirth is termed tokophobia and can range from mild to severe fear of childbirth (Hofberg & Ward, 2007; Richens, Smith, & Lavender, 2018). First-time mothers (Lukasse, Schei, & Ryding, 2014; Toohill et al., 2014) or women who have experienced a previous assisted or operative birth (Toohill et al., 2014) are more likely to experience childbirth fear.

On most occasions, a woman's fear of childbirth is considered mild or moderate and can be settled by reassurance that she has competent medical and midwifery staff caring for her. Some women have more intense fear, and according to Lukasse et al. (2014) who conducted a study examining the prevalence of childbirth fear across six European countries, as many as 11% of women (n=6870) reported experiencing severe fear of childbirth. More recently, Demšar et al. (2018) reported that 25% of study participants (n=191) experienced high or very high fear of childbirth. Tokophobia can have serious consequences during pregnancy and childbirth including sleep disturbance, expectations of poor health and difficulty completing daily activities (Striebich, Mattern, & Ayerle, 2018). In some cases, these women may request an operative birth because of their fear of a normal birth (Larsson et al., 2017; Stoll, Fairbrother, & Thordarson, 2018).

Considerable research has highlighted the influence of fear on a woman's experience of pain during childbirth (Haines, Rubertsson, Pallant, & Hildingsson, 2012; Stoll, Hall, Janssen, & Carty, 2014; Toohill et al., 2014). For example, in a longitudinal study of Swedish

and Australian postpartum women, participants who feared childbirth were more likely to report birth pain as more intense compared with women who did not fear childbirth (Haines et al., 2012). In an international study, Aksoy et al. (2016) reported that women with lower expectations of pain before their labour experienced less pain during labour (n=230). Thus, it seems that fear affects the experience of pain during childbirth and this corresponds with the understanding that fear is an influencing factor in the modulation of pain in the *pain matrix* centre of the brain (Morton et al., 2016).

For healthcare professionals, fear of childbirth is challenging to measure. The most widely used fear of birth measure is the Wijma Delivery Expectancy Questionnaire (WDEQ). However, challenges have been reported related to the multidimensional nature of this score (Nilsson, et al. 2018). Over time revisions have been performed to aid its transferability. The more recent WDEQ-A score continues to be scrutinised but shows positive correlations with severity of fear of childbirth and practicality of use (Rondung, Thomtén & Sundin, 2016).

Fear of childbirth that escalates during pregnancy may also have long term effects. In a recent Indian study childbirth fear was associated with depressive illness, while postpartum depression was influenced by inadequate pain management (Jha, Larsson, Christensson, & Svanberg, 2018). Other factors, such as immigration, may have an impact on childbirth fear. Swedish researchers investigated how giving birth in a new country affected childbirth fear. Immigrant women (n=606) were three times more likely to experience fear during pregnancy than Swedish-born women (Ternström, Hildingsson, Haines, & Rubertsson, 2015). Thus, this relationship between childbirth fear and the experience of pain may explain in part why women from CALD backgrounds often report negative childbirth experiences (Balaam et al. 2013). Culture may also exert an influence on the experience of childbirth pain and is discussed in the following section.

2.4 Culture

Culture is important in this study because it is known to influence the experience of pain. In a ground-breaking qualitative study, Zborowski (1952) explored the experience of pain from the perspective of ethnically diverse groups, each of which had been previously identified by his colleagues as displaying different pain responses. Jewish, Italian, and American-born men were recruited (n=103) and data were collected by interviews and observations. Zborowski found that culture influenced the means by which individuals processed and then expressed pain experiences. For example, Jewish and Italian men were more emotionally expressive about their pain compared with American men. Italian men were more likely to accept pain relief than Jewish men, who were concerned about the effects of drugs on health. Although this study only involved men, the inherent message referred to all individuals. Literature strengthening the link between pain and culture evolved over the following decades (Bates, 1987; Lowe, 2002).

During important life events and times of challenge, like childbirth, it is not unusual for individuals to draw on cultural traditions and customs (Callister, 2003; Chiejina, Odira, Sibeudu, & Okafor, 2012). Indeed, culture has been shown to have a substantial influence on a woman's experience of and response to birth pain (Chiejina et al., 2012; Reed et al., 2017; Whitburn et al., 2019). Culture has additionally been discussed in studies that explore the meaning of childbirth pain. For example, Reed et al. (2017) explored the childbirth perceptions of Tongan women (n=38) and highlighted how many women believed it was necessary to experience birth pain as a rite of passage and they were encouraged to stay strong in the face of pain, because this was a sign of strength and love for the baby. For this reason, many Tongan women refused analgesia and were opposed to caesarean section. Researchers emphasised the importance of clinicians being aware of women's wishes

regarding the experience of childbirth pain, because these may be culturally imbedded. Similarly, Murray, Windsor, Parker, and Tewfik (2010) performed a study among African women (n=10) giving birth in Australia. Participants believed that they needed to experience birth pain in order to become a mother. Thus, in some cultures, pain generates specific meaning and may be seen to be intrinsic to the experience of childbirth. Whilst Murray et al.'s study provides valuable insight into the experience of childbirth pain for African women living in Australia, it is now a decade old and had a small sample size.

Culture may also influence the manner in which pain is expressed. In some cultures, pain is not voiced or expressed externally whereas other cultures encourage the expression of pain (Flaskerud, 2015; Power, Bogossian, Sussex, & Strong, 2017). McLachlan and Waldenström (2005) described these two often opposing pain behaviours as stoic and emotive. In emotive expression, the experience of pain is shared and the individual experiencing the pain is encouraged to seek attention from others within the group (Narayan, 2010). Behaviours like moaning, crying and screaming not only symbolise the experience of pain, but may be encouraged as the best way to manage the pain (Narayan, 2010). For example, women from India are frequently considered to be vocal during childbirth, often calling out with each painful contraction (English, 2009).

In contrast, women from other cultures are considered stoic in the face of labour pain. McLachlan and Waldenström (2005) discussed how women from some CALD backgrounds were concerned that expressing and sharing their experience of pain may unfairly burden others in the group. Carson et al. (2017) reported that in some cultures, women were seen to be demonstrating courage and this was viewed by others as a valued achievement. Not being able to maintain a sense of calm or manage the pain internally may be seen as a weakness (World Health Organization, 2018a). This concept also appears in other studies.

For example, researchers exploring the childbirth experience of Ghanaian women reported that while some women screamed and cried out, others contained the pain and expressed no sign of pain, believing that crying was a sign of emotional fragility (Ampofo & Caine, 2015). Women were advised by family and friends to endure labour pain and were encouraged to remain strong in the face of pain (Ampofo & Caine, 2015)

Spirituality also has considerable influence on the expression of pain, or pain behaviour, during childbirth (Abdollahpour & Khosravi, 2018; Aziato, Odai, & Omenyo, 2016; Callister & Khalaf, 2010; Chiejina et al., 2012). For example, Chiejina et al. (2012) examined childbirth pain perceptions and behaviours among Nigerian women (n=202) and confirmed a significant relationship between religion and behavioural responses to pain. Other studies provided more detailed understanding of this (Aziato et al., 2016). For example, Abdollahpour and Khosravi (2018) examined the effects of spirituality on the experience of pain (n=245), and found that believing in a higher power reduced childbirth fear.

Spiritual practices that may be employed during childbirth include prayer, singing, thanksgiving at church, fellowship and emotional support. Aziato et al. (2016) explored the childbirth experiences of Ghanaian women (n=13) and found that participants reported that praying to God reduced their labour pain. The influence of spirituality on reducing and managing birth pain has also been recorded in other studies. For example, Callister and Khalaf (2010) performed a secondary analysis of studies that had recruited childbearing women from Christian, Jewish, and Islamic faiths. Women reported using spirituality to symbolise pain, and in doing so developed meaning and understanding of the pain, which also allowed them to stay focused during pain. In another study into the experiences of childbirth pain for Iranian women, religion was identified as helping to manage labour pain (Beigi, Broumandfar, Bahadoran, & Abedi, 2010). Indeed, there is strong research evidence

that spirituality can shape the way in which women express birth pain and can be helpful for women when managing pain. Thus, in many ways, culture, which includes spirituality, can provide a supportive and structured environment for a positive experience of childbirth pain. However, this supportive environment is in jeopardy when a woman is giving birth in a country other than her country of origin, particularly if her supports are overseas.

2.4.1 Giving birth in a new land

Revisiting the definition from chapter one; culture is a socially constructed phenomenon that is created from an individual's engagement with the social world. Living far away from family and friends, and separated from accustomed resources, makes women from CALD backgrounds vulnerable. Vulnerability renders such women, particularly those with lower health literacy, less likely to engage in general maternity care, resulting in less choice, and poorer birth outcomes (Ebert, Bellchambers, Ferguson & Browne, 2014). Thus, giving birth in a country that is culturally diverse from a woman's country of origin will likely prove challenging. Benza and Liamputtong (2014) suggest that women's experiences are influenced by the social factors that surround them and their adaption to their new environment. In this vein, researchers have described how cultural adaption and acculturation occur after immigration. One of many definitions of acculturation presents it as a process of cultural change that follows the combination of two or more cultures, including the adopting of new behaviours in the new country (Berry, Poortinga, Segall, & Dasen, 2002). Ward and Geeraert (2016) highlight that the less similar the former and new cultures are, the greater the challenge posed for individuals to achieve psychosocial equilibrium. Thus, individuals may have various experiences of acculturation changes over different time periods.

Over the last few decades, various acculturation models have also been offered and many have been criticised because of their linear and unidimensional nature (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006; Schwartz & Zamboanga, 2008). In contrast, Berry's model (Berry, 1992, 2017) of acculturation represents a bi-dimensional concept that classifies individual or group behaviour into four intersecting clusters. *Assimilation* involves adoption of the new culture and departure from the original culture; *separation* involves the refusal of the new culture and maintenance of the original culture; *integration* involves acceptance of the new culture whilst also maintaining the original culture; and *marginalisation* involves the rebuttal of both the new and original cultures (Berry, 2017). Berry considers the strategies that newcomers use in the new environment and their outcomes. Each classification represents a different path towards acculturation and results in differing psychosocial outcomes, with some groups assimilating more quickly than others (Pitts, 2017). More recently, discussions of acculturation have shifted to multi-dimensional models of acculturation that also consider contextual factors such as socioeconomic status, resources, interpersonal relationships and language skills (Espeleta, Beasley, Bohora, Ridings, & Silovsky, 2019). Thus, there is an increasing appreciation of the complexity of cultural adaption.

With this increased awareness, acculturation research related to healthcare has also increased, particularly about postpartum depression (PPD). Alhasanat and Giurgescu (2017) for example, performed a systematic review of quantitative studies examining PPD and acculturation, and concluded that women who had higher levels of acculturation and were considered to belong to an assimilated group had higher levels of PPD. Although this finding appears counter intuitive, it may be explained in the following ways. Assimilating may have resulted in women giving up practices that provided support and reassurance, and

possibly women who had assimilated had less contact with their family and familiar community and therefore felt more isolated. Many quantitative acculturation studies employed measurable data to indicate acculturation, for example, language skills and country of birth. Espeleta et al. (2019) considered other features including family and social support, and found that these features neutralised the negative relationship between acculturation and PPD (Espeleta et al., 2019). There has also been an increase in acculturation literature in health-related disciplines, but research related to childbirth remains scarce. In truth, no research was found that specifically explored or described acculturation in relation to the experience of childbirth pain.

Pregnant women from CALD backgrounds face many challenges when adapting to a new country, including health literacy and language and reduced access to birth resources and services (Balaam et al., 2013; Bassey Etowa, 2012; Benza & Liamputtong, 2014; Chalmers & Hashi, 2000; Hughson, Daly, Woodward-Kron, Hajek, & Story, 2018; Reed et al., 2017). Many of these studies suggest concerns related to pain management (Balaam et al., 2013; Bassey Etowa, 2012; Benza & Liamputtong, 2014; Higginbottom et al. 2015; Reed et al., 2017).

In the final section of chapter two, literature exploring the experience of childbirth and pain management from the perspective of women from CALD backgrounds is reviewed. This discussion is separated into two sections. In the first section, there is a broad account of international literature relating to the experiences of childbirth pain among women from CALD backgrounds. Literature from the perspective of women from CALD backgrounds living in Australia is examined in the second section.

2.4.2 Perspectives of women from CALD backgrounds living internationally

Internationally, quantitative studies examining immigrant women's experiences of maternity care have reported concerns about adequate pain management during childbirth (Husarova, Macdarby, Dicker, Malone, & McCaul, 2016; Raleigh, Hussey, Seccombe, & Hallt, 2010). For example, a Irish study examined administration of analgesia to immigrant women during labour (n=36,689), and found that women who had immigrated from North Africa, Sub-Saharan Africa, the Far East, North America, Eastern Europe or India were less likely to receive analgesia than women born in Western Europe (p<.05) (Husarova et al., 2016). The researchers postulated that the disparity in pain relief may be related to immigrant women's cultural expectations of birth pain.

Similarly, a United Kingdom survey examining equity in maternity care for immigrant women (n=26,325), found that most immigrant participants were less likely to report receiving adequate pain relief during labour compared with British-born women (Raleigh et al., 2010). Collectively, these quantitative studies suggest that immigrant women receive less pain relief. Although these studies provide some information regarding birth pain management practices, they provide little information about the reasons for lower use of pain relief among immigrant women.

Some factors related to less use of pain relief have been identified, including lack of communication and poor access to information and resources during pregnancy and childbirth (Balaam et al., 2013; Bassey Etowa, 2012; Chalmers & Hashi, 2000; Reed et al., 2017). Although these generalised concerns have been reported in most reviewed studies exploring the experiences of women from CALD backgrounds, only a few studies have

specifically reported on childbirth pain and pain management and these are over a decade old (Bulman & McCourt, 2002; Chalmers & Hashi, 2000; Herrel et al., 2004).

In a small number of qualitative studies that explored the childbirth experience of immigrant women, a lack of resources about pain was highlighted. For example, Bulman and McCourt (2002) explored the childbirth experience of Somali women (n=12) living in London, and revealed that women were ill-informed regarding pain relief options during birth. Similarly, another study of Somali women (n=14) living in the United States found that women were poorly informed regarding the options and side effects of pain relief (Herrel et al., 2004). It is important to note that, along with pain management concerns, many Somali women have low levels of education and low general and health literacy, which result in greater difficulties in communicating and understanding pain management (Herrel et al., 2004). Whilst these studies have provided valuable insight, they are over a decade old and have small sample sizes.

Whilst it is clear that the experience of childbirth pain is important and is often highlighted in studies exploring the childbirth experiences of immigrant women, it has received little focused attention. In response to this problem, Callister, Khalaf, Semenic, Kartchner, and Vehvilainen-Julkunen (2003) performed a secondary analysis of phenomenological studies that explored the experience of childbirth from the perspectives of women from CALD backgrounds, focusing specifically on pain. Their analysis highlighted that women's experiences of childbirth pain were culturally bound, including understanding of pain, coping with pain and expression of pain.

Internationally, women from CALD backgrounds have less than optimal access, understanding and use of pain management during pregnancy and birth (Husarova,

Macdarby et al., 2016; Raleigh et al., 2010). The situation in Australia is likely to be similar, if not worse, because Australia has one of the highest immigration rates in the world (Phillips & Simon-Davies, 2017), including many who were humanitarian refugees. It is estimated that nearly one in three people living in Australia was born overseas (Phillips & Simon-Davies, 2017), with many immigrants originating from diverse language backgrounds. It is for this reason that the experience of childbirth pain should be considered from the perspectives of women from CALD backgrounds living in Australia.

2.4.3 Perspectives of women from CALD backgrounds living in Australia

Considerable qualitative research has been undertaken in Australia over the last 20 years into the reasons for disparity in access to maternity care from the perspectives of women from CALD backgrounds (Hoang, Quynh, & Sue, 2009; Liamputtong & Naksook, 2003; McLachlan & Waldenström, 2005; Murray et al., 2010; Shafiei, Small, & McLachlan, 2012; Small, Yelland, Lumley, Brown, & Liamputtong, 2002). Small et al. (2002) explored pregnancy and childbirth experiences of women from CALD backgrounds and interviewed women (n=318) with the aid of interpreters about various aspects of care. Women conveyed a desire for more information about events that occurred during the birth process but also declared their satisfaction with pain management practices. Small et al. (2002) highlighted that this result was unexpected and emphasised that it could be a consequence of women focusing on how they believed clinicians responded to requests for pain relief, rather than the specific pain relief methods that were offered.

In contrast, McLachlan and Waldenström (2005) evaluated the experience of childbirth among Vietnamese (n=100) and Australian women (n=100). They reported that Vietnamese women found the experience of childbirth pain to be worse than expected. Possible reasons

for this finding included the influence of culture on pain behaviour and on preparation for birth pain. Inequity in access to pain relief was another possible influence that was briefly highlighted by the researchers, particularly in the context of Vietnamese women with lower English language skills. Low English language skills may have resulted in an inability to participate in pain management decision making.

Other Australian research has shown the greater challenges for women from CALD backgrounds when accessing pain services during the postpartum care. Hennegan, Redshaw, and Kruske (2015) performed a secondary analysis of data on women born in Australia (n=2722) and overseas (n=233) to examine experiences in the postpartum. They highlighted how women from CALD backgrounds reported greater challenges in managing postpartum pain. Participants were less likely to be included in decision making or to understanding the options available to them. This concern has been highlighted in many studies, along with the need to understand and highlight the necessity of providing healthcare information that all women can interpret and understand, and which meets their needs (Correa-Velez & Ryan, 2012; Murray et al., 2010; Shafiei et al., 2012).

The experiences of pregnancy and childbirth from the perspectives of many women from CALD backgrounds have been studied in Australia, including women born in Thailand (Rice, Naksook, & Watson, 1999), Vietnam (Liamputtong & Naksook, 2003; McLachlan & Waldenström, 2005; Small et al., 2002), Turkey (McLachlan & Waldenström, 2005; Small et al., 2002), Philippines (Small et al., 2002), Cambodia (Liamputtong & Naksook, 2003), Afghanistan (Shafiei et al., 2012), Korea and Japan (Hoang et al., 2009), who are now living in Australia. Whilst most of these studies are over a decade old, they overwhelming suggest that women from CALD backgrounds living in Australia often felt misunderstood by healthcare professionals and had greater challenges in accessing and understanding pain

management information during pregnancy, birth and the postpartum (Hoang et al., 2009; Liamputtong & Naksook, 2003; McLachlan & Waldenström, 2005; Rice et al., 1999; Shafiei et al., 2012; Small et al., 2002).

The cultural groups of interest for this study are women born in India and Vietnam, both of which are major immigrant groups in Australia (ABS, 2018) and constitute the most prevalent ethnic communities in this study's setting. Studies exploring the experience of women from these groups are few. The most recent study, conducted over a decade ago, explored the experience of Vietnamese women and indicated that they were stoic in dealing with pain in childbirth (McLachlan & Waldenström, 2005), probably related to cultural influences on acceptance of birth pain. Vietnamese women are expected to maintain a sense of peace and silence during the childbirth experience, expecting and accepting the pain (McLachlan & Waldenström, 2005). In another study that included a Vietnamese cohort, their experience of pain was complex and pain reports were not always directly related to the level of pain experienced or the forms of pain relief used. Experiences were more likely related to how the women felt that they were being cared for in general (Small et al., 2002). There is limited recent research exploring the experience of Vietnamese women giving birth in Australia, specifically focusing on pain during childbirth.

Research considering childbirth pain from the perspective of Indian women is also scarce. The Indian community represents the fourth largest immigrant population in Australia and the second largest in Victoria (ABS, 2017b), so it is telling that no research was found addressing experiences and needs of these women. This knowledge gap signifies a need for more research to explore the experience of childbirth pain from the perspective of Indian and Vietnamese women living in Australia and has contributed to the development of the current study.

2.5 Summary

Over the last decade, international and Australian research has reported that women from culturally diverse backgrounds have inequitable access to pain management in childbirth. Qualitative studies in Australia support this view, although the experience of childbirth pain itself has been poorly described, particularly from the perspective of immigrant women living in Australia. Similarly, the support needs and desires of these women are poorly understood. This research gap is important because Australia is a multicultural nation, with large and increasing numbers of women from India and Vietnam. The experience of childbirth pain from the perspective of these women has not been considered recently in research. At the same time, birth pain is important and is linked to numerous negative outcomes when not well managed. To better understand the experience of childbirth pain from the perspective of immigrant women and to improve outcomes for them, further research is vital. Exploring the experience of childbirth pain in greater depth may provide greater insight into the experience of childbirth pain from the perspective of women from CALD backgrounds. Such research will also inform clinicians who will, in turn, be better equipped to support women from CALD backgrounds during pregnancy, childbirth and the postpartum.

2.6 Conclusion

In Chapter two, background literature has been presented on the complex phenomenon of childbirth pain. In Part A, information was provided regarding pain in general and more specifically, pain related to childbirth. The nature and experience of childbirth pain was outlined, as were the options of managing childbirth pain. Discussions led to the pain conditions associated with childbirth and the effects of poorly controlled birth pain. In Part B, contemporary knowledge about childbirth pain and management was reviewed. This

discussion centred on factors that influenced women's experiences of childbirth pain, including attitudes and culture, showing particularly how a woman's cultural background significantly influenced her experience of childbirth pain. Moreover, a considerable knowledge gap was identified pertaining to the experience of childbirth pain from the perspective of Indian and Vietnamese women living in Australia.

Chapter Three: Methodology

3.1 Introduction

In Chapter three the research philosophy underpinning this study is described. The research philosophy encompasses the researcher's ontology and epistemology, which are based on the researcher's beliefs about how reality is created and how knowledge and understanding are developed, generally. This perspective guides the research question, the research approach and chosen methodology. In chapter three, the rationale for a qualitative research approach in this study is explained. The final discussion focuses on the methodology, chosen from the available qualitative methodologies. Because the methodology serves to support the process of inquiry and guide the researcher's actions, a detailed discussion of the chosen methodology, Interpretative Phenomenological Analysis (IPA) is provided, together with a rationale for how IPA was the best approach to explore the childbirth pain experiences of Indian- and Vietnamese-born women.

3.2 Research philosophy

Research is a process of searching for an answer to a question. In its earliest stage, there is a time where an idea or a concern evolves into a theoretical question. How this question evolves depends on the researcher's own beliefs about how reality and knowledge are created, otherwise known as ontology and epistemology. A researcher's ontology and epistemology will influence their perspective, also known as worldview or philosophy. The worldview is the platform on which the research question is posed. In the beginning, there is debate and considerable cognitive commitment and exploration. The purpose of this

discussion is to appreciate the complexity of the philosophy of research whilst also making a clear statement as to the principles and direction of the study.

3.2.1 Ontology

Ontology is the study of being, or how individuals view their existence. An individual's ontology reflects what that individual believes is true, factual or real. Theoretically, there are two beliefs in ontology, objective and subjective. Individuals with an objective ontology view their existence as independent of social influences, believing that reality is external to the self and that individuals are simply observers of reality. In contrast, an individual with a subjective ontology believes that human existence is created from interaction with the social world. From a subjective ontological position, the experience of reality is the result of a union between self and situation. In practice, most people are not so clearly delineated as to have a purely subjective or objective ontological view of the world, but often possess a mixture of both. Whichever belief is influential at any one time may depend on the context in which the individual is situated.

The ontological position of an individual influences their beliefs on a subject matter. Consider the 16th century ontology of childbirth pain. Centuries ago it was deemed that birth pain was a repercussion for the sins of Eve, thus the nature of childbirth pain was religiously bound (Williams, 2001). In this era, pain during birth was not considered an experience with any subjective ownership but was purely founded on the belief of an external reality. During and prior to the Renaissance period, the mainstream ontological position was objective. Over time, because of the study or epistemology of childbirth pain, this ontology has evolved. Childbirth pain is now considered to be an individual experience that is intrinsically linked to the social world. In this study, the researcher embraces a subjective ontology and considers

that the experience of childbirth is unique to each woman, and this experience is influenced by social and environmental factors. Additionally, the researcher's ontological perspective influences their epistemological position and the research direction, explored in the following section.

3.2.2 Epistemology

Epistemology is the process of knowledge creation and much like ontology, the concept of epistemology has also been debated for centuries. Before the term *research*, meaning the creation of knowledge and understanding, was introduced, ancient philosophers like Plato, Aristotle and the Sophists described the process of logical reasoning, which was known as the essence of knowledge creation (Targowski, 2010). Further development came in the 16th and 17th centuries when philosophers began to appreciate the importance of an individual's perspective and the influence of logical reasoning. Ultimately this movement gave rise to scientific discovery. With these changes came the notion of research, which was derived from the French term *recherche*, and means to *go about seeking* (Kate, 2017). Later, the individual's scholarly perspective became valued and was considered central to knowledge creation. The ways in which an individual studies knowledge or comes to know what they know is termed epistemology (Chamberlain, 2014). For an individual to engage in research, that individual needs to have a clear and articulate epistemological position, which will inspire a strong research direction (Willig, 2012).

There are various epistemological positions currently in debate (Chamberlain, 2014). For the purpose of this study the following discussion will outline two dominant schools of thought, realism and relativism. The epistemological position of realism suggests that knowledge is created from observing and assessing the external world. This position is most

often complementary to an objective ontology and considers that gaining information requires the use of tools and resources to test an outcome or to examine existence external to the researcher (Brooks & King, 2017). The opposing epistemology is relativism, which reflects the ontology of a subjective reality. Learning about this reality and gaining knowledge can only be achieved through consideration of human experience. There are many forms of relativism but the one that underpins this study is contextualism (MacFarlane, 2011). Contextualism is concerned with the search for the truth for a particular person experiencing a particular event, whilst also understanding that for another person or context, this truth might be totally different (Brooks & King, 2017). Contextualism is consistent with the researcher's philosophy of childbirth pain, because every experience of birth pain is considered a unique journey that can only be understood from the perspective of the woman experiencing the event, and from the nature of the birth.

In the initial stages of this inquiry it was necessary for the researcher to give sufficient time and energy to consider and understand her own ontological and epistemological positions. This foundation provided the framework for the research approach.

3.2.3 The development of a worldview

In preparation for an inquiry, a researcher must consider which lens to employ in order to achieve the best outcomes. The lens is also known as the worldview and most often corresponds with the researcher's own ontology and epistemology, meaning that the researcher feels comfortable with the underlying philosophy. Christians (2005) highlights that a researcher's worldview is founded on their inherent beliefs and principles. That worldview influences the research question and the methods for data collection and analysis. In preparation of this thesis, some mainstream worldviews were considered.

3.2.4 Overview of three traditional worldviews

There is a plethora of worldviews to consider and debate, however this discussion will focus on three worldviews, positivism, post-positivism and interpretivism.

Positivism

Positivism came to light in the 19th century when Auguste Comte (1798–1857) rejected metaphysics, the customary method of knowledge creation, and postulated that knowledge could only be created through the understanding of the real world (Kaboub, 2008). Positivism is a perspective in which the truth is objective and the world exists external to the self (Bryman, 2015; Walliman, 2015). In positivism, there is one truth, and if it is not possible to observe and measure it, then it is not true (Trochim, 2006). It is the researcher's role to uncover that one truth (Maltby, Williams, McGarry, & Day, 2014). Essentially, positivist researchers seek the absolute truth within a situation or event, believing that reality exists independent of the individuals experiencing the event. Neuman (2011) suggests that positivist researchers pursue scientific evidence to prove or disprove notions of how we perceive the world. Often in research, positivist researchers strive to identify a cause and effect relationship. However, over time some philosophers considered that it is nearly impossible to uncover a truth without having a possible impact on that truth (Denzin & Lincoln, 2011). This reasoning led to the concept of post-positivism.

Post-positivism

Like positivist researchers, post-positivists also consider knowledge to be external and gained through observation and measurement, but unlike positivists, post-positivists are aware of the influence that they may have on the observed context (Ryan, 2006). The primary difference between positivists and post-positivists is that the latter appreciate that an individual, in the search for the truth, may influence the outcome (Trochim, 2006). Post-positivists acknowledge the challenge of pure objectivity and try to be as neutral as possible, usually by seeking probabilistic evidence (Polit & Beck, 2004) and ascertaining the likelihood of an event occurring by chance. From a post-positivist perspective, knowledge is not absolute, theories can be tested and rejected but cannot be proven with unequivocal certainty (Trochim, 2006). Post-positivist researchers believe that although reality and truth exist outside of the individual, it is our interaction with this reality that serves as our lens (Lincoln & Guba, 2013). Post-positivism has always been a strong feature in healthcare research where researchers strive to measure outcomes and robustly link these outcomes to the context (Polit & Beck, 2004). The alternative, an interpretivist worldview, has gained momentum over the last two decades in healthcare research.

Interpretivism

> *Interpretivism advocates that "people intentionally create social reality with their purposeful actions of interacting as social beings. Social reality is largely what people perceive it to be; it exists as people experience it and assign meaning to it".* (Neuman, 2011, p. 102)

The interpretive worldview trusts that an individual's reality is created from interaction with the environment (Berger & Luckmann, 1967). Consistent with this worldview, every

individual has a different truth or reality. Essentially, every interaction is, in and of itself, another reality, and the impression of each reality is dependent on the experiencing person. Each individual will construct meaning and understanding of their own reality (Bryman, 2015).

Because interpretivism asserts that there are many realities and these realities are subjectively dependant, the role of an interpretivist researcher is to explore an individual's subjective reality. It is also evident that a researcher exploring the reality of an individual is also featured within the researched context (Neuman, 2011), because the reality is a result of these interactions. Essentially, an interpretivist researcher is one who seeks to understand an experience from the perspective of the participant (Neuman, 2014) and recognises that his/her own experience affects the interpretation of the research (Lincoln & Guba, 1985). Many interpretivist researchers indicate that adopting this worldview provides a platform for voices to be heard, and unique experiences to be understood, that would otherwise remain unheard (Haddrill, Jones, Mitchell, & Anumba, 2014; Lyons, O'Keeffe, Clarke, & Staines, 2008; Miquelutti, Cecatti, & Makuch, 2013; Puthussery, Twamley, Macfarlane, Harding, & Baron, 2010).

It is important to note that a researcher's worldview is not concrete, and a perspective may change depending on the context of the inquiry. Additionally, one worldview is not superior to another (Broom & Willis, 2007); they are simply two different ways of viewing reality. However, it is essential for a researcher to appreciate and understand their worldview in order to plan and focus the research inquiry. This study plans to explore the childbirth pain experience from the perspectives of Indian- and Vietnamese-born women living in Australia. The interpretivist worldview was chosen to be the most suitable lens for this exploration, because a woman's experience and perspective is considered central to this inquiry.

3.2.5 Choosing an interpretivist worldview

Childbirth is expected to be painful, and the nature of childbirth influences that pain experience. A woman's perception of childbirth pain is multidimensional, intertwined with many psychosocial influences, and may be influenced by social encounters that have occurred up to and until the time of birth. A simple example is the woman's increased fear of childbirth after hearing a traumatic birth story. As highlighted by Fenwick et al. (2015), unpleasant or distressing stories, shared by others, can heighten the fears and anxiety of a pregnant woman regarding her own impending childbirth. This can ultimately modify the pain perception and lead to a negative experience of birth (Henriksen, Grimsrud, Schei, & Lukasse, 2017). Using an interpretivist lens, with the belief that experiences are socially constructed, a woman has the opportunity to share her personal birth experience, and possibly seek meaning and understanding for her experience.

Interpretive research explores an experience through the eyes of participants with the intention to foster new knowledge and understanding (Neuman, 2014). Thus, choosing the interpretive paradigm to explore an individual's unique experience of childbirth pain was an uncomplicated decision. The researcher considered that the experiences of childbirth pain could only be fully represented through the perspectives of the participants and each participant's experience may be quite different from another's. This position of the researcher corresponds with the interpretivism worldview of subjective multiple realities. Universally, it is accepted that pain is subjective (Koyama, McHaffie, Laurienti, & Coghill, 2005; Williams & Craig, 2016), and as the interpretivist worldview aims to capture the individual experience, the interpretivist worldview is well suited to exploring childbirth pain.

In sum, a researcher needs to be aware of the foundation principles of ontology, epistemology and worldview to move to the next step in the research inquiry process. Moreover, it is essential that a researcher's ontology, epistemology and worldview complement one another, to provide harmony and stability in the research approach. The next step is equally important. It is often termed the *research approach* and it determines the manner in which the research is conducted. The principles of an interpretative worldview are complementary to this researcher's perspective, and the interpretative worldview is also consistent with a qualitative approach to research.

3.3 The research approach – qualitative research

A research approach is the pathway that is employed to support and conduct the inquiry process. There are two predominant research approaches, quantitative and qualitative, and one of these approaches or a combination of both may be used in a study. In this study, a qualitative approach was used to explore the experience of childbirth pain. Qualitative research provides a flexible approach for exploring questions related to social experiences, where the researcher is less concerned with the factors that influence the outcome and more interested in the journey along the way (Hays & Singh, 2011).

3.3.1 Foundations of qualitative research

In a qualitative approach, the researcher observes a situation, event, phenomenon or experience as it occurs within the context of the situation, for a person or people. The qualitative researcher aims to collect information in order to understand, describe, appreciate or find meaning in how the event occurs, is experienced or transpires, without preconceived ideas (Biggerstaff, 2012; Denzin & Lincoln, 2011). Data about the experience are transformed into research data, which are then analysed. Qualitative research is

founded on the principles of information creation and understanding (Denzin & Lincoln, 2011), and is complementary to an interpretivist worldview.

Qualitative research is intrinsically linked to the phenomenon studied, so it is not possible to separate the individual from the environment because one without the other would result in no experience. Therefore, qualitative researchers often immerse themselves within the environment of the participant, shadowing, observing and learning about the participant within the participant's world (Corbin, & Strauss, 2014). At times, this immersion may not be possible nor practical, and the qualitative researcher then uses techniques such as interviews to engage the participant and explore the experience at a level that is deep and rich enough to achieve the same intention, without having to be immersed into the participant's world (Walliman, 2015).

Qualitative research is an inductive inquiry process and the researcher approaches an experience with no preconceived ideas or expectations about how an individual or group may interact within a given context (Neuman, 2014). Inductive research allows the emerging data to direct the inquiry process. The emergent data is then analysed by the researcher, and conclusions are drawn. Typically, researchers share their conclusions in various forms depending on the underpinning methodology, but the participant's experience is always pivotal.

3.3.2 Advantages and limitations of qualitative research

Qualitative research is best employed when a researcher wishes to explore, describe and understand an experience from the perspective of the individual. It is only through qualitative research that deep and rich descriptions of a phenomenon can be achieved. Performing qualitative research can provide greater understanding of an experience, or at the very least, describe the experience as it occurs within the context (Sutton & Austin, 2015). This has a dual advantage. Firstly, the researcher has an open mind and will approach the research question with no hypothesis, preconceptions or possible outcome in mind. Secondly, the inquiry occurs either within the context or is linked to the context, and therefore the outcome of the inquiry is an authentic reflection of the world's influence on individuals in that context.

Qualitative research is also time dependant, meaning that the outcomes are only true for that person, within that social context, at that time. One person's experience may not be the same or even similar to another's experience, even in a similar context. It is for this reason that qualitative research has attracted criticism for the lack of generalisability (Schofield, 2002). However, more recently, the term transferability in qualitative research is seen to perform similarly to generalisability and represents the applicability of the study's findings to a similar situation. Transferability is discussed in detail in Chapter four.

Qualitative research is flexible and the exploration itself directs the questioning process, whereas quantitative inquiry is more rigid, with all influences needing to be controlled and variables considered. The qualitative researcher explores an individual's or group's experience, and this journey aims to discover and understand this experience for the purpose of knowledge creation and understanding.

3.3.3 Choosing a qualitative approach

The process of choosing a qualitative research approach is guided by the question being asked, and the question in this study resulted from concerns in clinical practice. It was evident that women from culturally and linguistically diverse backgrounds were presenting to the hospital for childbirth with little understanding of pain management for birth. Midwives and anaesthetists sought to understand why these women had so little knowledge or understanding about pain management strategies. The research question emerged from this phenomenon and a decision was made to explore how women from India and Vietnam experienced and managed childbirth pain.

Discussion with colleagues and literature searches provided many possible reasons associated with women's limited understanding of childbirth pain management processes, but none that provided an insight into the experience from the perspective of the women central to the concern. Qualitative research therefore was chosen as the most suitable approach, because it allows exploration of the experience of an individual as it pertains to the world around them.

3.4 The methodology – interpretative phenomenological analysis

There are various methodologies within the qualitative approach such as grounded theory, ethnography, phenomenology and interpretative phenomenological analysis (IPA). Choosing the most suitable methodology can be a challenging process, hampered by conflicting ideologies within a single methodology. In some cases, the methodology is obvious, as the research question may foster a particular methodology. For example, many ethnography studies are inspired by researchers wishing to describe the experiences of a particular population of people in relation to a particular culture. For this study, the choice of

methodology was also inspired by the question. The core question of this study centred on how women from CALD backgrounds understand their childbirth pain experience, and it lent itself to IPA. The choice of IPA as the preferred methodology for this research is discussed in the following section.

3.4.1 IPA as the chosen qualitative methodology

In the developmental stages of this study, discussions centred on phenomenology and IPA as methodologies suitable to achieve the study aims. Employing either methodology would enable an exploration into the meaning and understanding of childbirth pain from the perspective of Indian and Vietnamese women. Phenomenological research aims to explore an individual's experience of a specific event (Lopez & Willis, 2004) and in this exploration, only to consider the perspective of the individual who has experienced this event. This methodology could be considered purely an insider perspective (Offredy & Vickers, 2013). When considering the insider perspective, the researcher employing a phenomenological methodology will disregard all perspectives except those of participants, and only then describe and understand participants' description of an event (Flood, 2010). IPA as a methodology moves beyond this position, and aims to explore the deeper meaning of an individual's experience, possibly beyond the meaning of which the participant is conscious (Lopez & Willis, 2004). This ideology appealed to the researcher, who wanted to move beyond the superficial and explore the deeper meaning of the childbirth pain experience. These meanings may not be explicit to the women giving birth, and therefore would not be uncovered using a phenomenological approach, and hence the researcher selected IPA as the methodology of choice.

In IPA, it is considered advantageous for the researcher to have speciality knowledge within the area being studied. In this case, the researcher is a Clinical Nurse Consultant specialising in pain management. Similarly, the research supervisors have extensive professional experience in the fields of midwifery and birth pain management and thus are well equipped to guide the study. Using an IPA approach was fitting considering the collective professional expertise and the desire to explore the deeper meaning of childbirth pain. To view the researchers' journal entry relevant to this discussion, see Appendix A: 28th April 2017 – Methodology decisions.

3.4.2 The origin and development of IPA

IPA emerged from the phenomenology of Edmond Husserl (1859–1938), which dates back to the early 1900s (Yoshimi, 2016). In its original form, phenomenology was subjective and inductive, and the creation of understanding was linked to an individual's interaction with and experience of the world around them. Husserl's phenomenology has been termed descriptive phenomenology because it aims to describe the lived experience of individuals without prejudice or preconceived ideas and without considering the influence of culture (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). To achieve separation between the observer and the observed, Husserl employed the techniques of bracketing or reduction. Bracketing is a process which requires the researcher to distance themselves from their own beliefs in a bid to separate participants' perspectives from the influence of the researcher, so as to uncover the core understanding of the experience from the perspective of the individual. In this way, participants' understanding is viewed through various lens, akin to looking through the sides of a prism, at an object in the centre (Smith, Flowers, & Larkin, 2009). The process of bracketing promotes the emergence of deep and meaningful perceptions and understanding of an individual's experience, from the perspective of the

individual. The observer or researcher is an instrument that relays the individual's understanding, which represents a purely descriptive process.

Building on Husserl's phenomenology, Martin Heidegger (1889–1976), one of Husserl's students between 1909 and 1911 (Horrigan-Kelly, Millar, & Dowling, 2016), developed an alternative approach to phenomenology which explores the meaning of *being*. Heidegger was critical of philosophers, including Husserl, who focused on an individual's understanding of their experience, without first exploring what it means to exist or to be in the world. Heidegger's notion of phenomenology was revolutionary in 20th century philosophical communities, and in his first published book, *Being and Time* (1927) which was later translated (Heidegger, Macquarrie, & Robinson, 1962), he introduced the concept of *Dasein*. *Dasein* is a German term that means *being there*, translated to English it means *existence*, and it refers to the individual who is exploring their *being* (Wisnewski, 2012). *Dasein* is a concept that suggests that an individual's experience is shaped by how that individual interacts with the world around them and this relationship is time dependant. Being in a situation and experiencing the world relies on the interaction between the individual, the world and time, and the result is *Dasein* (Dostal, 1993). In an attempt to simplify a very complex concept, consider a person's life captured in slideshow moments, every picture with the same person but in a different time and place. Every slide displays an individual's unique experience. *Dasein* is this slideshow in its entirety. It is often viewed by others as captured moments in time, but in fact *Dasein* has unlimited slides, and the more experiences that shape an individual's life, the more complex their *Dasein* will be, with more layers within a single individual.

Dasein is not an entity outside the self or an object, but it will shape an individual's self, and thus Heidegger et al. (1962) emphasise the importance of exploring *Dasein* or an individual's

being. Heidegger describes *Dasein* but abandons the notion that an individual and the context are separate entities. He celebrates the theory that individuals exist within a world and this is the essence of *being in* the world (Miles, Chapman, Francis, & Taylor, 2013). *Being in* signifies that there is a relationship between the person and the context (Horrigan-Kelly et al., 2016), and Heidegger's aim was to explore how an individual creates meaning from being within the world. For an individual to understand *being in the world*, Heidegger argues, the individual must also understand others' or another *Dasein*. Socially constructed influences on *being* need also to be examined, to ensure that *being* is authentic and not a socially constructed inauthentic *being* (Horrigan-Kelly et al., 2016). The nature of the world, at that particular time, also needs consideration, because time is not stationary and neither is *Dasein*, and the outcome of exploring an individual's *Dasein* may only be true for that moment in time, much like viewing only one slide of the entire slideshow.

In the 1950s, Maurice Merleau-Ponty (1908–1961), a French philosopher, built on the notion of *Dasein* and further advanced the foundation of an interpretative phenomenological concept. Merleau-Ponty's celebrated work, *Phenomenology of Perception* (1962) details the influence that others have on an experience of an event and the perception that others have of that experience. Merleau-Ponty supported Heidegger's theory that an observer of a situation is always influential to that situation, because even just *being* there will impact on another's experience. However, Merleau-Ponty extended this further and encouraged the observer to use caution when observing the experience of another. He emphasised that although all individuals within a situation will influence the event, each individual owns their own experience and others within the same situation cannot truly know another person's experience. Merleau-Ponty (1962) articulated this concept thus:

> *The grief and the anger of another have never quite the same significance for him as they have for me. For him, these situations are lived through, for me they are displayed… I can, by some friendly gesture, become part of that grief, or anger, they still remain the grief or anger of my friend (p. 415).*

Similarly, a singular event like birth pain can elicit many experiences that are all different. Any person, for example, a husband, support person, or midwife will have a perception of that woman's experience, and will be able to empathise, but the experience of childbirth pain remains the woman's alone.

The last influential philosopher to be discussed in relation to the development of IPA is Jean-Paul Sartre (1905–1980). Sartre extended the concept of *being* and context and highlighted the influence that social relationships have on an experience. Moreover, he considered how the lack of a relationship can influence an experience. In his book *Being and Nothingness* (Sartre, 1943), Sartre encouraged a reflective process to include not only what was present in a situation but also what was not present, and how this lack of presence might have influenced an experience. Sartre brought together the abstract concepts of *being*, others, and context that were developed by Heidegger and extended by Merleau-Ponty and presented these concepts as practical processes occurring within the world that can be interpreted and then presented to others.

In summary, Heidegger's phenomenology underpins the enquiry of being within the world and regards an individual's understanding of an experience as situated within the context, not external as in Husserl's phenomenology. Merleau-Ponty and Sartre's work built on this foundation and paved the way for research methodology to be created with the purpose of interpreting the meaning of *being* for an individual within a given situation, in order to reveal

and express an individual's experience. Just such a methodology, Interpretative Phenomenological Analysis (IPA) was conceived in 1996 by Jonathon Smith (Smith, 2004).

3.4.3 Theoretical underpinnings of IPA

Researchers who use IPA accept the epistemological ideology that individuals make meaning from their experiences of interacting with the world around them. In order to interpret and portray an individual's meaning, the IPA researcher explores how a person understands their experience, through the meaning that person has attributed to the experience (Larkin & Thompson, 2012). Underpinning this process are the processes of double hermeneutics, reflexivity and cognitive psychology.

Double hermeneutics

Hermeneutics is the process of interpreting an event, experience or text (Given, 2008). With single hermeneutic the interpretation is unidirectional. As in descriptive phenomenology, the interpretation is generated from the participant's perspective only. The researcher withholds their preconceived ideas and is only concerned with the participant's perspective. This process of omitting any influence from the researcher is termed *bracketing* and as mentioned earlier, is often employed in phenomenology (Flood, 2010; LeVasseur, 2003). Double hermeneutics implies that interpretation occurs in a two-way process (Given, 2008). In the case of IPA, first an individual creates meaning from their interpretation of the experience. Thereafter, the researcher creates meaning from the participant's expression of this experience (Cassidy, Reynolds, Naylor, & De Souza, 2011; Smith, 2004). This process of double hermeneutics is referred to as a hermeneutic circle. Smith et al. (2009) describes the hermeneutic circle as a process of interpretation that not only engages with a singular text or episode or event but is also considered with the entire episode or event. By engaging

with the parts and whole of the context, different perspectives are revealed (Smith et al., 2009).

Reflexivity

Whilst employing double hermeneutics, Clancy (2013) encourages the researcher to engage in reflexivity. Reflexivity in IPA is the process by which the researcher acknowledges their contributions on the emerging themes (Fade, 2004). This involves the researcher exploring their personal perspectives, biases and preconceived ideas, and the relationship that these ideas have with the research. Reflexivity is a path of personal disclosure that helps to position the researcher and provide contextual awareness. For this study, extracts from the researcher's journal are in Appendix A. The following discussion is supported by Berger (2015), and highlights three main avenues by which the researcher in this study minimised unintentional influences on the research.

Sharing of stories

In situations where researcher and participant have experienced a similar event, it is tempting for the researcher to share this information with the participant to develop rapport in preparation for an interview. The sharing of stories from the researcher to the participant can unintentionally influence the participant's account of their experience. Berger (2015) provided the example of a participant sharing information that they would not normally have shared because they believed that the researcher, having had a similar experience, may be more sympathetic to their situation. The researcher in this study has experienced childbirth pain, and thus she will use the process of reflexivity to review critically this experience in preparation for participant interviews. A practiced researcher will have the ability to engage

in discussion and encourage participants' narratives without sharing stories that will influence this narrative.

The nature of the research relationship

Inadvertently influencing a participant's account of an experience can also be caused by the nature of the relationship between researcher and participant. For example, for personal or cultural reasons some women are less likely to discuss a childbirth experience with a male researcher. In this study, the researcher is female, but the relationship that requires consideration is the researcher's role as a pain management nurse. This role includes consulting with women before, during and after childbirth on pain related issues. The participants were aware of the dual role of this researcher, so it was essential for me to examine this influence by using reflexivity. This involved examining the influence that this relationship might have on participants' narratives (see Appendix A: journal entry June 20th 2017 - The woman's voice and 20th August 2017 – Finding meaning in text).

Worldview

A researcher's perspectives, experiences, social and cultural background can also influence participants' accounts of the experience (Berger, 2015). Experiences can also be influenced by a cultural worldview and a researcher with an alternative worldview might misinterpret a participant's inferred meaning. In this study, the cultural differences between the researcher's and participants' backgrounds might influence participants' accounts and meanings. For this reason, this researcher will employ reflexivity to encourage self-awareness, so her worldview has minimal influence on participants' narratives (see Appendix A: journal entry March 15th 2017 – Defining my worldview). Other strategies, such as confirming participants' meanings, will also be employed.

IPA is consistent with the philosophy that the participant and the situation are inseparable and create an experience through their interaction. Thus, the researcher, by simply being, sharing, listening and reflecting, is now also situated within the context. The influence on participants' narratives must be brought to light to interpret participants' own meaning of the narrative. Reflexivity facilitates interpretation, by positioning the researcher and providing contextual awareness.

Cognitive psychology

IPA is also underpinned by cognitive psychology. Traditionally, the underpinning premise of cognitive psychology was the belief that all behaviours could be understood by examining the mental processes that resulted in a certain behaviour (Sternberg & Sternberg, 2012). IPA diverges from this traditional and objective ideology, with its emphasis on behavioural outcomes, and instead emphasises cognitive psychology as a process of meaning-making rather than predictable mental processes (Eatough & Smith, 2017). Foundationally, IPA is concerned with the individual's experience situated within the context, its focus is on the interpretation and the creation of meaning from the experience (Pringle, Drummond, McLafferty, & Hendry, 2011). Cognitive psychology complements IPA because it is the study of an individual's cognitive processes with the aim of understanding how the person processes, develops reason and makes meaning (Smith & Osborn, 2015). IPA unites cognitive psychology and individual interaction. In this way, the individual's cognition is not viewed in isolation but together with the context in which the individual is situated, and meaning is derived from the individual's experience (Smith, 2004). Cognitive psychology explores how an individual generates understanding and meaning from their daily experiences, and IPA is the tool that a researcher can use to explore the cognitive psychology of an individual. A researcher using IPA encourages individuals to explore their

understanding of an experience and provide a deep and rich description of this understanding. The description is then analysed using concepts related to cognitive psychology to explore a deeper meaning of the experience, one that might or might not be evident to the individual.

IPA acknowledges the researcher's position and blends these interpretations into the analysis using reflexivity (Biggerstaff & Thompson, 2008). The finial product is a harmonious and rich interpretation of the essences of lived experience/s which have evolved from a fusion between the participant's expressions and the researcher's interpretations (Cassidy et al., 2011; Flood, 2010).

3.4.4 Characteristics of IPA

The characteristics of IPA are outlined by Smith (2004) and include idiographic, inductive and interrogative features. Moving through these characteristics will support a researcher to engage with participants' narratives and to be receptive to the messages, impressions and understandings therein.

IPA has a strong idiographic focus rather than a nomothetic one. An idiographic study is one that is concerned with an individual's experience and requires detail to understand the perspective of that individual, whereas a nomothetic focus relates to results of studies that can be generalised to a large population (Smith et al., 2009). In an IPA study, the researcher comprehensively analyses each participant's narrative. Starting with one participant's narrative, the researcher reviews this case until the personification and meanings are articulate and complete, essentially exhausting one narrative before moving to the next. Once all participants' narratives have clarity and are complete, the researcher is able to

move to cross-analysis between participants (Smith, 2004). This process reinforces the idiographic nature that is central to IPA research.

Because IPA is inductive, the researcher explores an experience without anticipating where the journey will lead (Smith, 2004). The researcher is receptive to emergent themes from the narrative, and only then seeks literature to support these themes. This stage requires flexibility from the researcher and the research design, to stay true to the essence of the inductive approach. Indeed, Smith (2004) highlighted that an inductive researcher may uncover unexpected themes that may alter the direction and course of the study. This is a potential benefit of IPA research.

As well as being idiographic and inductive, IPA is interrogative. In IPA, the outcomes of the exploration do not stand in isolation but are supported by psychological concepts (Smith, 2004). The meanings from the narratives that have emerged are examined in association with academic literature, as the researcher aims to provide supporting evidence for the interpretations and findings.

3.4.5 Critique of IPA

The most frequently declared criticism of IPA relates to the size and the homogeneity of the sample. Smith et al. (2009) recommended a sample size of fewer than six participants for an IPA study. Contrary to this viewpoint, some studies have recruited more than 20 participants (Clare, Rowlands, Bruce, Surr, & Downs, 2008; McCann, Lubman, & Clark, 2012; Quinn, Clare, Pearce, & Van Dijkhuizen, 2008). More recently, studies (Brownrigg, Burr, Bridger, & Locke, 2018; Hendrickx et al. 2018) have had fewer participants and in some cases only four participants were recruited, and this has been associated with the maturing of the IPA methodology (Smith & Osborn, 2015). Controversy continues regarding

the optimal sample size for an IPA study and in each study, the researchers should consider the characteristics of participants and the context when planning a sample size.

The homogeneity of the sample in an IPA study has also attracted critique. In IPA it is preferable for the researcher to select participants who will yield outcomes that are consistent with the purpose of the study. However, the researcher may be too restrictive during the selection process. Pringle et al. (2011) explored this idea, and concluded that when the sample size is restricted, the study will be too narrow, meaning that participants are too similar, and this will result in the study being less transferable. In contrast, Smith et al. (2009) highlight that in IPA, transferability is derived from the richness, depth and transparency of data, and it is these features which can be drawn on to evaluate the appropriateness for another's context.

3.4.6 Rationale for IPA in this study

Research in healthcare is performed for many reasons, and one of these reasons is to focus on an experience from the perspective of an individual. Like other methodologies, for example, grounded theory, phenomenology and ethnography, IPA focuses on the participants. IPA has become a familiar approach in healthcare research because it is concerned with patients' perspectives of an experience. Where IPA diverges from other qualitative methodologies is that it goes beyond pure description to explore the underlying meaning of the experience for participants. As every experience of pain is unique, so is the meaning of that experience, and thus it was decided that IPA methodology was a natural fit to explore the meaning of birth pain. It was anticipated that IPA would enrich understanding of the childbirth pain experience as it explores how people make meaning from an event that they have experienced (Pringle et al., 2011). Because IPA aims to create meaning from

participants' narratives it was foreseen that the IPA methodology would provide a distinctive and in-depth insight into Indian and Vietnamese women's childbirth pain experiences.

3.5 Summary

In this chapter, I have provided a description of the research philosophy underpinning this study, including epistemological and ontological views, with a focus on the interpretative worldview and the corresponding qualitative research approach. In this study, the researcher embraces an interpretative ontology and considers that understanding and meaning is created through interaction with the environment. Thus, birth pain is an experience that is best described from the perspective of the woman experiencing the phenomenon. This perspective complements the qualitative research approach because it focuses on exploring an individual experience without preconceived ideas. It is also the perspective of the researcher that the meaning of the childbirth pain may not be transparent to the women and may require a greater depth of exploration. To complete the research philosophy, in this chapter there is a detailed account of IPA, the methodology chosen for this study to explore the meaning of childbirth pain. IPA moves beyond pure description of experience and explores deeper meaning. It is founded on double hermeneutics, reflexivity and cognitive psychology, all of which support the process of exploring the deeper meaning of childbirth pain for Vietnamese- and Indian-born women. To support the methodology and provide the procedure, which complements the theoretical concepts discussed in this chapter, in the next chapter the methods used in the study will be discussed.

Chapter Four: Methods

4.1 Introduction

In this chapter, the methods employed in this study are described, including procedural components and the techniques chosen to explore the setting and collect the data. At the outset, ethical considerations are discussed, including pregnant women being a vulnerable group and English as a second language. Next, the study setting is described, starting with the region's demographics and focusing on the specifics of the study setting. Participants are considered central to this study, and participant selection and recruitment are explained. The processes performed to collect data are explained and thereafter an outline of the data analysis process, specific to IPA, is provided. Chapter four concludes with an account of how rigour was achieved for this study.

The overall design of this study involves a qualitative approach with an IPA methodology to explore the experience of childbirth pain, as discussed in Chapter three, and in Chapter four description of the study design is completed by detailing the methods involved in this study, including the processes associated with interviewing 24 women from Indian and Vietnamese backgrounds.

4.2 Ethics and ethical considerations

This section outlines the considerations associated with successful ethics approval.

4.2.1 Ethics approval

Ethics approval was obtained from the hospital Human Research Ethics Committee (LRN17/WH/144; 10th October 2017) and the University Human Research Ethics Committee (13th December 2017) (Appendix B - Ethics approval documents)

4.2.2 Ethical considerations

The participants in this study were considered a vulnerable group in ethical terms because they were pregnant from a CALD background and potentially with low literacy levels when recruited. Therefore, in preparation for ethics review two aspects of this study were given particular attention, the recruitment of *pregnant* participants and recruitment of participants who spoke *English as a second language*. Additionally, there is an overview of general ethical considerations associated with the informed consent process. Overall, in this discussion the supports that were provided in this study's design to ensure the participants were provided with ethically sound research conditions are described.

Pregnant women are a vulnerable group

In Section 4.1 of the *National Statement on Ethical Conduct in Human Research* (2007, updated 2015) pregnant women are identified as a vulnerable group, and as such the researcher took particular care to ensure that participants' wellbeing was supported. Safeguarding the wellbeing of pregnant women relates to the concept of beneficence, which

is concerned with balancing the benefit of participating in a research study against the risk of emotional and psychosocial harm. Having a skilled nurse conduct interviews with women with uncomplicated pregnancies would not be considered a high-risk practice and would be unlikely to result in emotional distress. However, measures were in place to deal with unexpected distress.

The researcher took particular care to prevent escalation of distress should a participant become distressed. Section 4.1.1 of the *National Statement* states that "the wellbeing and care of the woman who is pregnant and of her fetus always takes precedence over research considerations", which implies that researchers should ensure participants have access to measures that support them, such as counselling and appropriate care (*National Statement on Ethical Conduct in Human Research* (2007, updated 2015). Supporting maternal wellbeing was vital to the researcher in this study and if a situation had the potential to adversely affect a woman's wellbeing, the researcher acted swiftly to reassure the participant and be attentive to her concerns. The researcher had a 10-year history of consulting with pregnant and postpartum women and thus was well equipped to prevent emotional and physiological escalation. She was competent in developing positive relationships and managing sensitive closure. If a participant expressed signs of distress or emotional upset, the researcher planned to stop the interview and take care to ensure that the emotional needs of the participant were met. This may have involved offering access to counselling. The interview would only resume if, or when, the participant was ready to do so. No participants exhibited distress during the interview.

The researcher also supported participants in obtaining the most appropriate pathway to manage concerns. If a participant was unhappy about the care provided to her as an inpatient, the researcher directed her to the hospital's Patient Representative. A Patient

Representative provides support and help to resolve problems that a patient has with the care they received. If a participant presented with signs of low mood or difficulty coping with her experience, then the researcher encouraged her to seek support from her General Practitioner, obstetrician or treating midwife. The Patient Information and Consent form (Appendix C) also outlined the resources for psychological support, including Lifeline and Beyond Blue.

Women with English as a second language

In Australia, non-English speaking individuals are more likely to have greater difficulty understanding health related information than individuals with English as a primary language (Australian Commission on Safety and Quality in Health Care, 2014). Thus, recruiting CALD participants in a health-related project is considered a complex situation and participants' health literacy must be considered during the recruitment planning phase of a project.

Health literacy

The principles of health literacy were applied to support the complex process of recruiting CALD participants into this healthcare study. The World Health Organization defines health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (Nutbeam, 1998, p. 357). The Australian Bureau of Statistics (ABS) (2006) reported that approximately 25% of people in Australia who identified English as a second language had at least basic health literacy compared with 44% of people with English as their primary language. Greater attention was given to details in the informed consent process to ensure that the participants in this study were as well prepared to participate in this study as woman with English as a primary language (Mackey and Gass

2015). The Patient Consent and Information Form (PICF) was written so that participants with the equivalent of eighth grade English could comprehend the consent process, as advised by Foe and Larson (2016). Nonetheless, levels of education for Australian immigrants vary. In 2016, the ABS (2016e) reported that 65% of recent immigrants to Australia held a tertiary qualification, compared with 66% of all Australians (ABS 2017a), but local variations are seen between different ethnic groups. For example, Carolan, Steele, and Margetts (2010) undertook a study in Western Melbourne and found that 75% of Indian women had more than 10 years of schooling, compared with just 2.2% of Vietnamese women. Education level is just one factor that must be considered when recruiting participants with a non-English background. English language skills of immigrants reflect the length of time that an immigrant has been living in Australia. Immigrants who settled in Australia during childhood demonstrated higher English language skills than immigrants who were adult when they arrived (Guven & Islam, 2015). Other researchers have reported that English language skills differ between economic immigrants and refugees. Economic immigrants had the advantage of a planned settlement and therefore were most likely to have prepared for life in Australia, while refugees were unlikely to have had the benefit of time or resources to prepare before arrival (Hugo, 2002). Nonetheless, the Refugee Council of Australia (2010) highlights that refugees do not have the option to return to their birth country and therefore have greater pressure to learn the language and to contribute to social and economic responsibilities, possibly accelerating their skills development. The level of English language skills of women born overseas is a complex matter and because of these challenges, the health literacy needs of women from CALD backgrounds are variable. For this reason, health literacy was given particular attention during the informed consent process.

Informed Consent

Gupta (2013) outlines the principles of informed consent which are founded on the three interwoven concepts of decision-making capacity, voluntary participation and information disclosure. Decision-making capacity has been covered in the above discussion on health literacy and is specific to this study's participants. Voluntary participation and information disclosure are general concepts and are briefly outlined below.

Voluntary Participation

Voluntary participation implies that an individual has the ability "to judge, freely, independently, and in the absence of coercion" (Gupta, 2013, p. 26), whether participation in an activity suits their own situation. The researcher considered it essential to ensure that participants were aware that involvement in this research project was voluntary. It was highlighted in the PICF and during the consent discussion that participation was voluntary and that they could withdraw at any time without penalty.

Information Disclosure

Information disclosure in healthcare research is a process by which detailed information is provided to potential participants so that they have sufficient understanding to make an informed decision whether to participate in the study (Gupta, 2013). The researcher ensured that the participants were aware of the study specifics and was attentive to possible misunderstanding.

4.3 The study setting

Each year over 300,000 women give birth in Australian hospitals (ABS, 2016a). Care in public hospitals is free of charge and provides women and babies with prenatal, childbirth and postpartum care. This discussion relates to the context of the study and will focus on four central aspects: demographics of the study region, demographics of the setting, provision of maternity care in the study setting, and provision of pain management services.

4.3.1 Demographics of the region

This study took place in the Western region of Melbourne, Victoria, Australia. Victoria is the most densely populated Australian state, and Melbourne, the capital city, can be divided in five regions. The Western region of Melbourne has the largest area, spanning 1,352 square kilometres (Victorian Electoral Commission, 2020). In 2016, it was estimated that 18.6% of Melbournians resided in Melbourne's west (REMPLAN, 2017) and the region had experienced the largest suburban population growth of all Melbourne regions (ABS, 2016b). This population growth surge is of recent origin, as before World War II Melbourne's west had low population growth. After the War, the region became popular with immigrants from Italy, Greece, and Eastern Europe, then in the 1970s many immigrants from South East Asia settled in this region (REMPLAN, 2017). Today, Vietnamese and Indian immigrants are the largest non-Australian born populations in the region (ABS, 2016c).

Melbourne's west was traditionally considered predominately working-class, however, more recent evidence indicates an emerging middle class (Pink, 2011). The socio-economic diversity of a region can be estimated from Census data using parameters such as salary, housing, employment, education and occupation. In 2011, the scores for the Western region of Melbourne on each parameter varied widely, from low to very high (ABS, 2011b). The latest

scores in 2016 show a similar range of results, with most in the very low range but with a small number rated very high (ABS, 2016d). Today the Western region of Melbourne is home to a vibrant and diverse community within a predominately low socio-economic setting.

4.3.2 Demographics of the study setting

The study setting is one of the largest hospitals in Victoria providing perinatal services. There were 5,377 births reported in 2016 in this facility. The hospital cares for people from 110 different languages and dialects, with 38% of the population speaking a language other than English at home (Western Health, 2016). A minor thesis undertaken by the researcher in preparation for this study determined that almost half of all women who present to the hospital for pregnancy care are from CALD backgrounds. This is well in excess of the Victoria State Government figures (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2014–15) indicating that one-third of women who gave birth in Victoria were from CALD backgrounds. The diversity in the hospital's population adds to the complexity of the provision of care, and many healthcare facilities, including this facility, arrange CALD specific resources.

4.3.3 The provision of care for the culturally and linguistically diverse pregnant woman

Women attending for pregnancy care at the hospital have access to a number of CALD related support services and resources. Most supports are focused on the Vietnamese community, because Vietnamese women often have poor English language skills and lower education levels compared with other groups in the region (Carolan et al., 2010). Additionally, as determined in the minor thesis, they are the second most prevalent CALD group, after Indian women, presenting to the hospital for pregnancy care. This finding is

supported by ABS (2016c) figures indicating that Indian-born and Vietnamese-born were currently the most numerous immigrant groups in Melbourne's west.

Because of this multicultural patient profile, language interpreters are a valued resource at the hospital. A Vietnamese interpreter is present on site for face-to-face communication during business hours and telephone interpreting services out of business hours. For less frequently presenting languages, such as Arabic and Dinka, interpreting services can be booked for face-to-face communication and by telephone out of hours. Midwives and medical staff request these services to assist with situations that require health related communication, for example prenatal education and pain management during birth.

4.3.4 Models of maternity care

Models of maternity care describe who is responsible for a woman's perinatal care and where a pregnant woman attends outpatient appointments. Several models of maternity care operate in the study's setting, including Standard Care, Shared Care, Midwifery Care, and Midwifery Practice Group Care. These models and the differences between them are outlined in Table 2: Models of care (p. 95).

The model of care is usually chosen early in the pregnancy care period but may change because of circumstances. Certain situations limit the choice of care, for example, women with a higher risk pregnancy are advised to choose standard or shared care to facilitate regular consultation with an obstetrician or a general practitioner. In all models of care, women have access to pain management information and education during pregnancy.

Table 2: Models of care

MODEL OF CARE	**CARE IS PROVIDED BY:**	**PRENATAL CARE and APPOINTMENTS**	**CHILDBIRTH LOCATION**	**POST-NATAL CARE**
Standard Maternity Care	Obstetricians and midwives employed by the hospital	Take place in the hospital's outpatient clinic	In the hospital	
Shared Care	The hospital's obstetric team and the woman's General Practitioner (GP)	Women attend a certain number of outpatient clinic appointments at the hospital, but most appointments are managed by the woman's GP.		
Midwifery Care	Midwives employed by the hospital	Hospital's outpatient clinic.		
Midwifery Practice Group Care	A team of midwives in the Midwifery Practice Group Care employed by the hospital.	On choosing this model of care, the woman is allocated to a group of midwives who perform the required pregnancy care, attend the birth, whether at the hospital or in the home, and participate in postnatal care. The principal difference is that the woman is attended by a midwife who is known to her.		

4.3.5 Childbirth pain management

This hospital provides two main avenues for woman to access pain management information. At appointments, the midwives offer print information. For example, pamphlets are available regarding pharmacological options for pain management during labour and labour epidural analgesia, although these pamphlets are only available in English (Appendix D). Additionally, women can discuss birth pain management information in clinic appointments.

Traditionally, many women have sourced pregnancy and childbirth information through prenatal education classes. At the hospital, prenatal education classes are offered by physiotherapists at no cost to women. They offer coaching on position during birth and pain management using transcutaneous electrical nerve stimulation (TENS), but do not cover other means of pain relief in labour. Other education classes are available externally, at a cost of $100 per woman. At these classes, information is provided on a broad range of subjects, including preparation for baby and pain management during birth. Women with a specific request, or those who require more discussion on pain management in birth, can access information and advice from the Acute Pain Management Service (APMS), through a midwife. This service is under utilised and is drawn on approximately once per week or fortnight, perhaps because care providers lack awareness of it.

Access to pharmacological pain management is relatively simple when a woman is admitted for birth, and includes three standard options, nitrous oxide, parental opioid injection and epidural analgesia. All options are easily accessible, however nitrous oxide and parental opioid are the most readily available because they are prescribed and administered by staff working within the birth unit. Epidural analgesia is accessible 24 hours a day, 7 days per

week but involves a sequence of more complex steps and referral to the APMS. The APMS consists of a pain management clinical nurse consultant available during business hours, and an anaesthetic registrar available at all times for one-to-one consultations. The epidural insertion procedure is performed by the anaesthetist assigned to the APMS role.

4.4 Selection of participants

In the following section, the techniques used for selecting women to participate in the study are described, including participant sampling and inclusion criteria.

4.4.1 Purposive sampling

A purposive sampling approach was used to identify women best suited to the study aims, as suggested by Palys (2008). Purposive sampling involves identifying individuals who have experienced a particular event, and are chosen with an expectation that they will provide valuable and rich information to the study (Suen, Huang, & Lee, 2014). In IPA, Smith (2004), and Pietkiewicz and Smith (2014) advocate that participant numbers should be between 1 and 15 to ensure adequate representation of themes, awareness of diversity within narratives, and to prevent the researcher being overwhelmed with data. In line with these considerations and to ensure adequate numbers of participants in each of the two CALD groups, the decision was made to recruit 24 women for this study. The ratio of Indian to Vietnamese women in the local study setting is 2:1; thus, to reflect the current CALD prevalence of the study setting, 16 participants were selected from an Indian background and 8 from a Vietnamese background.

4.4.2 Inclusion criteria

Recruitment was guided by the following inclusion and exclusion criteria.

Table 3: Inclusion criteria.

INCLUSION CRITERIA	EXCLUSION CRITERIA
women born in India or Vietnam	women not born in India or Vietnam
conversational English	non-English speaking
first pregnancy	previous childbirth history
expected vaginal delivery	planned caesarean section
women over 18 years and under 35 years	women under 18 or over 35 years
singleton pregnancy	multiple pregnancies
uncomplicated pregnancy	complicated or high-risk pregnancy

The justifications for the inclusion and exclusion criteria are as follows:

Women born in India and Vietnam

As previously described women from India or Vietnam are the most numerous ethnic groups in the study setting.

Conversational English

The researcher was mindful that research involving participants from CALD backgrounds requires detailed consideration and planning, and also that communication can prove challenging. For these reasons, additional resources, such as interpreting services, may be required to overcome communication barriers. However, the engagement of interpreting

services was beyond the scope of this PhD project. To minimise language difficulties between the researcher and participants, it was decided that all participants should be able to communicate in conversational English. Hence, women from Indian or Vietnamese backgrounds were invited to participate if they had conversational English skills.

To assess conversational English language skills, women were required to demonstrate the capacity to make decisions based on information provided. Decision-making capability in healthcare is intertwined with health literacy, which is concerned with an individual's ability to make informed decisions about their own health (Sorensen et al., 2012). There are various processes for evaluating the health literacy of an individual (Altin, Finke, Kautz-Freimuth, & Stock, 2014; Rudd, 2015) and the subsequent discussion describes the process that was employed in this study.

During the prenatal clinic consultations, a pregnant woman is routinely provided with significant health information in the form of advice, instruction and recommendations from the clinic midwife. If a midwife suspects that a woman does not comprehend the information, therefore demonstrating poor health literacy, then the midwife enlists communication supports during the consultation to assist in understanding and decision making. Communication supports may include family and friends or an interpreter. Women requiring the assistance of an interpreter during an outpatient clinic consultation were not invited to participate in this study. Alternatively, pregnant women who were able to have health related discussions with a midwife in clinic consultation were considered capable of consent for this study.

First-time mothers

Participants in this study were first-time mothers. This is because previous birth experiences can influence subsequent birth experiences, including the woman's expectations and emotional responses, negatively or positively. For example, Beck and Watson (2010) explored the experience of a subsequent birth after a previous traumatic birth (n=35), and found that women reported high anxiety and fear during the subsequent pregnancy, with the subsequent birth either healing the previous poor experience or re-traumatising the woman. In other studies of non-traumatic births, previous experience of birth was believed to reduce fear and anxiety (Aksoy et al., 2016). It was decided that in this study, the best way to minimise this unpredictable influence was to recruit women with no previous birth experience.

Expected vaginal delivery

This study invited participation from women who expected a vaginal delivery, so that the women's expectations regarding the coming birth were conventional. This is because a pregnant woman may prepare differently depending on the expected mode of birth. If a woman has a planned caesarean section, her preparation would most likely be different from a woman preparing for a vaginal delivery. For example, a woman who planned to have a caesarean section would not be expected to experience labour pain and therefore the midwife may not emphasise options to manage the pain of labour.

Low-risk pregnancy

Women invited to participate in this study were considered to have *low-risk* pregnancies. A low-risk pregnancy refers to a pregnant woman within a certain age range (18–35 years), with a single foetus, who is not experiencing any general or pregnancy related health concerns, including but not limited to gestational diabetes or pre-eclampsia, with no foreseen complications. Only women with low-risk pregnancies were invited to participate, because a high-risk pregnancy may involve additional health related concerns such as increased pain, and anxiety, and is often more psychosocially complex (Byatt et al., 2013; Quartana, Campbell, & Edwards, 2009). Nonetheless, low-risk pregnancies may develop into higher risk pregnancies and a plan was devised to manage this eventuality. The researchers considered it disrespectful to preclude a woman from continuing to participate in this study based on a change in pregnancy risk status, especially if she wished to continue. If this occurred, it was decided to allow the woman to decide whether to continue with the study.

4.5 Recruitment of participants

In the following section the process after participant selection is described, including preparing, planning and recruitment.

4.5.1 Preparing

Midwives working at the hospital's outpatient clinics during the recruitment stage performed an initial assessment of participants' suitability for this study. In preparation for the recruitment phase, the researcher sent an email explaining the study to all midwives working in the hospital's outpatient clinics during the recruitment period. Having several models of care within the hospital added to the complexity of planning for recruitment, because

pregnant women could present for appointments at several locations. The decision was made to focus on recruitment from the hospital's main outpatient clinic because this would cover three of the four models of care. Midwives from the remaining model of care, Midwifery Practice Group Care, were also encouraged to participate but a separate strategy was arranged to advise them about recruitment. An email was sent to the Midwifery Practice Group Manager with an invitation for midwives to join in the recruitment information sessions.

4.5.2 Planning

A series of recruitment information sessions was provided by the researcher to the outpatient clinic midwives, with a PowerPoint presentation. Concurrent with these sessions, a flyer (Appendix E) was displayed in each outpatient clinic room as a reminder for the midwives to consider each woman for recruitment.

4.5.3 Recruiting

Potential participants were introduced to the study by a consulting midwife. During a clinic consultation, the midwife assessed the woman on the inclusion criteria and then introduced the study. Where a woman appeared interested, the midwife requested permission for her contact details to be given to the researcher, who contacted the woman by telephone. The script used at this first contact is shown in Appendix F - First contact script. The researcher then answered any questions pertaining to the study. If the woman elected to participate, the researcher arranged the location and time for a meeting at which further information was provided and if the woman remained interested, consent was obtained, and the first interview took place.

4.6 Data collection

Women who met the study criteria were invited to participate and written consent was obtained at the first meeting. Two interviews were scheduled, one before birth and another after birth. In-depth interviews were identified as the best way to collect data for this study. This is because in-depth interviews focus on the individual experience and complement the philosophy of IPA, the chosen approach. Moreover, in-depth interviews enable the researcher to gain a better understanding of the participant's experience with the world around them (Kvale, 2007). Within IPA, the researcher works together with the participant to explore and make meaning from evolving discussions (Reid, Flowers, & Larkin, 2005). This leads to the creation of considerable data from which themes emerge. In-depth interviewing is a popular strategy in the healthcare setting, when research seeks to generate meaning from experiences or events (DiCicco-Bloom & Crabtree, 2006). In the following section, the process of constructing the interviews and the interview format are described.

4.6.1 Constructing the interviews

In-depth interviews are typically one-on-one, and the researcher encourages discussion from a participant with the aid of an interview schedule or guide (Hays & Singh, 2011). As recommended by Pietkiewicz and Smith (2014), a prepared interview schedule (Appendix G) was planned to guide interviews in this study. This interview schedule consisted of three main questions, each of which had prompting sub-questions in case the interviewer required more conversation starters. This is consistent with in-depth interview schedules which are not rigid or fixed (Hays & Singh, 2011). It also ensures that the questions asked in the interview reflect the study design. The use of an interview schedule promotes consistency between interviews, with all participants being asked to comment on the same areas. When

there is good rapport with a participant who freely communicates on the topic, the researcher only needs the schedule as a guide. The challenge for the researcher in qualitative research, particularly with in-depth interviews, is that data collection relies on the participant's reflections and expression of their experience. Thus, the researcher needs to be skilled at encouraging the participant to describe their experience as fully as possible. It is through the sharing of the experience that the researcher has the opportunity to collect data. Hays and Singh (2011) similarly highlight the importance of the participant's experience and researcher's skill and suggests that "the participants know more about the phenomenon than we do, and we affect how much they tell us" (p. 30).

4.6.2 The interview format

Each participant was interviewed twice, during pregnancy and after birth. The first interview took place during the third trimester of pregnancy. This time frame was chosen because it was anticipated that by then, most women would have started preparing pain management plans for birth. Women may also have attended prenatal education classes and put together a birth plan. The questions and related discussions in the first interview pertained to these events and focused on the woman's preparation for birth, her wishes regarding pain relief and her expectation of pain management in childbirth.

The second interview occurred in the postnatal period. The second interview was planned to occur between 2 and 4 weeks after birth. However, for a few participants unforeseen events occurred, extending the interviews up until 8 weeks after birth. Participants who had a postpartum interview between 4 and 8 weeks were often more difficult to contact, providing reasons such as, turning the phone off while the baby was sleeping, or had re-scheduled the initial postpartum interview because of poor sleep the previous night. As these

postpartum interviews occurred later than planned, the researcher offered the participants the opportunity to withdraw from the second interview, but all participants were keen to continue, as such the researcher felt it disrespectful to not fulfil the commitment.

In all postpartum interviews, the focus was on two topics: 1) childbirth pain management and meeting the woman's expectations, and 2) the effect of pain management in adjusting to new motherhood. An interview schedule was used in both interviews (Appendix G). All interviews were recorded digitally and transcribed.

4.7 Data analysis

The data analysis phase in IPA research is a dynamic process where the researcher aims to make meaning from the text by moving between the perspectives of the participant (emic or insider) and their own (etic or outsider) (Pietkiewicz & Smith, 2014). The emic perspective provides the researcher with a description of what participants understand of their experience, while the etic perspective provides the researcher's analysis of what the participants understand of their experience. In IPA, the researcher's position is not only acknowledged but incorporated into the analysis using reflexivity (Biggerstaff & Thompson, 2008). The final product is a harmonious and rich interpretation of the essences of lived experience/s which have evolved from a fusion between participants' expressions and the researcher's interpretations (Cassidy et al., 2011; Flood, 2010). To arrive at this rich interpretation this study followed four stages, as recommended by Pietkiewicz and Smith (2014) and outlined in Table 4 (p. 106).

Table 4: Summary of IPA stages and key priorities

STAGE	TITLE	KEY PRIORITIES
1	Multiple reading and making notes	Data engagement
2	Transforming notes into emergent themes	Data transformation
3	Seeking relationships and clustering themes	Understand connections and relationships
4	Writing up	Interpretation and presentation

4.7.1 Stage one: multiple reading and making notes

Stage one involves the researcher immersing him/herself in the data. This includes reading the transcript text and listening to the digital voice recording (Pietkiewicz & Smith, 2014). The researcher documents observations, thoughts, use of language, context, reflections and initial interpretations and also notes personal responses as a process of reflexivity. Appendix H provides an example of this process. Stage one often involves returning repeatedly to the data for confirmation. This process continues until there is comprehensive documentation of the transcript which represents the perspective of the participant and the researcher.

4.7.2 Stage two: transforming notes into emergent themes

The aims of this stage are to transform the researcher's notes from stage one into themes. To do this, the researcher studies the narrative considering the participants' thought processes, language, outcomes, descriptions, expression and highlighting emerging themes (Fade, 2004; Smith, 2004). Based on the comprehensive documentation of stage one,

themes are generated from participants' expression of the experience. During this stage, it is not unusual for the researcher to revisit the transcript repeatedly for clarification. This is because IPA analysis is not linear and multiple revisits to previous stages may be needed for clarification of emerging themes. At the end of this stage, each transcript has been analysed and themes have been identified. The researcher in this study characterised themes in short and articulate statements that represented uncomplicated concepts expressed by the participant. These themes are the first layer of interpretation (Pietkiewicz & Smith, 2014) and signify the participants' understanding of the experience (Fade, 2004).

4.7.3 Stage three: seeking relationships and clustering themes

In stage three, the researcher identifies the relationships that exist between emerging themes. This is achieved by considering the themes identified in stage two and linking these themes in corresponding groupings. To link themes, the researcher in this study analysed each theme, considering the outcomes, decisions and participant reflections. As advised by Pietkiewicz and Smith (2014), themes that embodied similar conceptual features were clustered or grouped together, and a descriptive heading was applied to clusters of themes, subsequently each newly labelled theme had multiple sub-themes. The researcher then created a table with the first column denoting the descriptive heading (labelled as themes), the second column listing the multiple associated sub-themes that share relationships, and each sub-theme displayed quote extracts from the transcript with the associated page number (example provided in Appendix I).

4.7.4 Stage four: writing up

Stage four brings the table from stage three into a descriptive document. Pietkiewicz and Smith (2014) term the completed descriptive document from this stage, "a narrative account"

(p. 396). The narrative account is created from two separate narratives, the participants' accounts and the researcher's analysis, but is presented as a seamless story. To achieve the participants' perspective, each sub-theme is descriptively presented separately from the participants' position. Following each sub-theme, an example from a participant's transcript is presented. Pietkiewicz and Smith (2014) highlight how, "using interviewee's own words to illustrate themes", has two functions: One, "it enables the reader to assess the pertinence of the interpretations; and two, it retains the voice of the participants' personal experience and gives a chance to present the emic perspective" (p. 396). After the participants' account is presented and each theme has been analysed, the researcher's position is described in detail. The researcher's position demonstrates multiple layers of interpretation, from simple understanding to deeper level of meaning. The researcher's interpreted account completes the narrative account and is presented in the results chapter of this thesis. It is during the researcher's interpretation process that new insights are generated (Pietkiewicz & Smith, 2014), and these are presented in the discussion chapter, along with the literature to support the researcher's account.

4.8 Rigor or trustworthiness

In qualitative research, the principles of *trustworthiness* are applied to evaluate how scientifically sound a research study has been (Lincoln & Guba, 1985). The framework for evaluating the trustworthiness of qualitative research is based on four principles: credibility, confirmability, dependability and transferability and this framework has been applied in this study.

4.8.1 Credibility

Credibility refers to the study's ability to reflect collected data accurately. This study incorporated peer debriefing, as suggested by Lincoln and Guba (1985), to strengthen its credibility. Peer debriefing involves sharing the collected data with one or more peers to explore outcomes and propose alternatives. The interviews and outcomes were shared with the supervisors of this research study in a process akin to critical peer review. Additionally, parts of the de-identified interview transcriptions were shared with two midwifes, one Indian-born and the other Vietnamese-born, both working at the hospital in which recruitment took place. The purpose of this approach was to ensure that cultural nuances did not go unnoticed and to prevent incidental discrepancies in interpretation which may occur in cross-cultural research.

4.8.2 Confirmability

Confirmability refers to the confidence that another researcher would arrive at the same result given the same situation (Lincoln & Guba, 1985). Peer debriefing also adds to the confirmability of the study, which is the extent to which the study's outcome is influenced by researcher bias. Peer debriefing ensures consistency in data interpretation and aids in preventing a researcher's interpretations from being influenced by personal judgement. In this study, peer debriefing sessions included the researcher and her supervisors. This approach functioned as a community of practice where the researchers engaged in a process of initial individual interpretation of data then shared interpretations, to collaborate and strengthen the interpretations.

Reflexivity also adds value to this study's confirmability. As discussed in chapter three, reflexivity turns the focus on to the researcher, and it becomes the researcher's responsibility

to critically review their influence on the context and the position of the participant (Berger, 2015). Engaging in reflexive journaling provides the researcher with greater transparency of data collection and analysis (Clancy, 2013), which progresses to a better understanding of the participant's voice.

4.8.3 Dependability

Dependability in qualitative research refers to how repeatable the findings are, given the same participants and context (Lincoln & Guba, 1985). Dependability relates to the consistency of the findings and considers the research processes and techniques to measure dependability. For example, in this study, a detailed study protocol was developed and was reviewed by two ethics committees. All changes and versions of the protocol have been kept, aiding in tracking, auditing and consistency. A similar tracking process was performed for coding of the themes. Each update of thematic coding was labelled and appropriately stored, adding to this study's dependability.

4.8.4 Transferability

Transferability in qualitative research refers to how well details of the study's settings and participants have been communicated so that other researchers can judge to what degree the study is applicable to their context, and in what ways the findings can be considered for their situations or settings (Tracy, 2010). Transferability is achieved through the researcher generating thick description from the experience. Simply describing an experience does not provide the researcher with sufficient data. Thick description goes beyond the superficial experience and describes deeper, richer experiences. The researcher probes deeply into the participants' experience by encouraging each participant to explore and describe their

perspectives, their impressions, their intuitions and their understandings. This study had the advantage of having two interviews with each participant. In the second interview, the researcher could probe the participant about events that were not presented clearly in the first interview, and with more time to cognitively process the ideas, the participant was better able to articulate her thoughts. A second interview also provided an additional opportunity to clarify unclear concepts.

4.9 Summary

The aim of chapter four has been to outline the methods that were used in this study. There was discussion about how the researcher managed ethical considerations for the study. In the methods section, the study's setting and participants' characteristics were outlined to provide a detailed description of this study's atmosphere. The focus on pregnant women as a vulnerable group and English as a second language is continued in this chapter. The value and benefit of participant interviews was highlighted whilst describing the data collection process that was employed. In the section on data analysis, it was shown how the researcher engaged with the stages of IPA analysis, which is central to the creation of knowledge and understanding. Lastly, the processes by which this study achieved rigor, by applying the principles of creditability, confirmability, dependability and transferability were outlined. This comprehensive account of this study's methods provides a robust platform for the next chapter, the results chapter, to be presented.

Chapter Five: Overview of Findings

5.1 Introduction

In this chapter, the key findings are presented. An overview of recruitment is used to help describe the participant structure of the study. In the first discussion, the characteristics of the Indian- and Vietnamese-born participants are outlined. An overview of the participants' birth mode is presented and discussed under the birth sub-headings of normal, assisted, and caesarean birth. Throughout these initial discussions, abridged accounts of some participants' experiences will be presented to provide context for the reader. An overview of the themes that emerged during the course of this study is then presented. In subsequent chapters the prenatal, birth and postpartum themes will be considered in greater detail.

5.2 Recruitment overview

During the recruitment phase, a total of 38 women were invited to participate. Four Vietnamese-born and five Indian-born women declined to participate. The reasons that women gave for declining included not having time, work commitments, and not having information to share. There were five women who agreed be contacted about the study but who did not meet study criteria. Recruitment continued until 24 women had consented to participate, and as planned, this included 16 Indian-born and 8 Vietnamese-born women. Figure 1 (p. 114) illustrates an overview of participant recruitment. All women who consented participated in interviews during pregnancy and the postpartum, and no participants withdrew from the study. Table 5 (p. 113) provides an overview of participants. This includes, the stages at which the participants were interviewed during pregnancy and postpartum, and an illustration of birth outcomes including labour analgesia, mode of birth and complications.

Table 5: Overview of participants

PARTICIPANT NUMBER	PSEUDONYM	INTERVIEWS		MODE OF BIRTH	LABOUR ANALGESIA	COMPLICATIONS
		PREGNANCY (GESTATION IN WEEKS)	POSTPARTUM (WEEKS AFTER BIRTH)			
1	Aruna	36	2	Forceps	N_2O and EA	Minor tear and urinary incontinence
2	Diya	41	5	LUSC	NA	Nil
3	Ly	37	2	Normal	N_2O, pethidine and EA	Sutured episiotomy
4	Garima	35	1	Normal	Nil	1ST degree tear
5	Qui	36	2	Forceps	N_2O and EA	Sutured episiotomy
6	Krisha	37	2	Vacuum	N_2O	PPH, MROP and 3rd degree tear
7	Leela	39	4	Vacuum	N_2O and pethidine	Sutured episiotomy
8	Saavi	38	4	Vacuum	N_2O and pethidine	PPH and sutured episiotomy
9	Tanvi	38	3	Vacuum	N_2O	Sutured episiotomy
10	Anh	37	3	Normal	N_2O and pethidine	Sutured episiotomy
11	Kim	36	3	LUSC	N_2O, pethidine and EA	Nil
12	Zoya	37	3	Normal	N_2O	Nil
13	Eva	34	4	Forceps	N_2O	PPH and 3rd degree tear
14	Chi	34	3	Normal	N_2O	PPH and 2nd degree tear
15	Meera	35	1	LUSC	N_2O	PPH
16	Pyria	37	4	Forceps	EA	PPH and sutured episiotomy
17	Ira	37	3	LUSC	N_2O, pethidine and EA	PPH
18	Vanya	34	2	Normal	N_2O	PPH
19	Neha	38	5	Vacuum	N_2O and EA	Sutured episiotomy and shoulder dystocia
20	Han	36	2	Normal	N_2O, pethidine and EA	2nd degree tear
21	Heera	36	3	LUSC	N_2O and EA	Nil
22	Mai	37	2	Normal	Nil	2nd degree tear
23	Sang	37	3	Normal	N_2O and EA	PPH and 3rd degree tear R
24	Jara	36	2	Forceps	N_2O and EA	PPH, sutured episiotomy, uterine tear

LUSC = caesarean section EA = Epidural analgesia N_2O = Nitrous oxide PPH = Postpartum haemorrhage NA = Not applicable MROP: Manual removal of placenta

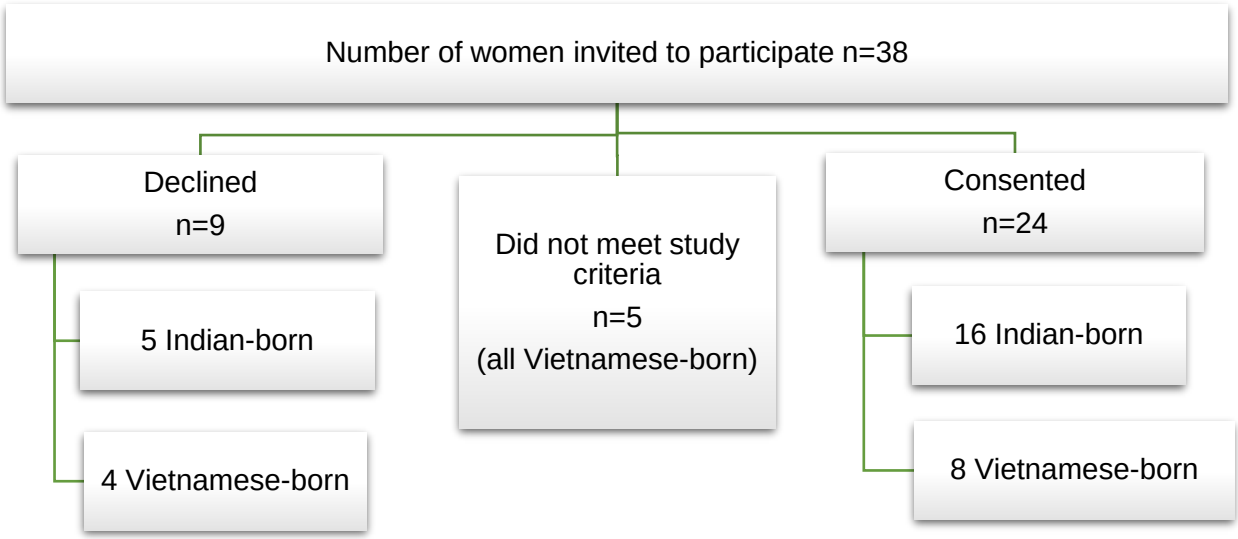


Figure 1: Illustration of study participant numbers

5.3 Participant characteristics

All women recruited in this study were first-time mothers, born in either India (n=16) or Vietnam (n=8), and at the time of the study all were residing in Australia. Information regarding the women's ages, length of time of residence in Australia, religion, education and work history is provided in two separate Tables. In Table 6 the socio-demographic information for women born in India is shown (p. 115) and in Table 7, the socio-demographic information of women born in Vietnam is presented (p. 116).

Table 6: Socio-demographic characteristics of Indian-born women

PARTICIPANT NUMBER	PSEUDONYM	AGE (YEARS)	YEARS IN AUSTRALIA	RELIGION	EDUCATION	WORK /STUDY	OCCUPTION
1	Aruna	30	3	Sikh	University	Home duties	-
2	Diya	35	11	Hindu	Secondary	FT work	Retail sales
4	Garima	28	1	Sikh	University	Home duties	-
6	Krisha	29	5	Sikh	TAFE	PT work	Customer service
7	Leela	30	3	Hindu	University	Home duties	-
8	Saavi	32	4	Islam	University	FT work	Health care
9	Tanvi	28	6	*Hindu	University	FT work	Accounts manager
12	Zoya	30	5	Sikh	TAFE	FT work	Childcare
13	Eva	30	5	Hindu	University	FT work	Finance
15	Meera	26	0.5	Hindu	University	Study	Information technology
16	Pyria	31	5	Sikh	Secondary	FT work	Hospitality
17	Ira	26	2	Hindu	TAFE	Study	Hospitality
18	Vanya	26	1	Hindu	University	FT work	Finance
19	Neha	26	4	*Hindu	University	PT work	Education
21	Heera	35	3	Sikh	University	FT work	Health administration
24	Jara	35	1	Hindu	University	FT work	Education

* reported as non-practicing FT = Full time PT = part-time TAFE = technical and further education

Table 7: Socio-demographic characteristics of Vietnamese-born women

PARTICIPANT NUMBER	PSEUDONYM	AGE (years)	YEARS IN AUSTRALIA	RELIGION	EDUCATION	WORK /STUDY	OCCUPTION
3	Ly	33	9	-	Secondary	FT work	Retail sales
5	Qui	35	15	Catholic	University	FT work	Health care
10	Anh	31	28	Buddhist*	TAFE	FT work	Customer service
11	Kim	24	3	-	TAFE	PT work	Beauty
14	Chi	28	3	-	TAFE	FT work	Beauty
20	Han	23	4	Buddhist	TAFE	PT work	Beauty
22	Mai	31	26	Catholic	University	FT work	Business development
23	Sang	32	31	Buddhist*	Secondary	FT work	Customer service

*reported as non-practicing FT = Full time PT = part-time TAFE = technical and further education

5.3.1 Women born in India

Women born in India were aged between 26 and 35 years. The average age for first-time mothers in Australia is 29 years (Australian Institute of Health and Welfare, 2018). All Indian-born women, except one, had immigrated to Australia in the 6 years prior to the study. One woman (Diya) had lived in Australia for 11 years. Three religions were identified by Indian-born women, Hindu (n=9), Sikh (n=6) and Islam (n=1). This is consistent with religions reported by other immigrants (not specific to ethnicity) living in Australia which include Buddhist (31%), Islamic (28%), Hindu (27%) and Sikh (8%) (ABS, 2016e). While no women reported not following a religion, some women chose not to practice cultural customs. An example of this is provided in Zoya's Participant Profile (p. 118).

All Indian-born women except Diya and Pyria stated they had been educated beyond secondary school level. Most (69%) were educated to university level, which is slightly less than the 76% of immigrants (not specific to ethnicity) reported to possess a bachelor's degree or higher (ABS, 2016f). In India, men have higher levels of education than women (Samir & Lutz, 2017), thus having an all-female study group could explain why the study group's education levels were lower than the immigrant national average. Indian-born women in this study had various work/study patterns prior to pregnancy. Women participated in full and part time work, while two women were engaged in study at the time of pregnancy and another three reported their current occupation as home duties.

Participant Profile 1: Zoya (participant 12)

Zoya is a 30-year-old Indian-born woman who had been living in Australia for 5 years. Zoya reflected on her experiences of living in India and explained that she was timid and uncertain in India. She viewed living in India as suffocating and restrictive, and explained that living in Australia suited her. Whilst she loved her family in India, Zoya enjoyed the independence and freedom that she had in Australia. She has established strong friendships in Australia and believes that navigating work and social experiences in Australia, without her family, encouraged her to develop her own identity. Zoya is strongly committed to her independence and did not follow any traditional cultural birth practices. She explained that her family in India were surprised but supportive of her new confident identity. Whilst Zoya was reluctant to follow cultural traditions, she did maintain her religious faith.

Zoya's labour commenced the day after her due date, but active labour was not established for another 24 hours. Zoya's pain started when she was at home, and whilst she experienced pain, it was not severe or regular enough for her to present to hospital. When she did present, 24 hours later, she was considered to be in early labour. At this time, Zoya used nitrous oxide to help manage her labour pain. Zoya's labour pain escalated in severity and Zoya requested an epidural. In preparation for an epidural, Zoya's progress of labour was re-assessed. Assessment revealed that she was ready for birth and thus unable to have an epidural. Zoya had a normal birth with no complications.

5.3.2 Women born in Vietnam

Vietnamese-born women in this study were aged from 23 to 35 years old. Some were recent immigrants while others had spent much of their lives in Australia. For example, Kim, Chi, Ly and Han moved to Australia during adulthood, while Sang, An and Mai had moved to Australia with their families, when aged 1, 3 and 5 years. Immigration for this group of women has spanned nearly 30 years, and because Sang, An and Mai were young children when their families immigrated to Australia, it is likely that they were involved in the wave of refugee immigration to Australia that occurred in the 1990s (Hugo, 2002).

Over half of the women born in Vietnam reported that they follow a religion. Two were Catholic, one a practicing Buddhist and two non-practicing Buddhists. Another three women reported that they did not follow any religion. Kim's Participant Profile (p. 120) provides some insight to her experience as a Vietnamese-born woman who does not adhere to any religious or cultural practices. This finding is consistent with recent trends that immigrants are less likely to report their religion as *no religion* compared with those born in Australia, although more immigrants now report *no religion* than ever before (ABS, 2016e). For example, the percentage of immigrants declaring themselves to be non-religious was 17% in 2006, 20% in 2011, and 27% in 2016. All Vietnamese-born women were working either full time or part time before pregnancy and four of the eight had TAFE level education. Two participants reported secondary school as their highest level of education and two reported completing university education.

Participant Profile 2: Kim (participant 11)

Kim is a 24-year-old Vietnamese-born woman who has been living in Australia for 3 years and was working part-time in the beauty industry prior to her pregnancy. Other than her husband, Kim has limited family support, because her parents and siblings live in Vietnam. Kim indicated that she was fearful of labour and because of this fear, she spent time learning about labour and care of a newborn on the internet. Kim also stated that she received advice from her mother in Vietnam regarding self-care after the baby is born; for example, not to go outside, or shower and wash her hair for one month. Kim did not inform her mother that she was not following these recommendations and feared that her mother would reprimand her. Kim viewed these recommendations as unnecessary in the Australian environment, where there are warm homes and clean water. Kim also believed that going out and interacting was important to her wellbeing, and she enjoyed her outings with her newborn. Kim also reported that she did not follow a religion.

Kim was induced just prior to her due date because the baby was "growing fast". Kim experienced over 10 hours of labour where she used nitrous oxide, pethidine and an epidural to help in managing labour pain. Kim was relieved when the doctors recommended a caesarean because she was keen for the labour pain to end but at the same time was worried for the health of her baby, because the baby's heart rate had become unstable. Four weeks after birth Kim did not think about the pain much and viewed her caesarean section as a better way for her to give birth.

5.4 Birth mode characteristics

All women gave birth in the birth suite except for one who gave birth in the emergency department. Of the 24 participants, nine women experienced a normal birth, ten women had an assisted birth (including vacuum or forceps) and the remaining five had caesarean sections. The specific characteristics related to each mode of birth are discussed in this section and are shown in Tables 8 (p. 125), 9 (p. 128) and 10 (p. 132). Most women in this study used pharmacological options for managing birth pain and women experienced a variety of complications. Mostly, women stayed in hospital for just a few days. All women were discharged from hospital with healthy babies within 7 days of birth.

5.4.1 Women who experienced a normal birth

Women born in Vietnam represented two-thirds of the participants who experienced normal birth, with the other one-third of participants born in India. Women commenced labour at between 38 and just over 41 weeks gestation, with most women giving birth before 40 weeks. The length of reported labour varied from a few hours to 2 days. For seven of the nine women who experienced normal birth, nitrous oxide was used for pain relief, making it the most frequently used pharmacological pain relief. This is consistent with reports that nitrous oxide is the most regularly used analgesia in labour and birth (Schug et al., 2015). One-third of women who had a normal birth used epidural analgesia and this is consistent with current epidural rates (Australian Institute of Health and Welfare, 2019). Four women used various combinations of nitrous oxide, pethidine and epidural analgesia for pain; and three women, Chi, Vanya and Kim used nitrous oxide only as the sole pharmacological means to manage pain. Participant Profile 3 (p. 122) provides an overview of Chi's experience, who had a normal birth and used nitrous oxide to help manage birth pain.

Participant Profile 3: Chi (participant 14)

Chi is a 28-year-old Vietnamese-born woman who has lived in Australia for 3 years with her husband. Chi and her husband have no family in Australia and have limited social networks after a recent move from interstate. Prenatally, Chi indicated that she was not confident to care for her newborn because she had no experience and little support. Chi's husband had stronger English language skills than Chi, and because of her social isolation, Chi reached out on the internet to connect with other pregnant women around Australia. She joined both Australian and Vietnamese online mothers' groups which she found comforting. Chi and her husband viewed themselves as the new generation and did not follow any traditional cultural customs. When Chi was informed about Vietnamese cultural customs from others, she was keen to research the topics herself. She viewed this as unique to the "new generation" of Vietnamese-born women living in Australia and she felt that this was because of globalisation and access to information. Chi explained that her family members who were pregnant in Vietnam continued to practice customs without challenging them.

Although Chi experienced a long labour of over 20 hours, she was satisfied with her pain experience. She used nitrous oxide to help manage labour pain but found her husband's support the most beneficial factor in managing pain. After Chi's long labour she gave birth to a healthy baby, but she did experience some complications. She was discharged 5 days after the birth, and her prolonged hospital stay was not related to birth complications but to allow time for Chi to become more confident in caring for her newborn. After birth, when Chi discussed labour pain with friends, she was vocal about the importance of partner support in helping to manage labour pain.

Two of the nine participants, one Indian-born (Garima) and the other Vietnamese-born (Mai), did not use any pharmacological means to manage birth pain during their short labours. Mai did not have time to use the TENS machine that she had planned, after just making it to the hospital in time to give birth. Consequently, she felt that birth pain was manageable with breathing exercises. Garima's labour was slightly longer, and she found that massage, support from her husband, and her faith were the best pain relievers. Garima's experience is summarised in Participant Profile 4 (p. 124).

During the interviews, all women described using a variety of non-pharmacological means of managing pain which frequently included massage, breathing, prayer and partner support. Some women, for example Chi, viewed non-pharmacological options as better in managing pain than the pharmacological options that they used during labour.

Of all nine women who had normal births, only one (Zoya) had no complications or perineal tearing. Four women experienced first- or second-degree perineal tearing. Two women experienced postpartum haemorrhages, and another (Sang) experienced a postpartum haemorrhage and a third-degree tear.

Participant Profile 4: Garima (participant 4)

Garima is a 28-year-old Indian woman who had moved to Australia one year earlier and was living with her husband and brother-in-law. She is well supported by her husband's family who lived close by, but she missed her parents who remained in India. Garima and her husband were keen to learn about pregnancy and childbirth. They were proactive in engaging in open discussions with family and friends in Australia, but they reported that this was not customary in India. Garima and her husband explained that their parents in India were supportive of their new learning styles. They also continued to practice other culturally expected practices like dress, food and celebrations. Garima particularly missed her mother but reported having a strong and close relationship with her husband and her faith.

Garima presented to hospital mid-morning and was assessed to be in active labour. At the hospital Garima used non-pharmacological options to manage birth pain, including massage. During labour, Garima felt that her husband and her faith were the most influential factors in helping her manage birth pain. Garima had a normal birth that same evening. She required no pharmacological pain relief during her labour but used nitrous oxide and pethidine when her 1st degree tear was sutured.

Table 8: Women who experienced a normal birth

PARTICIPANT NUMBER	PSEUDONYM	COUNTRY OF BIRTH	GESTATION (WEEKS)	ANALGESIA	PERINEAL TEARS AND COMPLICATIONS
3	Ly	Vietnam	39.5	N_2O, pethidine and EA	Sutured episiotomy
4	Garima	India	38.6	Nil	1ST degree tear
10	Anh	Vietnam	38.6	N_2O and pethidine	Sutured episiotomy
12	Zoya	India	40.2	N_2O	Nil
14	Chi	Vietnam	39.6	N_2O	PPH and 2nd degree tear
18	Vanya	India	39.4	N_2O	PPH
20	Han	Vietnam	39.1	N_2O, pethidine and EA	2nd degree tear
22	Mai	Vietnam	38.3	Nil	2nd degree tear
23	Sang	Vietnam	38.1	N_2O and EA	PPH and 3rd degree tear

EA = Epidural analgesia N_2O = Nitrous oxide PPH = Postpartum haemorrhage

5.4.2 Women who had an assisted birth

Overall, ten women in this study had an assisted birth and this was the most frequent mode of birth. Women in this group had greater analgesia requirements. Although statistical comparison is not possible, it is worth noting that evidence suggests that most women (81%) give birth without assistance or intervention (Australian Institute of Health and Welfare, 2018). This was not the case in this study. Interestingly, all assisted births except one (Qui) were among Indian-born women. Qui's birth experience is summarised in Participant Profile 5 (p. 127).

Women who had an assisted birth commenced labour between 38 and just over 41 weeks gestation, with the majority giving birth after 40 weeks. Unlike women who had a normal birth, all women that had an assisted birth used pharmacological pain relief. All except Pryia used nitrous oxide while Pryia had an epidural inserted towards the end of labour to assist with the pain associated with a forceps birth. Three women, Krisha, Tanvi and Eva, used only nitrous oxide for pain relief while Leela and Saavi used pethidine in addition to nitrous oxide. Four of the ten women who had an assisted birth used nitrous oxide and epidural analgesia to help manage pain.

All women who had assisted births experienced complications to varying degrees. Some were minor, for example Qui, Leela and Tanvi all required suturing of an episiotomy. Six women, Krisha, Saavi, Eva, Pyria, Neha and Jara experienced a combination of minor and major complications. Krisha's experience of birth complications is outlined in Participant Profile 6 (p. 129) and a summary of the characteristics of participants with assisted births is shown in Table 9 (p. 128).

Participant Profile 5: Qui (participant 5)

Qui is a 36-year-old Vietnamese woman who moved to Australia with her parents 15 years earlier, after her marriage. Qui and her husband continue to live with her parents. At the time of the prenatal interview Qui was enjoying spending days with her family and friends and shopping for items for her baby. Qui is grateful that she only had to work for 6 months of her pregnancy and she believes this opportunity is because of living in Australia where she and her husband were able to source financially viable work options, although this does mean that her husband is regularly away from home working. Qui has a close relationship with both her parents and planned for them to support her during the birth, because she expected her husband to be working away from home. Qui also indicated that her mother and mother-in-law were vitally important for support after the baby was born and would provide her with guidance on cultural customs.

Qui started to experience labour pain one evening, a week before her due date, when her husband was out of town for work. She restlessly stayed at home overnight, supported by her parents and presented to the hospital the following morning. Her labour continued for another 18 hours. At first Qui used nitrous oxide to help manage labour pain but the pain worsened and Qui was tired, and she requested an epidural. The epidural was successful in managing Qui's labour pain. Qui's birth was assisted by forceps and she gave birth to a healthy baby boy with the support of her husband, who arrived in time. Her parents and the midwives were also present and supportive during the birth.

Table 9: Characteristics of participants who had an assisted childbirth

PARTICIPANT NUMBER	PSEUDONYM	COUNTRY OF BIRTH	MODE OF BIRTH	GESTATION (WEEKS)	ANALGESIA	PERINEAL TEARS AND COMPLICATIONS
1	Aruna	India	Forceps	39.1	N_2O and EA	Minor tear and urinary incontinence
5	Qui	Vietnam	Forceps	39	N_2O and EA	Sutured episiotomy
6	Krisha	India	Vacuum	40.4	N_2O	PPH, MROP and 3rd degree tear
7	Leela	India	Vacuum	40.6	N_2O and pethidine	Sutured episiotomy
8	Saavi	India	Vacuum	40.3	N_2O and pethidine	PPH and sutured episiotomy
9	Tanvi	India	Vacuum	39.6	N_2O	Sutured episiotomy
13	Eva	India	Forceps	41.1	N_2O	PPH and 3rd degree tear
16	Pryia	India	Forceps	40	EA	PPH and sutured episiotomy
19	Neha	India	Vacuum	38.3	N_2O and EA	Sutured episiotomy and shoulder dystocia
24	Jara	India	Forceps	40.1	N_2O and EA	PPH, sutured episiotomy, uterine tear

EA = Epidural analgesia N_2O = Nitrous oxide PPH = Postpartum haemorrhage MROP: Manual removal of placenta

Participant Profile 6: Krisha (participant 6)

*Krisha moved from India to Australia with her husband 5 years earlier, when she was 24. Prior to her pregnancy she worked part-time in customer service and although she missed her parents who remained in India, she enjoyed the company of her in-laws who lived nearby. To help Krisha with the home duties, her parents planned to travel to Australia for the birth, and Krisha's husband was preparing to support Krisha during the birth. A few days after the expected birth date, Krisha experienced signs of latent or early labour**. Krisha and her husband felt well prepared for labour and birth and were confident to stay at home for as long as possible, where they felt comfortable and well supported by family.*

After 2 days at home, Krisha experienced greater severity of labour pain and the decision was made to present to the hospital. In hospital, Krisha was diagnosed as in active labour. Krisha decided to try nitrous oxide to help in managing labour pain but felt that it was not beneficial and instead found that prayer and massage from her husband were the best forms of pain relief. Krisha gave birth aided by vacuum extraction. Krisha and her husband were overcome with joy and happiness with the birth of their healthy baby. Not long after birth, Krisha was informed she required a procedure to remove some retained placenta and with this news, Krisha felt the celebration dwindle and her baby was given to her husband while she was taken to theatre. After many hours, Krisha was re-united with her husband and her newborn to resume celebrations. Krisha indicated that she was well prepared for birth but did not consider complications after birth which influenced her experience drastically.

**Latent/Early Labour: is characterised with the onset of painful uterine contractions, progressive changes to foetal positioning and cervical dilatation up to 5 centimetres (World Health Organization, 2018b).

5.4.3 Women who experienced a caesarean section

Of the 24 women who participated in this project, five had caesarean sections, one of which (Dyia) was performed prior to the onset of labour. All other women had induced labours. Women were of Indian background, except Kim, who was born in Vietnam. Gestation varied from 37 to 41 weeks. The four women who experienced labour pain used various means of pharmacological pain relief. Meera used only nitrous oxide, Heera used nitrous oxide and an epidural, while Kim and Ira used nitrous oxide, pethidine and epidural analgesia. For caesarean anaesthesia; Kim, Ira and Heera had an epidural top-up, while Diya and Meera had a spinal anaesthetic. Heera's experience is summarised in Participant Profile 7 (p. 131). Of the five women that had caesarean births, Meera and Ira had postpartum haemorrhages. A summary of the characteristics of participants with caesarean birth is provided in Table 10 (p. 132).

Participant Profile 7: Heera (participant 21)

Heera is a 35-year-old Indian woman who moved to Australia 3 years earlier with her husband. Heera and her husband both worked full time and Heera was slowing down her schedule because she was pregnant. Although Heera does not have family in Australia, she was in regular contact with her parents in India and they provided her with pregnancy advice. Early in Heera's pregnancy she took time to read online about others' pregnancy stories, but she found this activity increased her anxiety about potential problems during childbirth. Hence, Heera focused on only listening to medical and midwifery advice. Heera viewed herself as an anxious person and her faith in God provided her with comfort and reassurance that all would be well.

Heera was 38 weeks pregnant when there was a medical decision to induce because the baby's growth had slowed. The induction took place in the morning and at first Heera managed pain well with the support of her husband. As the labour progressed, Heera struggled more with pain and she decided to use nitrous oxide, and then with pain increasing she requested an epidural. While waiting for the epidural the induction was ceased because of uncontrolled pain, raised maternal blood pressure and increased heart rate of the baby. The epidural was inserted, and Heera received adequate pain relief, however the baby's heart rate continued to rise once induction was recommenced. After 6 hours of labour, the decision was made to have an emergency caesarean. Heera and her husband were overjoyed to meet their baby boy and Heera's anxiety lessened as she gained confidence in caring for her newborn during the hospital stay.

Table 10: Women who had a caesarean section

PARTICIPANT NUMBER	PSEUDONYM	COUNTRY OF BIRTH	GESTATION (WEEKS)	ANALGESIA	COMPLICATIONS
2	Diya	India	41.1	NA	Nil
11	Kim	Vietnam	39.6	N_2O, pethidine and EA	Nil
15	Meera	India	37	N_2O	PPH
17	Ira	India	40.6	N_2O, pethidine and EA	PPH
21	Heera	India	38.3	N_2O and EA	Nil

EA = Epidural analgesia N_2O = Nitrous oxide PPH = Postpartum haemorrhage

5.5 Overview of findings

Findings from this study highlighted that culture had a powerful influence on the entire journey from pregnancy, through birth and the postpartum. During pregnancy, cultural factors influenced how participants sourced information in preparation for coping with pain related to labour and birth. More specifically, participants' preparation was influenced by their family, communication with healthcare providers and their access to information from other sources, such as the internet. During labour, cultural factors influenced participants' perceptions and responses to labour pain and decision making regarding pain relief. For some participants, cultural expectations influenced psychosocial support in labour and consequently this had a significant impact on their satisfaction following childbirth pain. Possibly the greatest cultural influence was seen after discharge from hospital when participants decided whether to participate in cultural customs that were aimed at preventing pain in later life. Throughout pregnancy, birth and the postpartum participants made decisions and modified cultural practices to better suit their needs. They were changing the way culture influenced their choices, related to pain and managing pain. Overall, this study provides new insights into the experience of pain from the perspective of women from India and Vietnam who are living in Australia. It indicated that women from India and Vietnam were experiencing a transition in culture whilst preparing for childbirth pain and managing labour and postpartum pain.

Whilst the experience of pain is unique, participants in this study reported many similar experiences of pain to other women. From pregnancy to the postpartum, women regardless of ethnicity and culture had related experiences. During pregnancy all women, including participants in this study, desired reassurance as the birth approached. During childbirth, if pain was overwhelming then women felt trapped with a sense of hopelessness, and

consequently they were dissatisfied with their experience of labour pain. On the other hand, women who were satisfied with their experience of pain received positive psychosocial supports during birth and felt empowered. Women all over the world also describe similar experiences of postpartum pain and indicate that postpartum pain can negatively influence their bonding with their new infant, and their general wellbeing as a new mother.

5.6 Summary

In chapter five, an overview of this study's findings has been provided. Along with an overview of the recruitment process, there were descriptions of participant characteristics and their birth experiences. The chapter closed with a summary of the findings, which are presented in greater detail in chapters six, seven and eight.

Chapter Six: The Prenatal Journey: Information Gathering to Acceptance

6.1 Introduction

In chapter six I provide a detailed description of the two prenatal themes. Overall, these themes represent a trajectory, with participants seeking childbirth pain information, then filtering the information, and ultimately feeling resignation and acceptance of the approaching birth.

Before discussing the themes at length, some background is given and participants' feelings of uncertainty which led them to seek information about labour pain are explored. Theme one*, becoming informed*, describes how participants gathered information and their initial responses to the information they uncovered. Two sub-themes, *information avoiding* and *information engaging*, focus on how participants responded to information, either by engaging with it or avoiding further information.

Theme two, *towards acceptance,* explores how, as the birth approached, participants interacted with their new knowledge, and ultimately accepted pain as inevitable in childbirth. The first sub-theme, *seeking reassurance,* describes how reassurance from self and others supported participants' efforts to accept the forthcoming pain. The second sub-theme, *resignation and acceptance* of forthcoming pain, considers how participants became reconciled to pain as the birth approached.

It is important to highlight again that whilst participants were from two different CALD backgrounds, their underpinning views and reasons for their decisions were often very

similar. Thus, in presenting the themes, participants were not separated into cultural groups. All were interviewed once prenatally and spoke at length about their pregnancy journey.

6.2 Background: uncertainty and information seeking

Participants in this study felt uncertainty as birth approached and this is consistent with the anticipation of any first event. Many people feel trepidation and likely some excitement when awaiting an important new event and for participants in this study, preparing for the birth generated various emotions. Mostly, these were related to uncertainty and not knowing what labour pain would feel like and how they would cope. Participants also worried about the length of time during which labour pain would persist. They did not appear distressed, but a little nervous when they explained their feelings:

> *… I don't know what these contractions mean because this is my first baby and I don't know how the pain comes or goes, I am just listening [to my body], but I have not experiencing any pains. I don't know, still I am waiting for the time I will get the pains. - Diya*

Participants often emphasised that they could not imagine what birth pain would feel like or what a contraction actually meant and were waiting so that they would know and understand. The waiting or listening referred to by Diya, was not in the context of listening to others' experience but listening to her own body, and waiting for labour clues, so that she would understand birth pain for herself.

This uncertainty and lack of understanding led participants to worry about giving birth. In addition to concerns about labour pain and birth, many women specifically indicated that they were worried about perineal tearing. These concerns included how they would manage

pain associated with perineal tearing, and fears that tearing might impact on their mobility and their ability to care for their newborn baby. Most were concerned about the birth, particularly in relation to pushing during birth. Participants lacked confidence in their ability to give birth, with some participants declaring that they did not think they could do it:

> *…if something happens like tearing…maybe can't go on. - Qui*

To alleviate this uncertainty, participants sourced information on labour pain and birth.

6.3 Theme one: becoming informed

During pregnancy, all participants sought to learn more about childbirth pain. Theme one describes how they accessed and then responded to information they sourced (see Figure 2, p. 138, for an overview of prenatal theme one). The sub-themes explore this concept in depth and describe how information made the participants feel either assured or worried, and how it informed their decisions to either seek or avoid further information. Sub-theme one addresses *information avoidance* and explains how some participants found that instead of relieving their anxiety, engaging in information added to their concerns. If this was the case, they then avoided engaging with any further information. Sub-theme two considers *information engaging*, where the participants felt that the information helped them to ask questions, make more informed decisions and gain reassurance. Consequently, they sought further information. Some participants exhibited a combination of both, engaging with information early in the pregnancy, and then avoiding it later on; or the reverse sequence, early avoidance and later engaging with information. The following section describes how participants sought information and then explores the two sub-themes related to their responds.

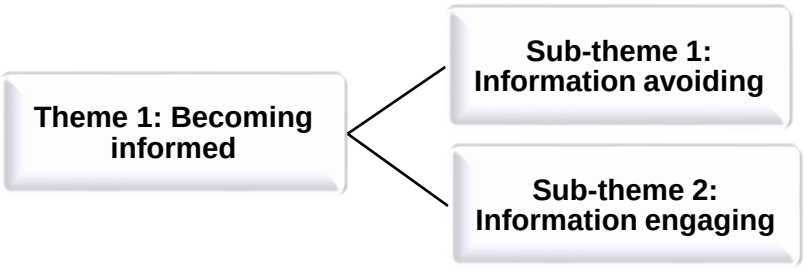


Figure 2: Overview of the prenatal theme one.

Information sources

Participants used a number of resources when seeking information including discussing their labour concerns with family and friends, requesting advice from healthcare professionals and seeking information on the internet, as discussed below. Family and friends were common sources of information and this was not unexpected considering most participants explained that cultural traditions discouraged them from speaking about birth pain to anyone outside the family unit. Participants considered advice given by their mothers and mothers-in-law with the greatest of respect. These older women were regarded as trustworthy because of their previous experience with childbirth matters and were also considered to have the women's best interests at heart. This idea was illustrated by Tanvi, who used multiple information sources, but her mother's advice featured strongly in her discussions. Tanvi's mother provided her with reassuring words and was considered a valuable help in preparing for labour pain:

> *My mum always tells me just to stay calm... My mum says if you feel the pain is too much, stay calm… Don't give up. [My] mother always just prepared me for that… -Tanvi*

In Krisha's case, she reported satisfaction with the information provided by her family and did not feel the need to seek our other sources. She viewed this information as valuable because it was based on personal experiences:

> *I… take advice from my mother and friends, and relatives who already have babies. So, I think I managed it well enough. - Krisha*

While some participants, like Krisha, only sourced information from family and friends, most sought information from external sources as well, which may have been influenced by not having family and friends living nearby. Many participants viewed advice from healthcare professionals as the most valuable resource and considered this information to be unbiased and tailored to meet the needs of the individual. Thus, many participants were keen for healthcare professionals to direct their specific information gathering. Consider Leela's experience, for example. In her view, information from outside healthcare sources was based on others' personal experiences but she desired evidence-based information specific to her needs. Leela considered herself uninformed on childbirth matters and wanted to ensure that she was provided with appropriate and relevant information:

> *…because hospital is information, is best information. It's not from the internet and family and friends. Because they are own experience, internet is own experience, family is own experience, friends is own experience. But hospital information is about me. So, I am happy with hospital information. Because I am blank, so I don't know best thing… - Leela*

Most participants sought information from various sources, and in most cases, the internet featured heavily in discussions. However, material received in this way was sometimes considered inferior or less trustworthy than information from healthcare

professionals. Some participants organised the information they found into categories, for example medical and general. This process helped them to consider the material and organise it based on importance and trustworthiness. Jara explained that while she was content to source general information from the internet, she preferred advice from healthcare professionals on medical matters. She viewed healthcare professionals as specialists in the birth field and any specific decisions about medical care were best guided by them:

> *I look for …different kind of information. It's going to be first kid… So, I look for the information like, how I'll come to know that water breaks or… which exercise is better for me? This kind of information I look on internet…If the pain is going to be very, very severe, then only I will take the medicine…I trust my midwife only for this, whatever she'll recommend, I'll do that. - Jara*

Some participants described positive consequences from seeking information on the internet, such as reassurance, while for others it was a negative experience and induced fear. In general, participants reported that the internet provided them with a foundation to have a better-informed discussion with healthcare professionals. Tanvi, for example, explained that she had no questions for healthcare professionals until she had sought information on the internet. This material provided her with a platform from which she was able to develop questions and ultimately a better understanding with the support of healthcare professionals:

> *I just looked on YouTube all the options… and videos on YouTube… Just looking for all of the options that I have for the pain relief like nitrogen gas and epidural. I just asked my midwife about all of the options… If I hadn't watched*

them on YouTube, maybe I wouldn't have asked the midwife. Because I didn't know what to ask… - Tanvi

For some participants, sourcing information was more challenging than for others. Factors such as health literacy, English language skills and culture impacted on the process of information seeking. Recent immigration to Australia and limited access to family and friends resulted in participants using the internet to fill the void. For example, Chi described how a lack of support from family and friends resulted in her reaching out to others on the internet. She sourced friendship from other pregnant Vietnamese women around Australia on Facebook groups and relied heavily on the internet to access information in preparation for birth. She had immigrated to Australia just 3 years earlier and was more confident navigating information on the internet than asking her friends or healthcare professionals:

…I don't have much friends here and family is not here as well so yeah, I reached out on the Facebook. I joined mum's group in Melbourne and they share a lot of information about their children. - Chi

A few participants indicated that they did not know how to start sourcing information. Ly, for example, acknowledged her uncertainty and anxiety about childbirth whilst also indicating a desire for more information. She explained that she was aware that labour pain would be worse than menstrual pain and therefore she was scared. During Ly's interview she posed many questions and was keen to seek out information but was uncertain how to proceed. This might have been influenced by the fact that her English language skills were not advanced, and she had less formal education than many other participants:

[I am] very scared and nervous. I am very scared of that pain (chuckle). Like… before when my period come, it was pain, a lot (chuckle) and maybe even more

pain [labour] than the period (bigger chuckle)… So, when I preparing to give birth and if I am too pain will [they] give me…. offer medicine… should I [take medicine]? …But for this information, where can I find out? - Ly

Although Ly was unsure of how to seek out information, she was proactive in engaging with the information that was available. Similarly, early in pregnancy, all participants attempted to seek information, even if they were unsure of how to do so. Once in possession of information, participants' responses were determined by how it made them feel. The next section explores these responses, as sub-themes, in more detail.

6.3.1 Sub-theme one: information avoiding

Some information provoked negative feelings for some participants and they then avoided further information of a similar nature. These participants described worry and fear in response to labour and birth pain information and avoided further information which might increase their fears. To manage their fears and consequently reduce anxiety, participants avoided different media that contained birth information, for example, videos, prenatal classes and stories from others. A few participants avoided any situation that involved thinking about birth pain. They described how simply thinking about labour pain negatively influenced their mood and wellbeing. Aruna for example, was concerned for her wellbeing:

A little scared [laughs]…of the pain…Yeah, yeah. Um, like, preparing myself for the pain … I don't want to think about the labour yet. Because if I think about it then I think that it's not good for me……Because it would be... maybe I go to depression. - Aruna

Other participants also resisted thinking about labour pain. In Jara's experience, she did not find stories from family and friends comforting and became fearful that events she had heard about would happen to her. Out of fear, she decided to not listen to any further stories and decided that she would deal with the event when she had to, at the birth:

> *I really don't like when they (family and friends) say that…it was so, so intense pain, we were not able to bear that. So that makes you [me] more scary, [the] more you [I] hear, more that makes you [me] scary. It's going to be horrible…Initially, I was curious that what will happen to me? …When I heard 2 or 3 stories, then I said it's going to be same for everyone so better not to ask anyone that what's going to be there. So, I think I should face it whenever it will come, I will face it. - Jara*

This "I'll face it when I have to" approach was common with participants. They chose not to think about labour pain, beyond knowing that it would be painful, and often their families supported their choice of information avoiding. In most cases, this approach was not the result of a care-free disposition but was based on avoiding fear. Han explains:

> *They [family] don't tell me that much because they know I will scare. …because it's [my] first baby. Make scare… Because I know that it hurts, it really hurt… that's why… I know that when the baby is born will be very painful, that's why I don't ask her [mother] about that…. just see how it's going yeah. - Han*

Some participants described their families as active participants in this fear avoidance, while for other participants information given by family and friends provided comfort and reassurance. Diya, for example, also presented a "I'll face it when I have to" attitude and

avoided watching videos about childbirth which increased her fear. However, she was comforted by stories told to her by family and friends:

> *I didn't thought about anything. Just I wanted to experience what's going on in the moment of this, so I don't have to watch videos to scare me (small chuckle), so just let's see how it goes, that all, just I have stories and that's it, I don't want to watch videos. - Diya*

In most cases, family members responded to participants' desire for information. In the previous examples, Han's family did not provide her with any information, at her request; and in Diya's case, family members provided some information, but were sensitive to control the information so as not to upset her. Still others relied on close family to shield them from upset. For example, Vanya considered that thinking about birth pain added undue stress and she was concerned, like Aruna, that it might lower her mood. She felt that it was her husband's role to protect her from this concern, until her mother arrived from India to provide support. She believed that she would seek more information about pain relief and childbirth when she had the emotional support of her mother and considered that stress without adequate support might affect her wellbeing:

> *How the pain will be and what are the difficulties we face. I don't want that…I mean it's like depressing? …I feel more comfortable if my mum is there. …if my mum is there I can share everything [about]… the pain. - Vanya*

Access to information was also limited by the influence of culture. Unconsciously, participants were not proactively seeking information. Whilst participants were not strictly avoiding information, many emphasised how, in their cultures, they were not accustomed to sharing birth information. For some, the custom of discussing childbirth with only female

family members and close female friends was accepted without challenge and thus this was the only information that they sought during their pregnancy. Ira was born in India and explained that childbirth was not discussed publicly in her culture, so she was unsure of what to expect. It was apparent that Ira was not actively seeking information, because information sharing was in contrast to her cultural norm:

> *You know in India, it's never told about these things [childbirth]. So, I don't have any experience, I didn't see anything like this, so this is first time. - Ira*

Mai, who was born in Vietnam, felt the same way. She articulated that she felt ill-equipped to deal with birth pain because she had not been prepared with information by her family. She was aware that childbirth was painful but explained that the Vietnamese people do not openly discuss childbirth, not even between a mother and daughter:

> *With Vietnamese family they don't really talk much about it [childbirth pain] …. I guess it's the culture… I don't know whether it's uncomfortable or they're too shy or it shouldn't be spoken about because of the culture ... so I don't' really know much … they've never really told me their experience. - Mai*

In other cases, external influences, such as the internet or stories from friends, provoked worries which might develop into fears. Such fears were amplified by a lack of information and understanding. Many women specifically indicated a fear related to perineal tearing, so much so that they spent considerable time thinking about what they could do, during labour, to prevent this occurrence. Women considered their role, and the clinician's role, and they were not always reassured by a healthcare professional's ability to prevent a perineal tear. Qui's experiences drew attention to this phenomenon. In Qui's experience, her fear was related to a friend's story. Her fear was so significant that she considered discussing a

caesarean birth with the clinicians, particularly if labour took longer than a pre-determined time. Qui's fear was intensified by her lack of understanding about birth:

> *I'm scared because my friend, …she had tear, … a painful tear because her cervix not open much and the baby is bigger and her hips small… So, after long time labour she had tear, painful. … I'm scared, I hope I don't have that situation. But if something happens like tearing or maybe can't go on. I'm scared… It shouldn't happen. …why she waiting for so long and then the tear is happen. It shouldn't be happening because waiting for 10 hours labour and then have a tear. - Qui*

In sum, all participants experienced a sense of uncertainty related to not knowing what to expect, and sourced information to ease their concerns. Some participants avoided further information, because additional information increased their worry and at times this worry developed into fear. At the same time, others engaged with new knowledge and sought yet further information.

6.3.2 Sub-theme two: information engaging

When participants found that their search for information resulted in positive feelings, they continued to seek further information. They explained that the information was empowering and reduced stress, fear and worry about childbirth pain. In some cases, for example with Chi, the act of learning from information encouraged confidence. Chi explained that she felt more prepared and in control because the information provided her with an awareness of what to expect:

I need to know that sort of information before going into labour. I feel better. At least I know what I can do when I feel like over my control, like it's too painful for me or I need to feel more safe. - Chi

When participants actively sought additional information, no one source proved superior to another, but certain sources were better in certain situations for individuals. Some participants sourced childbirth related websites and wanted ongoing information, so they subscribed to websites in order to receive up to date pregnancy related information on a regular basis. Neha, for example, explained that she was unaware of what to expect at birth and the information on the website gave her confidence and comfort. She felt proud of being proactive and proceeded to talk at length about what she had learnt. She presented her learnings in a positive manner, indicating that the information did not generate worry:

Baby centre they send each week… like you will have pain in your stomach like you are having periods but that's not the pain for labour. The labour pain is different… The pain which we experience during our periods is not labour pain. - Neha

Participants gained confidence when they learnt that their experiences during pregnancy were normal and they understood that the pregnancy was progressing as expected. Diya explained that she downloaded an application (App) on her phone to track her weekly pregnancy progress. Because her pregnancy progress was similar to that described in the App, she was confident that it was progressing well:

I have the …App, so from day 1, I'm using that one. [It] tell[s me] exactly what… is happen[ing] and me the same, whatever they explain in that [the App], it happens…so, I just use the App. - Diya

Qui described a similar experience and sought information on community website forums to learn about expectations during pregnancy and birth. Explanations about why particular events occurred during pregnancy provided reassurance that her experiences were normal and expected. In both Diya's and Qui's accounts, this visual reassurance gave comfort and encouraged belief that all was well:

> *It's what I [am] expecting anyway, because I just read a lot and the websites, a book, and people telling me, my friends and family. So, I was expecting and I'm enjoying to experience that... So yeah, expecting. - Qui*

Not all participants found accessing information uncomplicated, but with the support of family they successfully explored different information pathways. Garima was supported by her husband and family in India to engage in information seeking. She explained that in India, it is more challenging to seek information and sharing of information is limited between the genders in families. Garima had been living in Australia for 1 year and the ability to access information so freely was novel to her. Nonetheless, she felt empowered to participate in information access and sharing. Her enthusiasm and commitment to information sharing was tangible. By sharing this experience with her family residing in India, she inspired her family to reconsider their cultural norms:

> *They don't tell you about how to handle the labour pain. Nothing, no classes… You guys [Australians in general] can talk anything with anyone. In our culture we are not that much open with everyone. We can't talk all these things. …all girls will be told by our elders, from our mums. … We are telling our family back in India that we are sharing information and attending classes and they say it's good…. once you tell them, then they speak out. - Garima*

Many participants who sought additional information, whether through the internet, a healthcare professional or family, described that information reduced worries and fears about childbirth pain. Engaging in information provided them with reassurance and encouraged confidence, and for many participants it provided direction for still more information gathering.

In sum, all participants in this study either engaged with or avoided information to varying degrees, depending on what feelings the information engendered and how much culture influenced their actions. Some participants were extremely active in searching for pregnancy related information, subscribing to websites, attending classes and engaging with family, friends and a healthcare professional. They explained that information provided them with a sense of empowerment and confidence which reduced their worries. In contrast, because information provoked negative feelings of stress, worry and fear other participants avoided seeking further information and mostly felt they would deal with pain when they had to, on the day of birth. Some women both avoided and engaged with information, but most commonly, as the pregnancy progressed women managed their own information. They sought to balance the information that was given to them by avoiding and discarding unwanted information and engaging with wanted information. This blend of information, between what was avoided and accepted, was unique to each participant. Nonetheless, eventually they all achieved a balance and accepted the forthcoming pain.

6.4 Theme two: towards acceptance

As a result of the blending of information and individual interpretation, all participants displayed varying degrees of understanding related to labour pain and birth. It was at this point, regardless of the level of understanding, that participants sought reassurance, mostly from family, friends and healthcare professionals, about their knowledge. Theme two explores how participants developed confidence as the birth approached, and ultimately came to accept or be at peace with the inevitability of labour pain and birth (see Figure 3 for an overview prenatal theme two). Sub-theme one describes the activities such as reflection, positive thinking, trust and spirituality, that helped reassure participants and allowed them to develop confidence towards the birth. Sub-theme two concludes the prenatal journey by describing how participants demonstrated their acceptance of the forthcoming labour and birth. This involved the participants recognising that labour would be painful and then feeling resigned at the inevitably of pain.

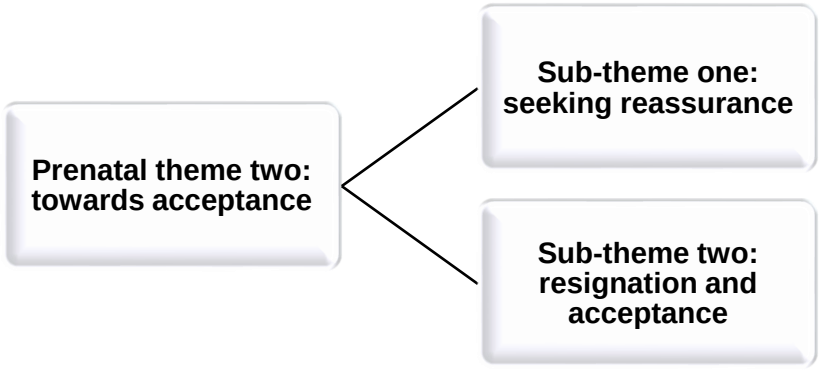


Figure 3: Overview of prenatal theme two

6.4.1 Sub-theme one: seeking reassurance

Every participant's journey towards acceptance was unique. They used various strategies to help and ultimately balance the information that they found in the prenatal period. This sub-theme explores the strategies that were used by participants, namely reflecting on experiences, thinking positively, trusting self and others, and spirituality. Each of these strategies provided participants with reassurance. For a few women, particularly those who had recently immigrated, reassurance was not easily achieved, and they struggled with communication and with developing social supports. Feeling reassured proved challenging when participants had difficulty in understanding pregnancy and health information. Poor health literacy resulted in participants feeling uncertain, even after attempts to reassure had been made by a healthcare professional.

Chi (see Participant Profile 3, on p. 122) explained how watching a video on the internet, in addition to stories from friends, reinforced her worries of perineal tearing. In her search for ongoing reassurance, she was reluctant to heed medical advice that deviated from possible avoidance of perineal tearing. In order to reassure herself about perineal tearing, Chi continued to consider further investigations, such as an ultrasound, even though healthcare professionals advised against it.

> *My friend says it very hurts. Very painful. She said it's like... she was painful for 10 hours and she said you know the bottom is like they cut her bottom. …It makes me feel worried. I'm just worried that my baby is a little bit big and it might be hard when I'm giving birth. …I want to do ultrasound to see how big she is, but the doctors said I don't need. - Chi*

All participants, regardless of their health literacy and the information they had read, sought reassurance. For most, reassurance was not as difficult to achieve as it was for Chi. Participants used a variety of strategies to reassure themselves to build confidence and ultimately to accept the forthcoming birth. Some participants focused on positivity, others sought advice from individuals they trusted, and some relied on spirituality. Many participants reflected on previous life experiences and others' experiences of childbirth to help build their confidence as the birth approached.

Some participants, mostly those who sought minimal information or understood very little of it because of health literacy challenges, gained reassurance through other women's experience of childbirth. The knowledge that others had experienced childbirth and that many of those women went on to have multiple children, gave participants reassurance that childbirth cannot be all terrible. Ly, for example, viewed birth pain as inevitable and reassured herself that because others had done it, so could she:

> *I think every woman have to give birth…so….they can do it, I can do it (big laugh). - Ly*

Mai, like Ly, also gained reassurance through other's experiences and while she acknowledged that while the thought of birth pain worried her, she was reassured because members of her family had managed childbirth. Mai also felt that birth pain would have been more challenging in her mother's and grandmother's generations, when there was little analgesia to help. Based on this understanding, Mai had confidence that she was in a better position to manage pain, because she had more options than previous generations:

> *Nervous... a little bit worried, but you know I'm trying to be positive like there are so many women that do this daily, like every day there's someone giving*

birth… My mum has done it four times, I'm sure I can do it. My grandma, she's done it like ten times so I'm thinking… And they didn't have medical assistance… and there was no medications, so if they were able to do it, I'm sure I should be able to do it too. - Mai

While some participants drew on others' experience of birth to gain reassurance, some drew on their own previous life experiences. Such personal experiences influenced their confidence to manage birth pain, specifically, previous events that symbolised their strength, endurance and perseverance. Jara explained how her anxiety was increased when friends or family members discussed labour, nonetheless, she also drew strength and resilience in preparation for labour from her own experiences. Previous feelings of achievement under challenging conditions had built her confidence in her ability to manage difficult situations and provided her with reassurance that she could manage labour pain:

Actually, I think that this pain is going to be different and I need to be prepared mentally for it [but]… I think I'm quite strong. Stronger than my husband [laughs]… Once we went for a trip… to visit a temple… on the top of the hill and you have to go there by walk only,… and it takes almost 2 to 3 hours. So, when we were walking…my shoes were tight so it was really difficult to walk and he was walking in the half pace [laughs]… And for every 15 minutes, we took a break because he was not able to walk properly! …Maybe because of my emotional strength, because I know I have to reach there so I prepare myself accordingly. … Emotionally I'm much more stronger than him [husband]. - Jara

Another example of how confidence was developed from previous personal experiences was given by Saavi. She recounted her friend's experiences of prenatal pain and related her friend's experiences to her own experience of severe dysmenorrhoea prior to pregnancy. Her confidence grew because she viewed her experience of dysmenorrhoea to be equally as painful as her friend's experiences of pre-labour contractions. Saavi believed that she managed her dysmenorrhoea well and this provided her with confidence to manage labour pain:

> *…My girlfriends when they had to visit hospital and had to have morphine because they thought they had Braxton Hicks… because their stretch pain was immense. I think I can relate because I had pretty bad dysmenorrhoea, my period pain is really, really bad so I think that's why I have built up this threshold for the pain. …so I think that because of that dysmenorrhoea, I have this threshold for this stretch pain. - Saavi*

Other previous life experiences, unrelated to pain, also shaped participants' confidence. Zoya, for example, described her travel from India to Australia and settling in a new country as a time of great personal growth. She felt the weight of cultural expectations in India and moving from India to Australia encouraged her independence. In Australia, she did not have her family and friends to guide and support her decisions and activities. Therefore, it was necessary for Zoya to support herself emotionally and socially, and this process enabled her to gain confidence in her ability to manage situations. Zoya was proud of her personal growth which she attributes to transitioning to a new country:

> *When I was in India, I wasn't that strong... but when I came here I had to do all the things by myself and I was feeling very, very strong at the moment…*

> *because I was being really scared, staying home (in India) …someone needs to come with me. Then I came here and have to do everything myself. So, I feel so strong at that time…I came here (Australia) I found…life totally different here. Very independent. I was living in a joint family in India and I was feeling a bit congested, like, I was doing everything according to what they need. Like, culture as well, …where (here) everything will be independent, I don't need to ask someone what to do and here I have to do these things. - Zoya*

While some participants, like Zoya, were able to reassure themselves with life experiences, others employed strategies including thinking positively, to support the development of reassurance as the birth approached. Many participants explained that they made an effort to focus on the positive aspects of pregnancy and childbirth. This positive thinking consequently led to them feeling more reassured as the birth approached. Participants may have used this life strategy frequently when faced with uncertainty. Some used positive thought to counteract negative thoughts and maternal stress, which may result in poorer mother and baby wellbeing.

Pryia, for example, felt that stress might have a negative influence on herself or her baby. Her focus on the positive helped her to stay calm and maintain a sense of control, highlighting that thinking positive thoughts was a strategy she frequently employed. The repetition of this strategy may also indicate that, at that present moment, she needed to reinforce the thinking positive strategy regularly to prevent an escalation of current stressors:

> *It is not good for the baby or the pregnant woman, the stress, …I don't take stress in my life and as well in the pregnancy…. I'm positive … because I don't have any stress in my life and I always go and think about the positives. I*

> *always think about the good thing like it will be easily handled and it will be controllable like that. Not impossible, not in my life. - Pryia*

Like Pryia, Neha also choose to think positively. Neha, however, drew attention to how others' negative experiences could influence her expectations. She explained that when she was exposed to another's negative experience, she used self-talk to reassure herself, reminding herself that all women have different experiences. Neha explained that others' less favourable experiences of childbirth should not influence her thoughts about her forthcoming birth:

> *…it's worse than [to] die she (a friend) said to me… But if I'm going to concentrate on her message only then I will definitely scared and I will say no, no, no, I'm not going to do this, but I have to do it. So, her experience is different from my experience. - Neha*

In these ways, participants made sense of information and balanced their interpretation with positive thinking. Ultimately a peaceful acceptance was achieved. Some participants explained the strategies that they used to help maintain a positive attitude. For Saavi, imagery helped. She imagined herself in early labour, at home, in comforting surroundings, relaxed and watching *Star Trek* with her husband. She provided considerable detail in her imagery, for example her location, the type of tea that she was drinking and the progression times of her labour. This was a scenario that required substantial cognitive commitment. Saavi also showed that she was emotionally committed to this imagery. She frequently closed her eyes during her recall, possibly to visualise herself within the scenario. Saavi also acted out some moments of the imagery. For example, she cupped her hands together and brought them up to her nose, to symbolise the smelling of her favourite herbal tea. All of

these features indicated that for Saavi, imagery was a tool that aided in creating a positive attitude towards birth and provided her with reassurance:

> *I keep having daydreams… I'm telling my husband I'm getting pains but I think that it's too early… and then I'm telling my husband while we're watching Star Trek because there's a movie and… he just rubs my back and I have a cold pack at my back or heat pack and we're sipping favourite cinnamon tea and watching and having snacks. Then at 5 in the morning I say that it's increasing in intensity and they tell us to come through and... when we go there, they say I'm 8cm dilated! [laughs]. It's just a positive approach. - Saavi*

In addition to positivity, reassurance was also developed through trust. Participants communicated that they were not worried because they trusted healthcare professionals to manage their birth well. They showed a confident manner and explained that they would inform the hospital when labour commenced. Zoya's example illustrated this feeling, showing how she trusted in the medical care at the hospital to provide her with reassurance and minimise her anxiety as the birth approached:

> *[I] don't worry… just call the hospital number and tell them how I'm going. Like what kind of pain is… They are worried more than me… Don't worry, everything will be fine. - Zoya*

Similarly, Anh described how she was fearful of complications, particularly a cord prolapse. Nonetheless, because she trusted the healthcare professionals, she felt reassured that all would be well:

I just try and look at the positive side. If it [cord prolapse] does happen, then I know that doctors will have a solution. - Anh

Saavi also described her trust in healthcare professionals and emphasised that, whilst she found the internet helpful, she received greater reassurance from the midwifery team. Unlike the internet, where the information can be contradictory, the midwives provided educated instruction:

I watch a video I'm not as confident as when I listen to it from the midwife. …Because I don't want to blindly believe everything on the internet because it's all mixed. …people have 10 different reviews for one thing. So, I'm relying on midwife, what she is telling me. - Saavi

When considering the uncertainty of childbirth pain, a few participants gained reassurance through spirituality. Although participants were, at times, reluctant to discuss their spirituality in detail they nonetheless made brief but strong statements explaining that they trusted that God would safeguard them. For example, Garima believed that spirituality would shelter her from harm:

Everything will be fine, I have faith in God. …to have prayers to have faith in God everything will be fine. - Garima

Mostly, participants described how the activities they undertook, like prayer, provided them with reassurance when they were worried and this activity helped achieve calm. Pryia stated that she used prayer to help relieve stress caused by previous memories. She expected that if she used the same practice during birth, she would be able to cope well with pain:

[I] …pray to God, then all the memories and the stress gone out from the mind, so I think the pain as well will also go out of my mind. From the pain to the God.

- Pryia

In sum, reflecting on experiences, thinking positively, trusting in self and others and spirituality were essential strategies that participants used to gain confidence as the birth approached. Towards the end of their prenatal journey, participants felt reassured and accepted that labour and birth would be painful.

6.4.2 Sub-theme two: resignation and acceptance in pain acceptance

The last prenatal sub-theme explores how participants accepted and felt at peace with the coming birth, while recognising that labour would be painful. They did this by depicting labour pain as a passing moment in time, or as an inevitable expectation of labour. Mostly, participants simply and genuinely stated that labour would be painful. This final discussion explores how the participants came to accept that labour and birth would be painful, and their feelings of resignation related to accepting the forthcoming birth.

Some participants demonstrated their acceptance of childbirth pain alongside considering the positive aspects of the forthcoming birth. They viewed pain as a negative influence, but instead of avoiding it, they acknowledged pain as an expectation of childbirth and did not dwell on this feature. Then for reassurance, they focused on maintaining a positive attitude by thinking about seeing their baby. This is how Tanvi communicated her acceptance of the coming birth:

People always ask me, are you not scared? But actually, I'm fine. Obviously, if I start thinking about the negative part of it like how much the pain will be and

> *stuff, I'm just thinking like I'm going to see my baby. …it doesn't matter how hard the process will be. After that, I'm going to see my baby, I'm just waiting for that and thinking about all the positive side. So, yeah, I'm fine actually… It will happen, it (pain) will go, it's not permanent. - Tanvi*

Acknowledging that pain was an inevitable feature of childbirth was part of the journey to acceptance. Participants recognised that the occurrence of labour pain was not in their control and instead directed their focus to the more positive aspects of birth. This was indicated by Zoya, who explained that pain is not something that should be dwelt on, just knowing to expect pain is enough and it did not change the situation, focusing on the positive was a better pathway:

> *Pain… it will happen… It's going to happen. When I was planning to be pregnant, I was like, it's going to happen, one day it's going to happen… It's going to happen, so I can't, you know, do anything for this. But the main thing is the baby. She is going to be in my hands. - Zoya*

Eva's experience provided another example of how participants accepted childbirth pain as inevitable. Although Eva indicated that she expected that childbirth would be painful, she was confident that she would be able to manage. Her confidence developed from the support she received from her female family members who had previous experiences with childbirth. She felt that her family knew her well and they believed her to be strong enough to manage pain during birth. This support reassured her that she would be able to manage the pain of birth:

> *… I know how the pain would be... I feel that myself, I'll be ok, I'm strong enough to take the pain… My elder sister had a normal delivery, my second*

sister, my cousin she had a normal delivery. So, when I speak with them, they say that I should be fine with whatever, they saw me since my childhood, the way I am strong. …that boosts me. So, I'm positive that I can take the pain. - Eva

For some participants, acceptance was about understanding that their birth pain would be unique to them. Whilst also acknowledging that they did not know what their experience was going to be, they were certain that it would be different from others'. Leela, for example, was uncertain how she would manage labour pain and was reluctant to arrange plans for pain relief because she wanted to wait to see what her own experience of pain was before making decisions based on other's experiences:

I'm waiting for my own experience, my own pain! I don't know about how I'll handle the pain or not. – Leela

In Tanvi's experience, the diverse experiences of others generated uncertainty, but she was also quick to discard other's experiences and wait for her own experience of childbirth pain:

…like because it's different for everyone. So, in short, actually it's just going to be my experience and how I'm going to feel. - Tanvi

In sum, participants accepted the coming birth and because they felt reassured, they recognised that labour would be painful, and felt resigned about this inevitability. Participants explained their acceptance in a variety of ways. Some participants focused on the positives, and others did not make assumptions and found peace in waiting to experience birth for themselves. On this journey of labour pain acceptance, participants often negotiated with cultural factors such as family supports, expectations, and spirituality.

6.5 Summary

In summary, participants in this study experienced a journey that began with uncertainty and concluded with accepting pain as an inevitable feature of childbirth. Theme one described how, because of uncertainty, they sought information from a variety of sources, including family, friends, healthcare professionals and the internet. After uncovering information and depending on how this information affected their wellbeing, they responded in two ways. Participants either avoided seeking further information or engaged with it. Irrespective of which choice they made, as the birth approached, they came to accept childbirth pain. Theme two described how participants came to accept pain as a feature of childbirth. Acceptance was achieved through reassurance from reflecting on experiences, thinking positively, spirituality, and trust in self and others. Once participants felt reassured, they came to recognise that labour would be painful no matter what and were resigned in the fact that pain was an inevitable feature of childbirth. In Figure 4 (p. 163), an overview of the prenatal themes is presented. The process, from information gathering to acceptance of labour pain, was not linear. There was a dynamic interplay between external influences, like culture, and internal forces, like thinking positively, that chaotically traversed and interacted until participants arrived at a place of peaceful acceptance with the coming birth. This dynamic interplay between the sub-themes is represented by the circular structure in the background, of the process.

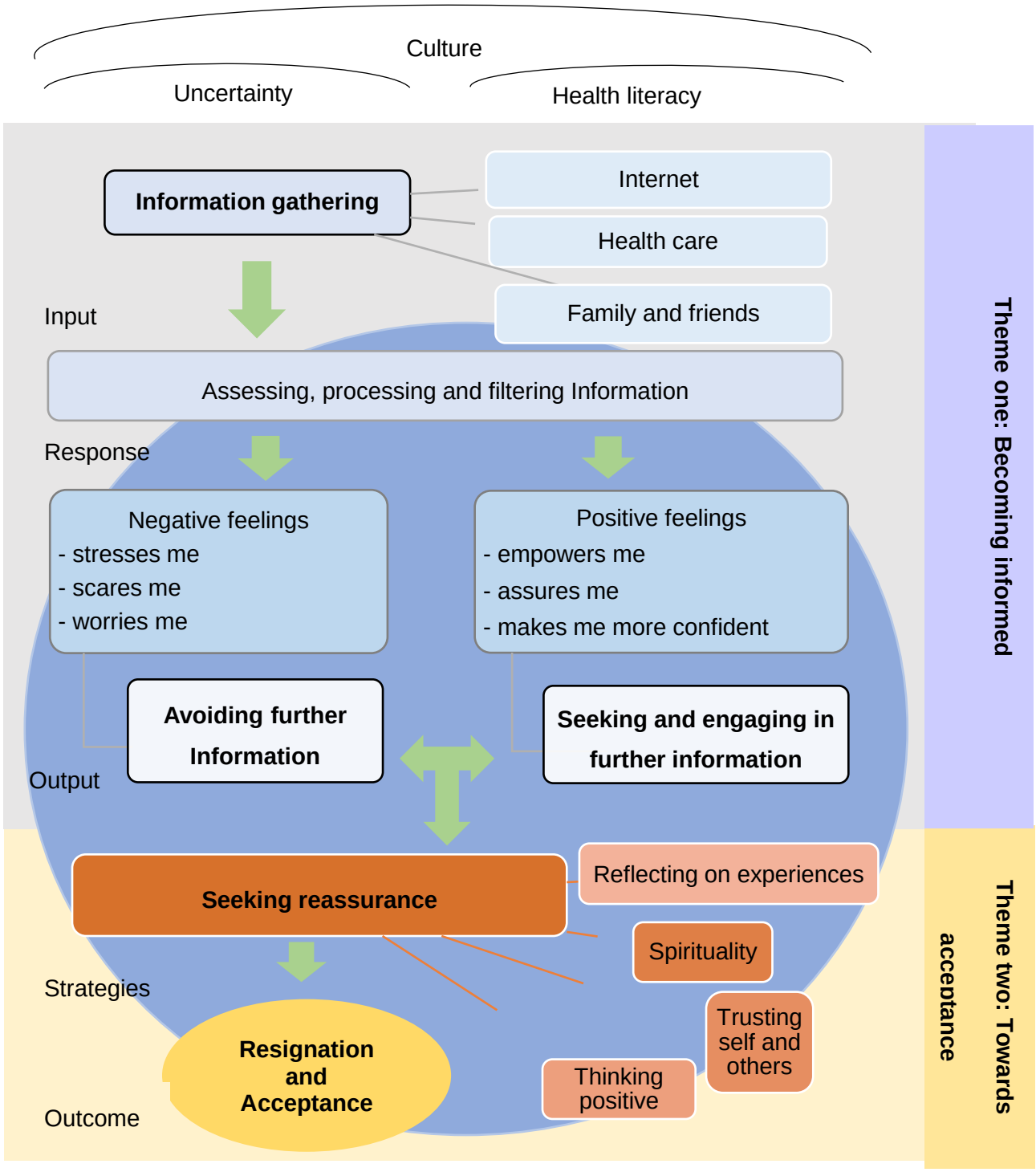


Figure 4: Trajectory of prenatal themes - becoming informed and toward acceptance

Chapter Seven: Pain and Chaos

7.1 Introduction

Participants described a journey to childbirth that started from the first uterine contraction and continued until immediately after the baby was born. The duration of each journey varied. Some participants had a short experience of a few hours while others described their labour as lasting for days. Regardless of the duration, participants' perceptions of their experiences were unique, and their responses were equally diverse. In this chapter, themes in relation to participants' perceptions and responses to labour pain are explored. Theme one, *pain and chaos*, considers in detail the thoughts, feelings and language that participants used in response to labour pain. Theme two, *managing pain,* explores distinct experiences that were highlighted by participants in their journey to managing pain, including feeling content or dissatisfied with experiences of pain. Theme three, *release from pain,* is the concluding theme and explores how participants felt freed from pain after birth. Before presenting the themes, some context is provided in the following section.

7.2 Background: describing labour

Throughout history, women's descriptions of labour pain have been diverse, intense and evocative. The participants of this study described their pain with the same variation and tangibility. Words like "throbbing", "squeezing", "stretching", "cramping", "pulling", "cutting" and "stabbing" were used to describe their pain during labour. Many participants used more than a single term and often their accounts were associated with labour progress. Most participants articulated the pain they experienced very clearly. Commonly, they described

pain as “cramping” in nature, which is a term that is often associated with painful muscle contractions. Consider Pyria, for example:

> *It's like a cramping, cramping around the waist and it's goes down… - Pyria*

Another commonly used term was “squeezing”, which is also a sensation associated with muscle contractions:

> *…it's like someone pushing, [and]… a kind of squeezing pain, [a] lot of squeezing pain - Vanya*

Some participants explained their experience of labour pain with simple and relatable language. For these participants, the pain was described as relatively manageable and they did not feel overwhelmed. Chi’s example highlighted this unambiguous quality:

> *I think it's not too pain for me …my back very hurt and it's like the feeling when I had period. ….... I thought it [would be] more painful. I thought it's okay, it's not that [much] pain. It's sort of like when you have stomach ache. - Chi*

Participants frequently used similes to describe labour pain, to emphasise their experiences and to clarify their explanations. The similes were other bodily conditions and pain disorders, for example, abdominal and bowel pain likened to severe gastroenteritis or menstrual pain. These similes were about pain that was severe but not unmanageable. For example, Sang compared labour pain to constipation:

> *…it felt like …you're constipated. A really intense stomach ache… - Sang*

A small group (n=2) of participants went one step further when they described labour pain as manageable. They were expecting the pain to be much worse and did not realise that they were in active labour. Mai explains:

> *…the contraction was… like …you've got really severe food poisoning. …That was …active contraction(s), and I didn't realise. - Mai*

In contrast, most participants described pain with language that clearly focused on the severity of pain. They emphasised that the pain was "terrible", the "most severe", or the "worst pain" they had ever experience. Most women communicated that the pain was worse than they expected:

> *…it was the worst, more pain than I thought it was going to be. - Ly*

Participants who elaborated were more negative in their descriptions than those with more moderate pain, like Mai, Chi and Sang. Participants also tried to use similes to explain their expectations of labour pain but were at a loss to find an event that was similar to their pain experience. Their expectations of labour pain and their experience were unrivalled. Leela's descriptions illustrate this concept:

> *…it's terrible. I think before labour pain, I think labour pain is normal, just like first time periods. But [it is] not. [laughs]. My pain is high, high, high… So labour pain is horrible [laughs]… [Even] pain [in] my back and my bottom. And sometime my pain is tummy. - Leela*

Like Leela, other participants also referred to pain that had multiple points of origin. "Back", "abdomen" and "rectum" were commonly referred to in discussions about contraction pain. These participants also used more negative language than those who did not refer to a pain

location or who communicated a single location of pain. One possible explanation for this difference is that participants who experienced more than a single pain location may have felt more overwhelmed and had greater difficulty maintaining focus and managing labour pain. This might explain why these participants conveyed such a negative experience of pain. A few women used metaphors with very negative, strong and dramatic language. For these participants, their pain experience was so extreme that they compared it to an event that they considered just as extreme. For example, Zoya described a pain similar to being cut with a knife and Kim explained that the pain felt like someone was breaking her bones:

> *It was a very sharp pain, like someone is cutting with a knife… it was very bad pain. - Zoya*

> *My back, my tummy, everything feel really, really hurt. And it's come about a few minutes then it gone, it come, it gone… I've never had that pain before so it's hard to explain that. I feel like someone is like breaking my bone. Like ... all of my bones in my body feel it really hurt like someone hitting me. - Kim*

It was clear from their accounts that the pain was different than they expected. Some participants expected more severe pain, others less severe pain. A few participants had trouble articulating what the pain felt like and could only explain it was a very severe pain and something that they had never felt before:

> *It was a very, very bad pain. I haven't realised this type of pain before. So, it was very painful. - Krisha*

Other participants also had trouble describing their pain, particularly when they were explaining their experience of labour induction and were surprised that the induction process

was so painful. Ly, for example, explained how scared she was to have a second Prostin pessary (induction medication) because of the pain she experienced with the first. For Ly, the pain associated with induction was extreme and she catastrophised this event when the healthcare professionals considered a second Prostin pessary. After this statement, Ly chuckles. This shows that Ly was likely aware that this response was extreme, and she was not going to die if she had the second pessary:

> *It was very, very, pain, painful. …I thought, oh my God, if they are going to put [in] another one (likely Prostin pessary), I am going to die because very hurt (chuckle). …that was very scary. But …the doctor came and …said, no, you don't need to [have] another. – Ly*

Another example was given by Ira. She had difficulty explaining the induction process and did not understand why after such a long time in pain that she still required a caesarean section. Ira assumed that the induction did not work and was confused. She also indicated that she had trouble managing pain during the regional anaesthetic procedure. This appeared to be linked to multiple interacting events including feeling pain for an extended period of time, poor understanding of the induction process and disappointment that the induction had failed:

> *They give me some medicine for pain for give me some water for pain (intravenous syntocinon) and some balloons (balloon catheter), I don't know what they did but they try to start labour pain, but it didn't work and after nearly 14, 15 hours [of] pains it didn't work and then they did surgery. … Because then they did treatment for the labour pain it's very, very hard and painful and*

when they did injection to me for caesarean it's very, very hard, because in my back it's very painful. - Ira

The level of understanding of the induction and labour processes is likely related to the length of time that these women had lived in Australia, their level of education and cultural influences (health literacy defined in methods chapter, p. 89). Often participants had limited understanding of anatomy or procedural terminology. For example:

I can't stand the pain, I get the something in my back. I'm not sure what it [is] called - Kim

A few participants displayed sound understanding of induction and labour processes and although they also indicated moments of misunderstanding, they had adequate health literacy and were able to articulate their experience clearly. These participants also offered rationales as to why they made the decisions they did regarding pain management. Reasons included, “I was unable to rest” and “the contractions were continuous” and related this directly to the process of induction. Participants who were induced indicated that their pain was worse because of the induction, and they believed that if they had not been induced that they would likely have managed the pain with less pain relief. Neha, for example, provided a brief example of why she was induced and compared natural labour pain to induction labour pain:

The pain. Like initially, it was less pain. I can bear, …but when they started artificial [induction] pain that was unbearable for me and I was telling [them to], stop the drip, decrease the speed, that was really unbearable …I was taking gas but …with the artificial pain, it was like I going to die. I will not live anymore. I would say if you get natural pain that would be better …If my water …[did not]

break, …then I can have natural pain …because my water … break that's why they give me artificial pain. - Neha

Like Neha, Heera showed adequate health literacy and understanding around the reason for induction and believed the induction to be the cause of her severe pain, as below:

…they …started the hormone to dilate the cervix [induction]. …I was able to sustain those pains. … I took gas in the beginning [it] was helping …Initially when they were giving me the lower dosage of hormone… there were no contractions, so they gave the dosage to quite a high dosage …and then it started contracting. After that, …the contractions became continuous …it was terrible experience … there was no rest and … I was not able to bear the pain. Maybe the contractions had become very frequent, that was why I was not able to bear the pain. ... it was a lot of pain and…I was in so much pain that I could not comprehend what was happening, I was just saying, I need an epidural. So they …stopped the medication and …were waiting for the contractions to stop …and after giving epidural they started off with the hormone again. - Heera

In summary, participants showed varying levels of health literacy. Those with better health literacy provided more detailed explanations and illustrated a greater understanding related to labour and pain. Participants' level of health literacy is likely related to their educational background, and the time they have spent in Australia. Women with higher levels of education demonstrated higher levels of health literacy. Sometimes, even with this understanding, they still had difficulty comprehending their pain during labour. Regardless

of health literacy, all participants indicated that at some time that they felt confused in the chaos of labour.

7.3 Theme one: pain and chaos

Whilst it is commonly accepted that labour is painful, every individual has their own unique experience of labour pain. Understanding of participants' experiences in this study begins with exploring their perceptions and initial responses to labour pain. Theme one, *pain and chaos*, is the start of this journey. The first sub-theme, *captivated by pain*, considers how pain influenced participants' ability to think, which resulted in poor concentration and occasionally confusion and irrational thoughts. Sub-theme two, *trapped by pain*, discusses participants' feelings of entrapment and their responses, including hopelessness, frustration, determination and anger. Sub-theme three, *the language of pain*, explores how participants expressed their pain vocally. An overview of these themes and associated sub-themes is provide in Figure 5 below.

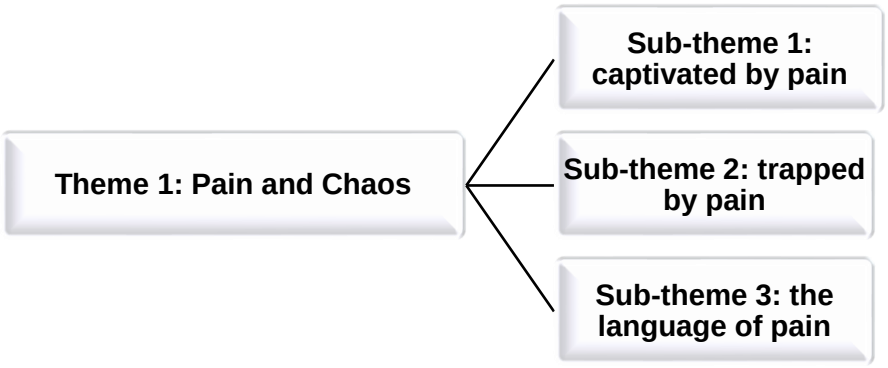


Figure 5: Overview of birth theme one

7.3.1 Sub-theme one: captivated by pain

Participants reported that pain captured their attention and occupied their thoughts. Having trouble concentrating during labour was a recurring challenge, and whilst most participants reported experiencing poor concentration, not all described being upset by it but they were perplexed. They stated factually how the pain influenced their ability to concentrate. Tanvi, for example, discussed how her pain had increased prior to arriving at the hospital and was influencing her ability to connect with her baby. She became fearful and decided it was time to go to the hospital:

> *...because of pain, I couldn't notice that if my baby is moving or not. Like I know he's moving but I couldn't concentrate, so I was getting scared. - Tanvi*

Similarly, some participants reported that the pain was so severe it influenced their ability to concentrate on pain management techniques as planned. For example, Heera explained that she was unable to use prayer as planned. She described that the pain prevented her from focusing on anything external and that she was only able to focus on this moment in time. She was not upset by this, as shown by her light-hearted chat about her experience:

> *The pain is so much you're not even able to pray. …I wanted to, but I was not able to. It was just pain. …When the pain was gone I was like … "it's going to come back again, it's going to come back again and then is it there... is it there? Oh, there it is, where's the gas?" [laughs] so you're always just conscious of what's happening inside, is the contraction starting or not. - Heera*

Many other participants felt labour as a complete upheaval and were unable to concentrate on anything outside of the pain. Pain became their primary focus. When they felt the pain,

they thought only about the current contraction and when it ended, they thought only about the next contraction. Many participants indicated that their thoughts were solely focused on stopping the pain. Ly conveyed her experience:

> *I cannot even think, just think, how can I make baby come out, how to make baby come out. - Ly*

Along with poor concentration, pain influenced their ability to think and reason. Participants commonly reported that they thought they were going to die. On reflection, these participants were aware that this was not likely and that the pain contributed to a feeling of impending doom, which was often accompanied by experiencing disorientation and difficulty making decisions. This inability to think clearly was reported by most participants, affecting some more severely than others. It was often at this time that participants abandoned their birth plans and pleaded for more pain relief than they had intended. Saavi explains:

> *I think that at one point, I was like, if I didn't have that pethidine, I thought that I was dying. I was not going to take it. …When I had my birth plan, I was like no to pethidine… But at that time, I was so [not] lucid, I couldn't make decisions, I was like, I'm going to die if I'm not going to have pain relief. - Saavi*

In summary, most participants indicated that pain captured their attention completely and they experienced difficulties thinking and reasoning. Some participants showed awareness of this fact and were unperturbed, while others experienced extreme feelings of impending doom. For participants who focused solely on the pain, some described feeling trapped, as explored in sub-theme two.

7.3.2 Sub-theme two: trapped by pain

Participants felt unable to escape the pain and this factor significantly affected the participant's mood. In this second sub-theme, *trapped by pain*, labour pain was linked to feelings of hopelessness, frustration and anger, with a few participants vacillating between hopelessness and determination.

Experiencing pain was emotionally and mentally wearing, and some participants started feeling hopelessness. Feelings of hopelessness and "wanting to give up" were often related to the inability to manage pain. In turn, relentless pain with no relief gave rise to despair. For example, Sang explained how she just wanted the pain to end and her description had a tone of finality about it. She appeared puzzled about why the pain had made her feel that way, but at the same time accepted this feeling as a true and real indication of how she felt at that time:

> *It was really bad. I felt at one stage I was like, oh my god, I'm so over it, can it just stop here? …just want to give up. I don't know, it's weird but in my mind it's just like... [I] want to give up. - Sang*

For a few participants the feeling of hopelessness came after an unexpected pain event. Participants explained that after experiencing pain for a long period of time with little reprieve, the slightest unexpected event would result in emotional chaos. Eva described this response, when an intravenous cannula was required. Even though she knew that this was a small pain in comparison to the pain of the contraction, it was still unexpected, and she felt unprepared for that additional pain:

> *I was already in so much pain, a little bit of pain was also too much for me… [that is when I] started …to lose my hope and then, …only concentration was to hold the contraction pain. Anything more than that my mind was not prepared for that. …I can't take any more pain. So…I lost it. [A] small pinch or anything was more terrible for me because my mind was not prepared for that… Even though it sounds like [a] very small pain, at that stage it was very big thing for me. - Eva*

Other participants reported mixed feelings of hopelessness and determination. They described extremes of emotions as the pain of contractions captured and took over their thoughts. When the pain was present, they only wanted to escape so that the pain would end, and when the pain subsided, they wanted to persevere and see their baby. Each participant experienced these feelings for different lengths of time. Some participants described much of the labour in this way and others, for example Tanvi, described short moments of time just prior to birth:

> *The last 10 contractions they were killing me. …I couldn't control... I was... telling my husband to kill me, …I don't want to live. Just kill me, I don't want anything in the life, but then when contractions [were] going, [I was] like OK, one less, now …baby will come… I was kind of mixed. - Tanvi*

While many participants responded to pain by feeling hopeless, a few responded in anger, and this anger was used to convey the frustration of feeling trapped by pain and inability to manage the pain. Anh explains:

> *I did get angry. It's because it's got to that point where it just hurts like I don't want the gas anymore. I think it was the pain that was making me angry. I think it was just like, get it out, I don't want this pain anymore. - Anh*

A couple of participants indicated that they felt anger towards those who they viewed as obstructing their decisions. Pyria explained that she managed pain best by herself and viewed interaction from staff as an interruption:

> *Because I'm in pain, and they touch me again and again, and they talk to me, but I'm not talking anymore because I'm in pain, and that's why I'm angry. I'm comfortable when I'm [alone] and can control my pain. - Pyria*

Anger also resulted from situations where participants felt disempowered. A few participants explained how they felt angry, frustrated and confused about the lack of clarity in their thoughts. They had difficulty making decisions and communicating their needs. A lack of control in these situations led to feelings of disempowerment and anger. Some felt that they could not harness their anger. In Zoya's experience she felt that the nitrous oxide resulted in her thought disorientation but also having control over the pain relief empowered her. Her anger was directed at her husband, who she viewed to be the controller of the pain relief. She was aware that her thoughts were irrational but had no control over how she felt or the anger that she displayed:

> *I was yelling at my husband, why are you giving me that much gas, you know I'm getting mad. He said, I didn't, you were asking! …Again, I got the contraction, I said, give me the gas! …[I was] being very funny [odd]. …I knew what I'm doing but it wasn't in my control. - Zoya*

In summary, many participants felt trapped by pain. Feeling trapped and not being able to escape led to feelings of hopelessness. Some participants also experienced anger towards those around them. It is also possible that as well as being a response brought about by pain, anger could also have been a means for participants to express their pain.

7.3.3 Sub-theme three: the language of pain

All participants spoke about how they expressed their pain and this sub-theme, *the language of pain*, explores communication of pain during labour. Participants mostly spoke about screaming as an expression of their pain severity, which unexpectedly provided some participants with an avenue of release. Screaming was considered an expected response and they had developed this expectation through stories from family and friends, and through the media. Participants had expected that the severity of pain would result in them screaming but as Mai explained, this did not always occur:

> *…you watch all these birth videos, you see these women going crazy, screaming their head off. I thought that [labour would be] really painful and I had that in my head… but I didn't scream, … I don't know whether it's my high pain threshold or it wasn't as bad. - Mai*

Some participants were more vocal than others. Mai, like a few others, felt that the pain was not severe enough for her to scream or that she had particularly high pain threshold. Participants from both Indian and Vietnamese backgrounds explained that although their pain was severe, they did not scream because it was not compatible with their personality to do so. In each case, participants believed that their expressions were based on their personal attributes. For some, screaming was a reaction that promoted attention, and they avoided screaming for fear of embarrassment. Overall, participants held contrasting views

on whether screaming helped manage labour pain. Among participants who did not scream, few acknowledged screaming as likely to be helpful during labour, as described by Anh:

> *I don't show much of pain. …I think that's why it didn't come across as I was in excruciating pain, but I was. I think that's just how I am. At one stage I cried. …but… I try not to scream because I'm scared. …I just heard people scream and I don't want ...[to] be like that. …but I know that they say that if you do, …it probably makes it better for you, makes you feel better… I think that's just me. I don't think it's a cultural thing. - Anh*

Anh is Vietnamese-born, and most likely she was aware of the social expectation that Vietnamese-born women are less vocal in labour. Nonetheless, Anh did not view her response as culturally imbedded.

Some participants described screaming in labour as a means of expressing the severity of pain. They were likely frustrated at their inability to manage pain and often explained that they felt that their body was failing them, they were unable to talk and sometimes they felt unable to breathe. They could only scream:

> *I'm screaming lots because pain [I can] not tolerate…during the pain, I can't breathe, I'm screaming "Owww"… - Leela*

Some participants perceived screaming as an indication that they were not managing pain well, nonetheless, they were unable to avoid screaming. They explained that it felt like a channel for the pain to escape. Zoya's explanation illustrates this point:

> *I was just screaming …I can't speak. …I didn't want to scream, …but it was coming naturally, and I was feeling bad at that time, when I was screaming.*

> *…I'm telling them, no, I'm not doing well, because I didn't want to scream. …The way I was screaming. I was feeling a little bit shy. I am screaming in front of the people… I'm feeling silly, but it was helping. Really helpful. When I was screaming, the pain was coming out [and] I was just screaming. - Zoya*

In summary, screaming was an instrument that participants used to express the severity of their pain. Some participants considered screaming an expectation, but others felt their pain was not severe enough to scream or were uneasy with the act of screaming. Participants also viewed not screaming as a consequence of personal attributes. A few participants indicated that they felt that healthcare professionals viewed their pain as less severe because they did not scream. For participants who did scream, they felt that the act of screaming helped them to manage labour pain.

To recap, theme one explored feelings of difficulty paying attention, poor concentration and irrational thoughts. Many participants felt captive to the pain. These feelings resulted in a sense of hopelessness, frustration and anger. Lastly, theme one explored how participants identified screaming as a language in labour which helped them express their pain and, in some cases, aided in managing pain.

7.4 Theme two: managing pain

After the initial responses to labour pain, participants strived to gather their thoughts and focus on managing pain. In theme two, *managing pain*, these responses are explored with the aim of understanding how participants made decisions during labour that helped or did not help them manage pain. Participants were both satisfied and dissatisfied with their pain experiences. Sub-theme one, *feeling regretful* and sub-theme two, *feeling overwhelmed*, explored how participants felt dissatisfied with their pain experiences. Sub-theme three,

feeling content considered how participants made decisions that ultimately led to their satisfaction. Conceptually, the three associate sub-themes have been represented in a pyramid termed the *labour and birth pain management pyramid* shown in Figure 6. The base of the pyramid represents dissatisfaction for differing reasons. On the one hand, participants made decisions that helped them manage pain, but they were left with a feeling of regret (sub-theme one). On the other, participants experienced severe, unrelenting pain that became overwhelming and they had difficulty coping, which also led to dissatisfaction (sub-theme two). The peak of the pyramid represents the point of successfully managing pain (sub-theme three) and includes factors that participants described as helping manage their pain.

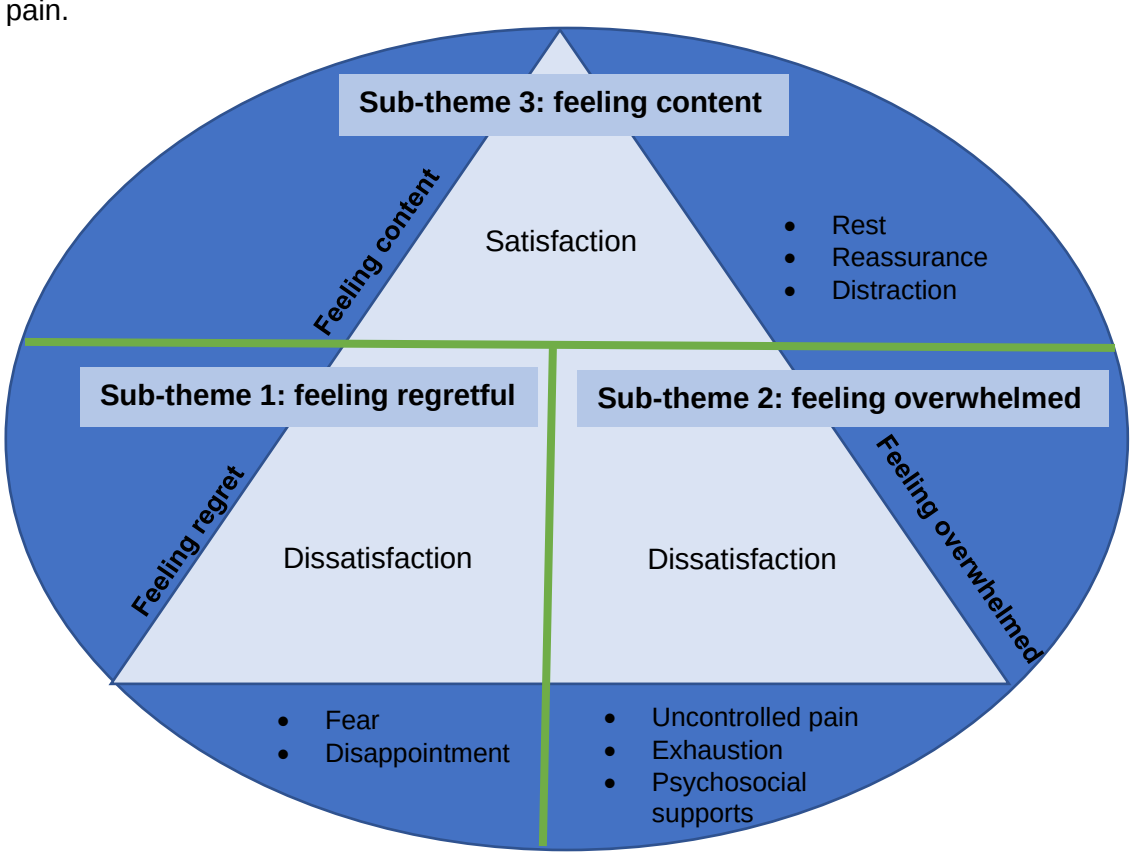


Figure 6: Overview of birth theme two - labour and birth pain management pyramid

Prior to exploring the labour and birth pain management pyramid in greater depth, the ways participants engaged in pain relief decision making will be considered. Influences on decision-making included healthcare, culture, family and friends. These factors remained in the background, operating simultaneously whilst participants attempted to manage pain.

Participants relied on others for guidance when making decisions, and at times this resulted in confusion and indecision. This was particularly evident with participants who were not prepared for the severity of labour pain or those that had not considered pharmacological agents for managing pain. These participants found decision making a huge challenge because they had little information about options and in some cases did not know how to ask for pain relief. Participants struggled more when the opinions of family and friends were in conflict with advice from healthcare professionals. Although they found it difficult to weigh up the risk versus benefit whilst in pain, participants viewed advice from doctors as more valuable than anything else. Consider the example provided by Kim:

> *I have ...the gas…first. Then after that, I can't stand the pain, I get the something in my back…[epidural]. It helped me a lot. I feel …no more painful. …I just expected to do the gas only because some of my friends told me that the [epidural] it's not good for my health when I [am] getting older. But I feel really hurt [and] I'm asking for this. They [medical/midwifery staff] say…It's safe. - Kim*

Many participants were concerned about having epidural analgesia and were reluctant to request this during labour because of a belief that it may contribute to back pain in later life. This view was passed on from family and friends but on one occasion, it was supported by comments made by a healthcare professional. Opposing advice was challenging and

participants felt the need to validate their request for an epidural during labour. Neha's experience provided an example:

> *My sister, … she asked me not to take epidural. Because…in future then you will have back pain… The midwife …she was saying the same thing… But I was saying … the pain was unbearable for me. The other doctor was saying, have epidural, … [others are] personal opinions…So I took it. - Neha*

Making decisions about pain relief was more difficult for some participants than others. Nonetheless, more often than not, advice from a healthcare professional was considered valuable and informed their decisions. Pain management was not simply about having pain relieved, and relief did not always equate to satisfaction with the pain experience. Sub-theme one explores the multidimensional concept of managing labour pain.

7.4.1 Sub-theme one: feeling regretful

Even though they were satisfied with pain relief during labour a few participants felt regretful later. The sub-theme, *feeling regretful*, explores this discontent. On reflection, these participants indicated that they would make other choices of pain relief given another opportunity. This feeling was not because the agent did not relieve their pain. On the contrary, often the agent was effective at managing pain but participants felt that something had been lost. Participants were unable to articulate their feelings exactly, possibly because they were still trying to understand them themselves. Another possible explanation is that culture influenced their communication of these complex feelings. Two situations that led to participants feeling regretful were fear and disappointment within self.

Because this was their first birth, participants were not sure what to expect and were fearful. They indicated that because of fear and the anticipation of even more severe uncontrollable pain, they choose epidural analgesia before the pain escalated. These participants believed that the pain experience was worse because it was unexpected. Now, with hindsight and an understanding of labour pain, they believed that for subsequent births they would manage better as they knew what to expect. Consider this example by Han:

> *Because it's first baby, that's why, I didn't know how painful. That's why I use that [epidural]. But if I had another baby, I would not use it with my experience already. [I would] try to be brave [not scared]. - Han*

Participants who were disappointed in their choice of pain relief also conveyed a sense of regret. Instead of persisting with pain they felt like they had surrendered. These participants wished that they had been more determined to manage labour pain. Similarly, disappointment was not induced by ineffective analgesia, but their performance. Aruna explains that she was regretful because with little time left until birth, she requested an epidural instead of persisting with the pain:

> *Before epidural it's too much pain and then …at the end, almost 8 cm is open and if I didn't took epidural then maybe it took half an hour more. So now I think like if I didn't take it, then it would be alright. Because it's already 8cm open, so just 2 cm left. - Aruna*

In summary, in attempting to manage pain, participants engaged in decision making that resulted in some regret. A few participants made pain relief choices based on fear of the pain and others wished they had been more persistent in coping, which led to self-disappointment. In both events, even with adequate pain relief, participants still experienced

regret. Overall, it seemed that this sort of regret negatively influenced participants' satisfaction with their childbirth experience.

7.4.2 Sub-theme two: feeling overwhelmed

Along with regret, feeling overwhelmed during labour also led to dissatisfaction for participants. Sub-theme two, *feeling overwhelmed*, explores the phenomenon of uncontrollable pain, where pain consumed participants' thoughts and they were unable to manage. Three circumstances stood out in this theme: inadequate pain relief, poor psychosocial support and exhaustion.

A few participants who were dissatisfied with their experience felt that their pain was not well controlled. These participants described feeling overwhelmed because pain influenced their ability to think and rationalise, as discussed in theme one. For some, they felt that it inhibited the development of bonds with loved ones during labour and birth. For this reason, a few participants thought that they would definitely consider an epidural for their next birth, even though they did not have an epidural with their first. Participants felt that the techniques that they used did not help relieve labour pain and they could not think beyond the pain. It is possible that these participants were disappointed that they were unable to experience the beautiful childbirth they had imagined. They viewed pain as the obstruction that prevented them from having the experience of childbirth they anticipated, and subsequently that experience influenced their overall satisfaction. Anh provided a detailed account of her thoughts in the following example:

> *...I wouldn't go through it again. … I think the epidural… and therefore I can probably notice things around me …rather than just focusing on so much and letting the pain take over me. …I really didn't notice him [husband] at all. …He*

> *was beside me. He was holding me, but …it was more of just my pain. …I think just the pain overrides everything. I couldn't concentrate on anything else… - Anh*

Inadequate pain relief was not the only factor to consider. For one participant, feeling inadequately supported by her husband also led to feeling overwhelmed by pain. Most participants shared the personal view that the husband should be present in the birth room, irrespective of their cultural influences. For Vanya, she and husband had beliefs that were conflicting, and it is likely that neither had discussed their views with the other leading up to the birth. Vanya expected that when it came to the labour, her husband would disregard cultural expectations and support her in her time of need. She believed that her husband's presence would provide her with support and reassurance to help manage pain. Her husband did not attend, and she felt dejected and had difficulty coping with the pain. She felt alone and abandoned because her husband followed the cultural expectations and left the room during labour:

> *He [husband] didn't do anything. …I felt very sad about that. …Even though midwives would have been there but someone like who is close to you should be around to help as well. …I just couldn't handle …He gave some reasons, and all which I am not happy with. …I was expecting he'd be around me and he'd be taking care of me…which didn't happen, which hurt me a lot. A traditional thing and elders told [him that he] should not, so he just obeyed their rules. - Vanya*

Some participants highlighted how their exhaustion reduced their ability to manage pain and to participate in the birth. They felt that their exhaustion influenced the decision for an

instrumental birth. Pryia, for example, explains how she was too tired to participate in the birth and attributes this tiredness as the reason for a forceps delivery:

> *…it is open 9 to 10 cm but she is not delivered because I'm really tired, I didn't get sleep properly for 2 days, because of contractions start before 30 hours, that's why I'm not pushing properly, so they[I] try for the best but that is just not good. - Pryia*

To recap, a few participants reported feeling overwhelmed by the pain. Like participants that felt regret, others were dissatisfied with their childbirth pain experience but for different reasons. These participants highlighted inadequate pain relief, poor psychosocial supports and exhaustion as negatively influencing their overall childbirth pain experience. However, whilst a few participants were either regretful or overwhelmed, most participants were content with their pain experience.

7.4.3 Sub-theme three: feeling content

Most participants were satisfied with their experience of pain and this was represented as the apex of the labour and birth pain management pyramid. Participants at this point had successfully managed the pain, they had made decisions that positively influenced their experience and although labour was painful, they appeared to be content. Sub-theme three*, feeling content*, considers how these participants successfully managed labour pain, although this did not mean that they were pain-free during labour. Feeling content was about finding a space where they were satisfied with what they were experiencing. This was highlighted by Mai:

Especially the intense contraction, like even though I do the breathing, I can still feel the pain and then I just kind of let that through just take it on. - Mai

When participants described managing pain, three factors were constantly mentioned, rest, reassurance and distraction. Mostly, participants aimed to achieve enough pain relief to have some rest. Nearly all described relentless pain resulting in no rest, which was exhausting and reduced their ability to manage pain. Total alleviation of pain was not the goal:

I didn't want something for the pain really, I just wanted to rest. - Saavi

For some participants, rest was not easily found, and they resorted to pharmacological options. These options often provided them with the rest that they needed then to manage the pain. While pain was a secondary consideration, rest was only achievable when pain was adequately managed. Jara explained how she found that the epidural enabled her to rest and reduced her fear:

After having epidural … I was so relaxed. I was laying on the bed and my husband was sitting next to me and we were just waiting for the right moment when baby will come out…there was nothing scary. - Jara

Reassurance also played a vital role in helping participants manage the pain. Some participants reported that the midwives and medical staff were encouraging and supportive. Encouragement from the staff reassured and motivated them, particularly when they were feeling despair. Neha explained how one doctor was attentive and this gave her the reassurance that she could give birth:

> *…[the] doctor she was [saying] don't worry, you can do it, just a little more, just 5 minutes more. …These things motivated us a lot. Like if somebody gives you sympathy and pampers you…and then we can do it, we have…the energy. - Neha*

Unlike in sub-theme two, where Vanya felt unsupported by her husband, most participants reported that their husbands provided invaluable support in helping them manage labour pain and, for a few participants, this was unexpected. These participants explained that it was a cultural expectation that the husband was not in the birth room because of fear that they may not wish for more children. Nonetheless, on seeing his wife in pain some were unable to leave and stayed to provide support and encouragement. It is likely that this unexpected act filled them with reassurance:

> *I was expecting …nobody will be staying in labour room except my mother... But it was totally different story. When they started …the pain …he [husband] was there next to me and I didn't leave his hand at all [laughs]. …He's given me very good support. [Husbands are] not supposed to be in that room. He saw me in pain and stayed, …and I didn't leave his hand [laughs]. …Because before that, …our culture say we should not do like that. …because if [the husband] see the part and we might not go for other babies. - Eva*

Some participants spoke about needing their husband's strength during labour. They associated their husband's strength with reassurance that he would take care of them when they were frightened and in pain. In some cases, the simple presence of the husband was enough to provide them with comfort in the face of the unknown. Zoya explained that she

believed that her husband wanted above all else to take care of her and this was proof of his love for her:

> *…My husband said, no, [I] need to stay here ..I'll stay with her, and even I wanted my husband be there with me…because I knew he is strong enough and I need some strong person who can encourage me…so he was very supportive. I think because of his support, I could do it better because. …He was calming me down, he was holding me, he was…showing his love to me and he was saying, you can do it… - Zoya*

Husbands also played various other positive roles during labour, including distraction therapy and encouragement. Husbands distracted their labouring wives by using comic relief and telling them stories. Neha provides an example of this:

> *…when I was crying, he was saying some jokes to me so he can divert my attention…and I can forget the pain. - Neha*

Many participants describe their husbands as encouraging during labour, cheering them on in the challenging times and providing gentle comfort at other times. Having them present and providing active support was important for these participants. It resulted in greater reassurance and helped them manage the pain:

> *He (husband) was …quite encouraging, …every time a contraction came, I squeezed his hands [laughs] and …instead of the pain, I feel like my mind is like squeezing his hands, it kind of help[ed] …and it's quite comforting. … and towards the pushing stage, he was …saying come on, you can do it, encouraging. - Sang*

Participants used other avenues to help distract themselves from pain including spirituality, breathing exercises and setting achievable benchmarks. Spirituality provided participants with a focus while prayer and stories helped distract participants from the pain. Eva offers this example:

> *…whenever I got this contraction …I was trying to deviate my mind, thinking of other stories because I believe in spirituality. …recollecting the spiritual stories. That…helped me. - Eva*

Like Eva, other participants drew on their spirituality during labour and birth and this allowed them to manage the pain. Participants spoke about spirituality guiding them through the pain, easing the pain and providing sanctuary from the pain. These participants relinquished accountability for the management of their pain. They were able to endure the pain because of their faith. Essentially, they shared their pain, and shared their success of managing the pain, with their God. In Jara's example, she explains how spirituality provided her with guidance to navigate her way through the pain:

> *I was praying all the time and it was only that religious belief that took me out of that thing because… we are strongly tied with that religious belief, that there is someone who can guide …how to come out of pain. - Jara*

Another example is offered by Garima, when she surrenders all responsibility for managing labour pain and celebrates this accomplishment in terms of a gift that was afforded to her by her God:

> *…everything went well because of God…not because of me…That's why I did well. I didn't do anything. God helped me a lot. He helped me…God gave me strength to do that well. Otherwise I can't do anything. - Garima*

For some participants, spirituality was a sanctuary from pain and promoted an ability to manage labour pain. Spiritual activities, like prayer, helped distract the participants from the pain. In addition to spirituality, other distraction activities were highlighted. Activities like breathing and setting benchmarks were successfully used by other participants and provided a focus away from the pain. This promoted confidence and reassured them that they could manage the pain. A few participants divided labour up into small manageable sections. Achievement of one section promoted confidence that the next could be achieved. These participants often had a backup plan, an escape route, that would help them if they could no longer achieve the following section:

> *I have to do it, until I'm [un]able to do it. If I'm not able…I'll ask for…an epidural. …Just 1 more hour... I was just sort of setting benchmarks for myself. Just 1 more hour. …Then once that 1 hour was over, then I was like…maybe just 15 more minutes. - Heera*

Engaging in distraction activities not only helped participants escape the pain, it also provided them with reassurance that they could manage the pain.

Recapping sub-theme three, *feeling content*, participants arrived at a space where they were satisfied with their pain experience. Absence of pain was not the primary aim. Feeling content was about feeling rested and having some escape from the relentlessness of pain. To ensure rest, all participants used pain relief options, either or both non-pharmacological

and pharmacological. Husbands and spirituality played pivotal roles in helping participants manage labour pain and provided reassurance and distraction.

Summarising theme two*, managing pain*, many participants had trouble with decision making during labour and pain inhibited their ability to think. Opinions of family and friends, and culture also influenced decision-making. Participants sought to manage the pain, and three distinct sub-themes emerged. These sub-themes, feeling regretful, feeling overwhelmed and feeling content, are illustrated in the *labour and birth pain management pyramid*. Managing pain was a challenging and consuming process that was influenced by many factors. Alleviation of pain did not always result in a satisfying pain experience. Participants were dissatisfied when they felt regret or when they felt overwhelmed by pain. Rest, reassurance and distraction were highlighted by participants as essential features that helped them manage the pain. Managing the pain absorbed nearly every moment during labour, from the first contraction to the last. Thus, with such intense focus, over many hours, childbirth came as a relief.

7.5 Theme three: relief

With the birth imminent, participants described contrasting views of pain, and immediately after birth, all participants experienced an intense feeling of relief. Theme three, *release from pain*, explores this concept and considers the immediate relief of birth. When released from pain, participants primarily responded with joy or exhaustion or a combination of both. Sub-theme one, *joy*, considers the feeling of joy that participants described immediately after birth; and sub-theme two, *exhaustion*, explores the experience of feeling overcome with exhaustion. Figure 7 (p. 193), provides an overview of birth theme three.

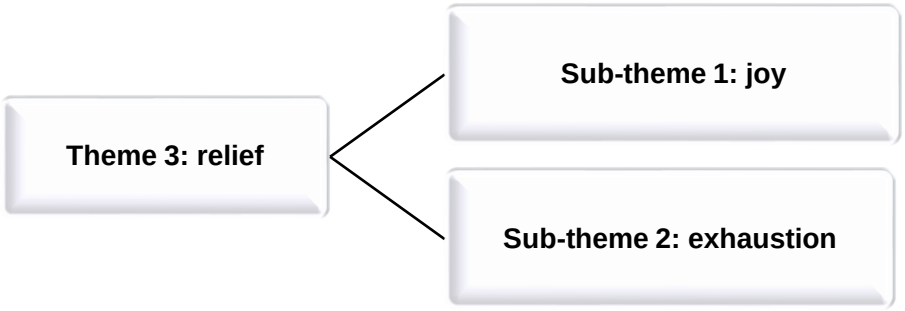


Figure 7: Overview of birth theme three

Before exploring the post-birth experiences, in the following discussion some insight into birth experiences is provided. With the birth imminent, many participants described escalating exhaustion. Some reported that they were so tired that they had trouble communicating, participating and following instruction. Consider the statement given by Jara, where she described how her exhaustion influenced her ability to communicate during the birth:

> *…I was…pushing but his head was not coming out, …his legs coming upward towards my ribs. That pain was really hurting me, …I was unable to open my eyes. …I'm tired but it was like I cannot even speak. - Jara*

Alternatively, other participants found that birth was the easiest part of the labour. They described the pain as insignificant compared to the contraction pain. Some participants had thought that giving birth would be the most painful stage, yet for them it was not:

> *I was always thinking when baby will come out that part will be the most painful, but I didn't even feel it…. It was just the contractions which were bad.- Tanvi*

Some participants were surprised about how little pain they experienced associated with perineal tearing compared with their expectations, and as many feared prenatally. Leela provided an example of this:

> *...Because whole thing is pain. I can't feel [the] cut and vacuum, just feel the baby is pushing. - Leela.*

The birth was the pinnacle moment for all participants. They described labour and birth in terms of a marathon. From the start of this marathon to nearing the end, it had consumed their every thought, emotion and energy. During labour, every sense was focused on getting to the end of their marathon, even though they were unable to see the finish line. With the finish line in view, some participants felt that giving birth was the easiest part and others found it the hardest challenge yet. Immediately after the birth all participants described feeling released from pain. The pinnacle moment had come and had then passed, and with its passing they felt immensely relieved. Theme three, *released from pain*, considers participants' extreme sense of relief immediately after birth. Some participants described how the feeling of relief was so intense that for the moment after the birth they were unable to acknowledge that they had given birth. They were suspended in that moment. Consider Anh's example:

> *When the baby was on me, it was more of relief of the pain, than the baby. …It wasn't, oh yeah [surprise] the baby's here! It was, oh God, the pain is gone, I don't feel any more pain. - Anh*

In the wake of such relief, some participants experienced joy while others were overcome with exhaustion.

7.5.1 Sub-theme one: joy

After birth, along with relief, many participants described feeling overjoyed. Sub-theme one, *joy*, explores this phenomenon. Many of these participants had difficultly articulating their happiness, probably because there were so many complex emotional aspects to this moment. Possible explanations alluded to by participants included relief and joy that their baby was well and healthy, relief from pain, the satisfaction of achieving a goal and the opportunity to have participated in the creation of life. Overall, all participants reporting joy also indicated that this was the most significant moment that they had experienced in their lives:

> *It was so happy! [laughs] ... it was like a feeling which can't be expressed. It's like... a new thing to me. ...Best moment in my life…after seeing the baby you'll feel like... you'll forget all the pain. [The] birth was...amazing. I...totally forgot the pain. - Vanya*

For participants who experienced post-birth joy, their pain had completely resolved after the birth. While some participants, like Vanya in the above example, described that they had forgotten about the pain, others felt that the pain had disappeared. Participants described a moment of where they went from one extreme to another; first extreme pain, then no pain followed by extreme joy:

> *Very big relief. ...The feeling when she came out, and they straight away put her on my chest. It was so good feeling. All pain went away. ...Nothing at all. Just that moment, it was very precious for me. - Zoya*

While many participants felt overcome with joy, some were relieved that their suffering had come to an end and were completely and utterly exhausted.

7.5.2 Sub-theme two: exhaustion

The feeling of exhaustion was reported by a few participants. They likened their experience to running a marathon, one that they had not prepared for. Some participants felt this in an extreme way and after the birth, they were completely consumed by exhaustion. Eva and Saavi describe this feeling in the statement below:

> *…it went for 11 hours, very long labour. I was totally exhausted. I'm already half dead. - Eva*

> *I was so exhausted because as you know that it was really a long journey… - Saavi*

For a few participants, this exhaustion influenced their ability to respond to their newborn. They described that the release from pain was followed by an intense exhaustion, such that they were unable to physically acknowledge their newborn. Often these participants indicated that they wanted to participate in the care of their newborn by holding and cuddling, but were incapable of doing so. Chi describes her feelings after birth:

> *After giving birth [my husband had to] take the baby. ...because I was so tired, I couldn't open my eyes but I know everything.... I can't open my eyes. – Chi*

Similarly, Ira explained this feeling after labour and then having an emergency caesarean section. She highlights the length of time that she was in pain as the primary contribution to feeling weak after birth:

> *I'm in pain in 2, nearly 2 and a half days and after ... and then they do caesarean. It's very, very, very hard. …It's very long time, very hard time and after caesarean I feel very weak and painful. …I have no more power to hold him because my arm is not working well…. - Ira*

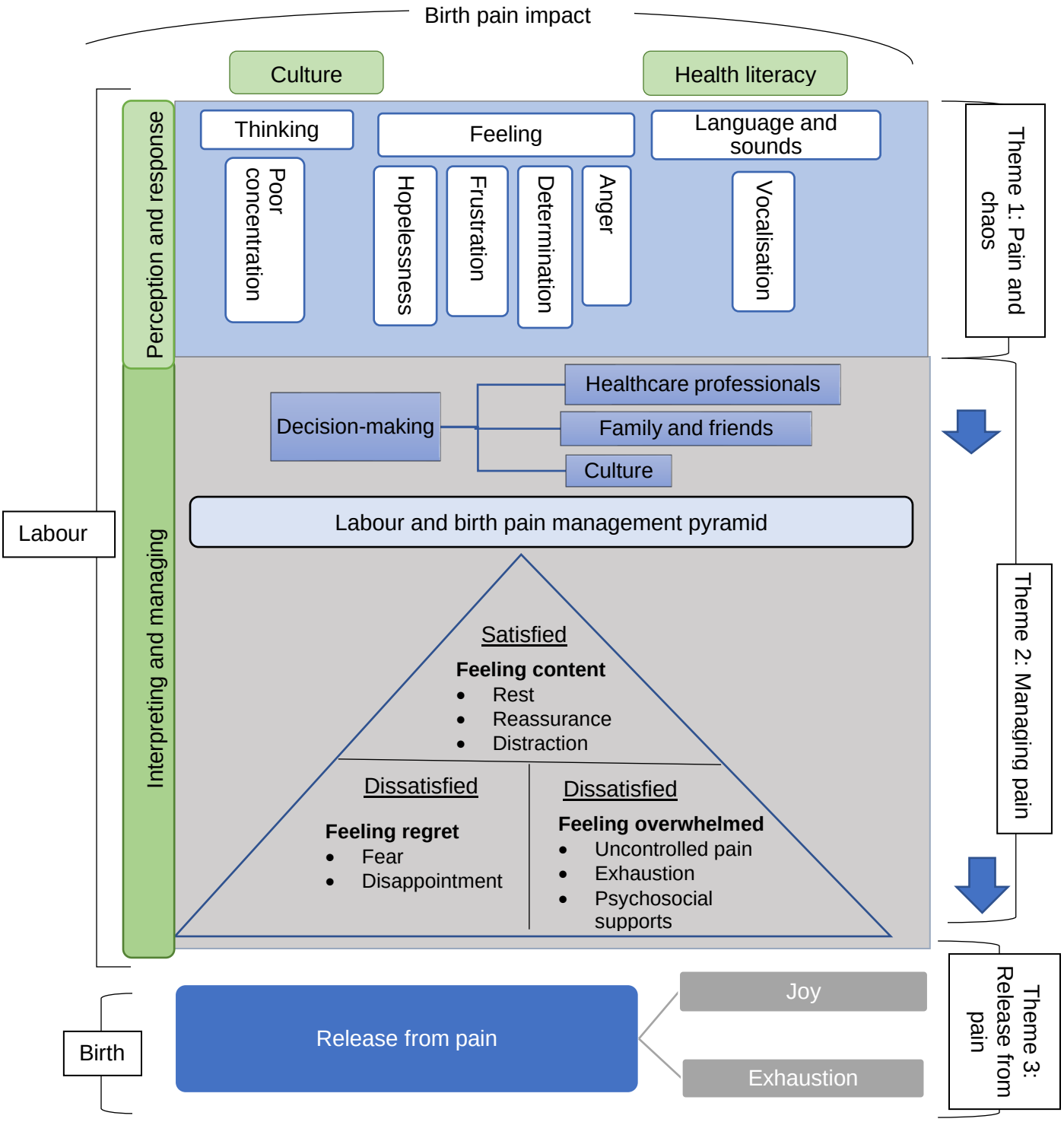
To recap, theme three, *released from pain*, explored the moments immediately after birth. During this short but intense time all participants felt overwhelmingly relieved. The marathon of labour peaked at the birth and for many this was a joyous occasion; but for a few, it was the point where they were overcome with complete exhaustion. Both experiences, joy and exhaustion, were all-consuming and for many difficult to articulate. Overall, participants felt that the birth of a child was the most significant event in their life.

7.6 Summary

Participants' experience of labour and birth pain have been described in chapter seven. Accounts of participants' labour pain illustrated the diversity in experiences and pain sensations. Theme one, *pain and chaos*, explored how pain captured participants' attention and influenced their thinking. Participants often felt trapped by pain and while this led to feelings of hopelessness, frustration and anger for some, these feelings were entwined with transient determination. Theme one also described how participants understood their expressions of pain. Theme two, *managing pain*, explored how participants strived to manage the pain and engage in decision making, which was influenced by their health literacy, prenatal preparation, healthcare professionals, culture, their family and friends. In the pursuit to manage pain, a few participants were left feeling regretful and some were overwhelmed by pain and were unable to manage. Most participants found a balance, and they were content. This did not necessary mean that they were pain free, but pain did not

negatively influence their experience. Theme three, *released from pain*, explored the experience of birth and the subsequent moment after birth. Immediately after birth, all participants were overcome with relief. Relief was accompanied by contrasting feelings of joy or exhaustion. Many participants felt overjoyed in this moment, but a few were completely exhausted and unable to bask in the joy of birth. An illustration of the birthing themes is shown in Figure 8 (p. 199). Figure 8 represents a dynamic process where participants moved through themes; starting with their perceptions and responses to labour pain (theme one), moving through to pain management (theme two) and finishing with the birth of their baby (theme three).

Figure 8: Concept map: the childbirth pain experience – from chaos to managing and final release



Chapter Eight: Pain and Motherhood

8.1 Introduction

Most participants expected that pain would resolve soon after birth, however this rarely occurred. In chapter eight, participants' experience of pain in the weeks after birth is explored. There are two themes. Theme one, *postpartum pain,* explores post birth pain in the hospital and at home with a newborn baby. Post birth pain was influenced both by the care that was provided in hospital and by family and cultural influences at home. Pain during this period had far reaching consequences and influenced various aspects of participants' wellbeing. Theme two, *reflections of childbirth*, explores how the participants looked back on their labour and birth pain after many weeks. For some participants, as time passed and they recovered from childbirth, their reflections of labour and birth pain changed. For some participants, labour pain seemed like a faded memory, others found that the pain was etched deeply in their memory. Some participants felt proud to have endured such pain, while for others the pain of labour and birth continued to affect their wellbeing. Reflecting on the birth caused anguish and some participants were regretful of their decisions related to pain relief but were optimistic for future childbirths.

8.2 Background: experiences of postpartum pain

Overall, participants described various experiences of pain including back pain, perineal pain, breast pain and complete body pain. This was a surprise for most, as they did not think that pain would be an issue after birth. Some considered that postpartum pain was worse than labour pain. Consider Mai's example:

> *. …nobody tells you…I think that the process of the labour and …giving birth wasn't as bad as everything else that comes after. …dealing with the baby, the breastfeeding, like the pain of your boobs… - Mai*

Chi declared that her postpartum pain was worse than labour pain. She explained, like many others, that pain influenced her ability to move and take care of her baby:

> *Oh, the stitches. …I couldn't …get off the bed…. I didn't walk a lot because it hurt. …I thought more that the pain before the baby pain [was greater]. But in fact, the pain after the baby is more ... - Chi*

Along with perineal pain, participants described generalised body pain. They were sore all over and it was common to describe aching in their legs. Pyria and Zoya explained that along with perineal pain, they also experienced generalised body pain. It is likely that this pain was a consequence of physical exertion during labour:

> *…stitches pain, I'm not comfortable and I also have legs pain, …- Pyria*

> *…after delivery, 1 day, I was feeling so much pain because of pushing. Whole body pain…aching. I was feeling…so much pain. The stitches [were] so painful. - Zoya*

8.3 Theme one: postpartum pain

Participants highlighted two central factors which influenced their pain during the postpartum period¸ which are discussed in the sub-themes. Sub-theme one, *factors influencing postpartum pain*, explores how healthcare and family and culture influenced pain during the first few weeks of new motherhood. Participants were surprised at how much pain affected their daily routines. For some participants, pain had more lasting effects than for others. Sub-theme two, *consequences of postpartum pain*, explores how pain led to feelings of sadness and affected relationships with the woman's newborn baby and husband. All participants stated that postpartum pain influenced their ability to perform activities of daily living and their total wellbeing. Figure 9 provides an overview of postpartum theme one and the associated sub-themes.

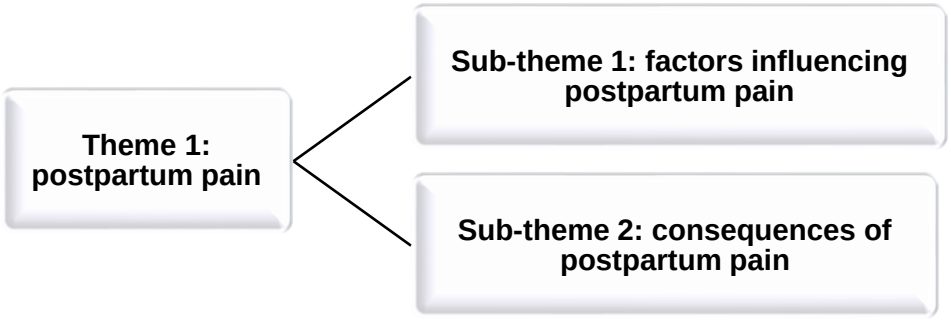


Figure 9: Overview of postpartum theme one

8.3.1 Sub-theme one: factors influencing postpartum pain

Sub-theme one, *factors influencing postpartum pain,* explores how immediately after birth, the care provided by healthcare professionals, particularly midwives, influenced participants' pain experience. After arriving home from the hospital, participants' family and culture were the major influences on their experience of pain.

Most participants were happy with their care. They described how support from midwives during the first few days in the hospital significantly contributed to their management of pain. Pain affected basic activities like walking and getting out of bed, and participants felt that the midwives were empathetic to this experience and supported them in performing activities:

> *The midwife help[ed] me. The first day, I can't [do] anything….- Kim*

> *…in the hospital…[the] midwives helped me because …I couldn't get in and out of bed - Sang*

While many participants like Kim and Sang experienced severe postpartum pain, others described mild or moderate pain. In these situations, midwife care was central in helping participants manage postpartum pain. Consider Han's example:

> *It's not that hurt. …sometimes it's a bit sore, it's hard for me to walk but the midwives they give me the Panadol so that's much helping me. - Han*

Most participants described how midwives were not only empathetic to their experience of pain but provided them with support and reassurance so that they could provide care for their newborn baby. A few participants stated that postpartum pain affected their emotions but it was minimised by the support of the midwives. Ira explained:

> *I didn't feel good…to move…because my stitches is very painful. When I go for walk, it's hurt me a lot so for that reason sometimes I crying… I need someone for help…I need to stand up again and again and it's very painful, not helpful [to care for baby]. They [the midwives] are very good … and help me a lot. They understand what the patient need. - Ira*

A few participants also described how postpartum pain generated fear and worry for them, probably because they were unprepared for it. They assumed that pain at this time was unusual and a cause for concern. Midwives provided reassurance that pain was normal in the immediate postpartum period. Heera reported:

> *I was feeling very sore …my breasts are very hard, …I became anxious and I'm feeling pain. …The midwives they were so nice to come and explain…what is happening to you. - Heera*

While most participants reported positive experiences, a few participants did not. In one case, the participant was disappointed and explained that some midwives declined to help:

> *I had tailbone pain…I was not able to move. Few midwives they helped me…move around but a few midwives they denied to help me. They said, no we're not supposed to help you …and it was very difficult… - Eva*

To recap, most participants felt that the midwives provided invaluable support in the first few days after childbirth. Participants did not know what to expect and they did not anticipate much pain after childbirth. This may be because of poor health literacy, or perhaps this topic is not often addressed in health literature. Commonly, participants described back, perineal, breast and generalised body pain; and participants described how midwives' support and

reassurance helped them care for their newborn babies. This care also extended to emotional support during the women's time in hospital. When participants transitioned to their home environment, the family took over the support role.

On returning home, many participants reported that they were surrounded by family. Some families had travelled from their birth country to support the new mother for up to 6 months. For these participants, the extended family of mothers, fathers, mothers-in-law and fathers-in-law were staying in participants' homes for this period. A few participants had extended family living close by or shared a home with relatives, as they had done before the birth. Most participants described being heavily influenced by family through cultural traditions and customs. These cultural customs centred on prevention of pain in later life. Not going outside the home, not showering and placing cotton balls/wool in ears were common instructions. Families encouraged participants to perform these activities for various time periods ranging from 30 days to 3 months. Some participants explained that performing these activities for this time period was believed to reduce the likelihood that they would suffer from general aches and pains, including headaches, as they aged. Women in this study described various customary practices related to childbirth, including many practices associated with pain and others concerned with general wellbeing. Appendix J provides a list of the practices referred to by participants during the interviews.

Some participants believed in these customs and performed the activities with no resistance. These participants discussed at length the recommendations that their family made in relation to their daily living and restrictions to their diet. They believed that these interventions would support better health for the future. A few participants also highlighted customs related to the newborn infant's general wellbeing:

> *…mainly food restrictions …because it doesn't help the digestion, …as per the custom. …I need to do the head bath, I don't know the reason, …they [family] say I have to do 15 head baths in the month. She (participant's mother) bought some Ayurveda medicines from India, they apply on my head and on my foot so that coolness will not enter my body. And that dots [on the baby] …I mean people might jinx the baby... That negative energy should not enter the baby. They [family] feel that black dot will stop that. - Vanya*

While a few participants were unaware of the rationale behind these requests, others described that the activities were to prevent them from experiencing pain in later life. In some cases, participants felt that husbands and families pressured them to conform. Sang describes this situation:

> *…my husband told me off…you know you've got to stick to it, because you get headaches later …that's what they [family] believe in. If you …go outside you have to stick cotton balls…into your ears so there's no air going in and out into your ear holes….I see the really old people in Vietnam and all that they're very strong, ...they really look after themselves, …that's why in later age they don't feel all the pain, they don't get aches and pains. - Sang*

Other participants, like Kim, decided not to follow the advice:

> *I [am] not allowed [to]…go to the shower, not allow me to wash my hair. And [they] ask me to use something to put in my ear was well… When I come home, I just wash my hair... - Kim*

A few participants viewed these cultural customs as old wives' tales that were passed from generation to generation and they did not consider this information reliable. As such, they did not act on these instructions from family. These participants had performed their own searches for information through the internet and also asked healthcare professionals, and had made an informed decision not to follow custom:

> *Everything I did, I ask the doctor first. Yeah. Everything... I don't follow any traditional thing, any …culture thing. - Chi*

> *My mum is telling me a lot but I'm not following anything [laughs]. …because I search online as well and they're saying it's just some myths. … An Indian myth. - Eva*

A few participants indicated that they had considered these cultural customs in depth and had rationalised the reasons as to why their family had conveyed these expectations. They also provided plausible reasons as to why pain would not be a future concern for them and why they chose not to follow expectations:

> *Usually, I cannot go out for after 1 month, but …I already went out. You cannot take shower for 1 month (laugh), I said, no, every day I take shower. Then whenever I go out I have to put something in my ears, I have to wear the stocking, but I didn't do it...Not really necessary [in Australia]… In Vietnam the weather is different than here. Because whenever they shower, maybe they cold, the water is cold. Some people in Vietnam don't have hot water... And some time in the house its cold… Different weather, different house. - Ly*

Some participants stated that they did not believe these customs, yet they became uncertain when family members provided them with examples of others who had not adhered to the customs and as a result now have long term pain. They believed it possible that the long term pain resulted from not abiding by the customs and started to doubt their original decisions*:*

> *…my aunty, she …said, you should do it because my cousin she gave birth…[and] she [Mai's cousin] didn't listen [to Mai's Aunty], and ….now she's feeling a lot of like joint aches, like back aches and back pains. Then [cousin said to Mai] … I don't know whether that's because I didn't listen to them or maybe it's just my [cousins'] body. So, I'm [Mai] not sure. - Mai*

Like Mai, Heera was also conflicted about the plausibility of the customs. Nonetheless, she felt that as the advice provided by her family was not harmful to her, in comparison to the alternative of not performing the customs which could result in long term pain. Heera weighted up her risk versus benefit, and felt that it was best to heed advice for fear that her family were right, and she would develop pain in later life*:*

> *I don't believe in such things, but I'm so much afraid of it because everybody says so. … When all the elders in your family, …say such things, you really become apprehensive. … I don't want to take the risk! … They say that if you have back pain during this month and then that back pain is going to sustain for life. …I was like, 40 days! I won't go out for 60 days! [laughs] That doesn't matter! I'm so afraid of it! - Heera*

Many participants conveyed that they did not believe in these customs but performed them out of fear of upsetting their family, or fear of being reprimanded by family members. As

such, they performed the cultural customs on instruction from their family and only whilst their family was present. When their family was absent, participants reported that they returned to their normal habits. These participants would masquerade adherence to these customs only in the presence of their family for fear of upsetting them. Many participants did not want to be reprimanded by their family, so they performed the customs whilst the family was present. Then ceased the activity once they were alone:

> *It's all about being warm… so they're [family] making me wear socks, they're making me wear jumpers, like scarves, beanies. …cotton buds in your ear…I didn't do that, and I got a grilling. I just say "Yes, yes, yes" so they be happy with it and then I just do my thing. …when they leave, I'm just walking around doing my thing, took the scarf off. - Mai*

Some participants, regardless of their personal beliefs, decided that they would follow customs. Many stated that they did not believe in the customs but irrespective of their thoughts, they nonetheless followed customs because they did not wish to upset their family. Some felt it disrespectful to go against their wishes. Consider the examples given by Han and Anh:

> *They [family] tell me …the wind into my [ears]... makes headache. …I do them to make them happy. …I don't know if it helps me or not… - Han*

> *…we're all used to the Western way now. … we don't really follow. Like if it wasn't for my parents, I probably wouldn't follow their tradition. I think just respect for them. - Anh*

Whilst many participants undertook the customs for various reasons, some refused to do so and explained their rationale to their family. These participants often indicated that their family were accepting of the decision and agreed that some customs were complicated to understand:

> *In India, most people just stay in bed, they have rest… otherwise in future you will have this pain. They [parents] don't force anything on me, …she [mother] knows that there are a few things that don't make any sense … it's not like they're mad at me or upset. - Tanvi*

To recap, all participants agreed that the purpose of some customs was to prevent pain in later life, and a few believed that this was true. Many participants were either unsure or felt that many customs were no longer relevant. They felt that new knowledge was more evidence based and the living conditions in Australia were different than in their home countries where the customs were likely more appropriate. While a few participants shared their beliefs with their family and this was accepted, many felt uneasy and instead kept their thoughts to themselves. Because of respect for the family, some participants performed the customs, but only whilst family members were present.

In summary, this sub-theme*, factors influencing postpartum pain,* considered the factors that influenced the experience of pain in the postpartum period. In the immediate period after birth, participants focused on alleviating pain that resulted from the birth. Whilst in hospital, participants generally felt that the care that they received from the midwives was the most influential factor in helping them manage their pain. When participants returned home and as they recovered, most participants changed their focus from relieving postpartum pain to preventing pain as they aged. They explained that family views and traditional customs

featured strongly in this prevention. Whilst most participants looked towards the future, they continued to experience pain during this time and often spoke about how pain influenced their daily lives.

8.3.2 Sub-theme two: consequences of postpartum pain

As highlighted earlier in this chapter, participants were surprised to have pain in the immediate post-birth period, and they were equally unprepared for pain that was ongoing after discharge from hospital. In sub-theme two, *consequences of postpartum pain,* the influence of pain on participants' experiences is explored, both in hospital and after returning home. In these discussions, back and perineal pain were highlighted as influencing their activities of daily life and care of their newborn baby. For a few participants, pain also influenced general wellbeing including mood and relationships. Living with pain during this time was noticeably more challenging for some than others. Some participants briefly mentioned their experiences of postpartum pain and appeared to be accepting and unperturbed:

> *Only the back pain still I'm having – Neha*

Others were accepting, but also uncertain as to the rationale. In some cases, they considered that having had an epidural was possibly linked to ongoing back pain. Participants clearly described pain similar to contraction pain or muscular spasm, and as highlighted in Chapter two, uterine pain is often referred to the back. It is likely that because of their lack of understanding of postpartum physiology, the source of their pain was unknown to them and they attributed the pain to the most obvious cause. Consider Heera's experience:

Back pain, if I do more work [general house work]. … I don't know why. Because of epidural or I don't know why…. Sometimes it's OK, sometimes it's a lot. Like we have periods, that kind of pains. …- Heera

Some participants articulated the aggravating factors:

I have back pain a lot because he crying a lot I need to sit more time and when I'm feeling a little bit cold it's pain a lot. When I change his diaper [nappy] and I stand at that time I feel painful and when I change my clothes going up and down, go upstairs, … time I feel pain.- Ira

Many participants explained how the pain affected activities of daily living:

I suffer a lot of pain and after caesarean because of back spinal injection and I can't able to sit properly …and even legs pain and stitches pain…- Meera

Some participants highlighted how the pain affected their ability to care for their infant, but at the same time they gave the impression that they were managing the pain well and also that the pain did not affect their general wellbeing. Jara explained:

Now [3 weeks postpartum]…I'm having some back pain. …I'm using heat packs. And when it's worse, I use Panadol [paracetamol analgesic] …When I'm sitting for a long time because I'm feeding my baby …And because I got stitches …that really hurts. …Because of that I can't hold my baby for a long time. - Jara

Like Jara, other participants highlighted the effects of perineal pain and while most participants seemed unconcerned, a few appeared worried. Sang, for example, experienced

ongoing perineal pain and was concerned enough to seek advice from family and friends. This advice did not alleviate her concerns:

> *I still feel it [3 weeks postpartum], I can't sit properly still… I asked around and they [family and friends] said that …normally [it] heal[s]…within 2, 3, weeks, [and] not as much pain. But when I walk…it hurts. - Sang*

Although unexpected, many participants accepted pain as part and parcel of recovery from birth. For a few participants however, the effects of pain were far reaching. These participants described emotional responses such as feeling sad, and some also felt that pain influenced their ability to bond with their baby. These feelings developed at varying times later. For some, they occurred within a few days of the baby's birth and for others they occurred weeks after birth. Most participants experienced these feelings for a short period of time only.

Participants described feeling sad in the hospital because they felt lonely and were experiencing pain. They explained feeling that there was no one to help and that they missed the support of their loved ones. Both Ira and Zoya indicated this in their discussions:

> *I feel very sad during my pain …and I crying a lot …when my husband [goes] home, … I'm alone in room… - Ira*

> *That was the horrible part. At night time, the hospital didn't [allow] anyone to stay with me. … I was crying at that time, I was feeling so much pain. - Zoya*

For Ira and Zoya, their sadness was fleeting, and they only felt this way whilst in hospital, away from their loved ones. For these participants, pain coupled with loneliness and the lack of support resulted in lowered mood.

A few participants felt that pain was continuing to influence their mood a few weeks after the birth, even though they were home and surrounded by family. Eva described feeling overwhelmed by pain, particularly perineal pain. Eva's experience was complicated by her recall of labour pain, as below:

> *I was having …problems with my stitches in the first 2 weeks, with the pain. …So, these things made me a little bit low in first 2 weeks… [it] was very, very horrible because of all the things came at same time. The stitches pain, my back pain, feeding problems, everything. And then I was still thinking of the labour pains often. All these things did affect a little bit. - Eva*

Another participant described how ongoing pain negatively influenced her mood and reduced her ability to care for her baby. Sang described feeling emotionally distant from her baby and physically withdrawn, because much of the care was provided by her mother. Pain appeared to be a significant contributor to Sang's low mood:

> *When I got home, I couldn't even get in and out of bed. I couldn't even like sit up properly … and I bottle fed him formula. Now Mum helps with feeding and bathing, changing nappies and all. It got …depressed sometimes too. I feel like…I'm not really…I think [it] is the pain. …I'm not spending much time with him, I'm just in my room and he's here with Mum. I would like to hold him more, [but] if I stand up too long it feels really painful. …But … I still can't sit properly on the bed. That's why I don't carry him much. Even feeding, like I couldn't... I tried stand and feed him, and then I have to give him back to Mum so I can lay down. - Sang*

A few participants described that pain positively influenced their relationships with their husbands. Tanvi explained that because of her bravery in enduring the pain, her husband had a new-found respect for her, and she felt more admired:

> *He [husband] was amazed.... I could see it on his face…he just says thanks to me…I'll always appreciate it, he just told me, you're a super mum. ... I don't know how you did it, but you did it. - Tanvi*

In summary, theme one, *postpartum pain*, explored the experience of pain that participants unexpectedly faced in the postpartum. The first sub-theme, *factors influencing postpartum pain*, provided an overview of the factors that participants consistently highlighted as influencing their experience of pain. In the hospital, support from midwives in helping manage pain was valued, whilst family and culture were influential when the participants returned home. Sub-theme two, *consequences of postpartum pain*, explored the effect of pain on participants' wellbeing in the immediate postpartum period. For most participants, pain influenced their ability to perform normal activities and to care for their newborn baby. Whilst many participants felt unperturbed by this situation, some felt that pain was a significant contributor to their low mood. One participant felt that postpartum pain negatively influenced bonding with her baby. For some participants, postpartum pain featured significantly in their transition to motherhood. Alternatively, and on reflection, a few participants described that their relationship with their husband was stronger after birth as a result of their pain. Figure 10 (p. 216) provides an overview of theme one.

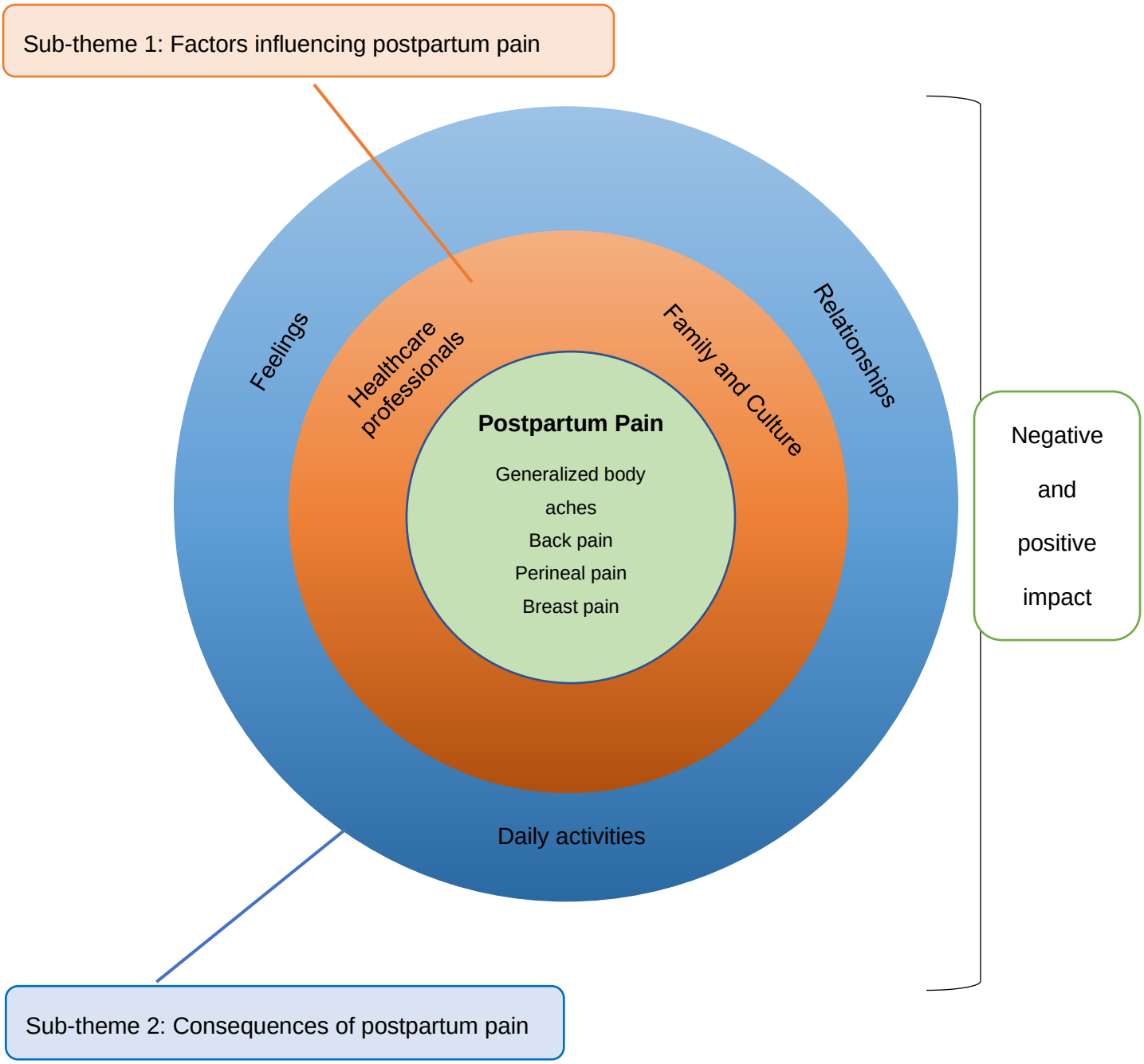


Figure 10: Postpartum pain - influences and consequences of postpartum pain

8.4 Theme two: reflections on childbirth pain

In the weeks after childbirth, participants were able to reflect on their pain experiences. This reflection generated a mixture of emotions. Theme two, *reflections on childbirth pain*, explores the thoughts and feelings of participants, at 2 to 8 weeks after birth. For all participants, pain was either a fading memory or an unforgettable memory. Sub-theme one, *a fading memory*, explores how some participants forgot the severity of pain and viewed their pain experience with rosy retrospection; often declaring their experience was surreal. Theme two, *an unforgettable memory*, explores how participants who were unable to forget the severity of labour pain either felt proud of their achievements, or anguished, or regretful but optimistic. Figure 11 provides an overview of theme two and associated sub-themes.

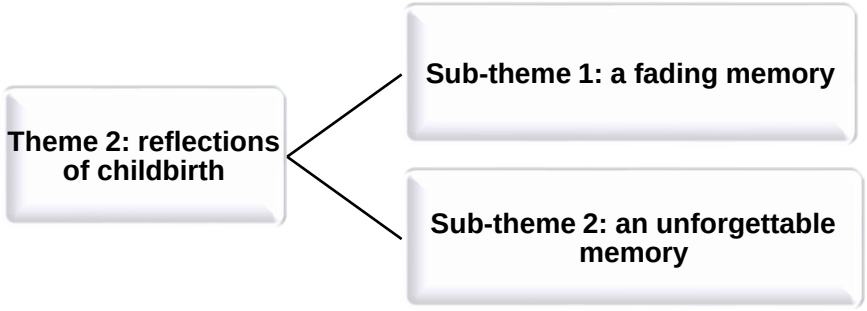


Figure 11: Overview of postpartum theme two

8.4.1 Sub-theme one: a fading memory

Sub-theme one, *a fading memory*, explained how for many participants the pain associated with labour and birth was forgotten the moment they held their baby, and for many weeks after birth they continued to feel this joy. The joy and happiness that they felt overshadowed the pain, and thoughts about pain dissolved into the background. They viewed their labour and birth with rosy retrospection. This was described by Mai, Ira and Vanya:

... [I] look at her …and [I] just don't think about the pain. - Mai

When I saw my baby [at birth], I feel very, very happy…. [Now] I feel very happy when I hold him. He just smiles [and] I forget everything, every pain. - Ira

...after seeing the baby [I] forget all the pain…[Now] Not even for a minute I remember that pain... - Vanya

A few participants described feeling so caught up and busy with their baby that they did not think about the pain anymore. Pain was a feeling associated with past events and they were distracted by the present:

Now, I just forget. I forget about this. I think just because I got my baby. So, I [have] something to do now. So, I forget it. - Kim

On reflection, many participants downplayed or minimised the pain experience. When they discussed their thoughts of labour pain at the time of labour, these thoughts centred on “no more children”. They were adamant then that they never wanted to experience such pain again. On reflection, many participants had changed their views and they definitely wished for more children. Leela provided this example:

I think .... now [more babies]. During pain is no baby. No baby anymore. - Leela

It is possible that when participants reflected on their pain experience, they rekindled emotions related to pain that were now less intense. During labour, they were present in their pain experience which was very intense, later, on reflection, the pain they experienced seemed surreal. With passing time, the pain experience evoked less unpleasant thoughts and thus pain was now a dreamlike memory:

> *I was thinking [during labour], I'm not going for second one [child] and now it's okay, I'll go [for] a second... Pain is okay. …it's for a day we are feeling pain, that's fine. …Even when I [am] trying to recall that pain, I can't imagine that kind of pain now. …it feels like a dream…it doesn't like it feels like an actual moment that happened to me. …like a bad dream. - Zoya*

To recap, sub-theme one, *a fading memory*, revealed how, weeks after birth, most participants reflected on and viewed their labour and birth pain experience with less intensity than they had during labour. At this stage, reconsidering their pain experience did not evoke unpleasant feelings. They viewed their pain with rosy retrospection, or they thought their pain less severe now that it had passed. Some were distracted by current events and did not spend time considering their labour pain. A few participants indicated that labour and birth pain was now surreal to them, much like it did not occur. However, for some participants their pain experience of labour and birth had not faded.

8.4.2 Sub-theme two: an unforgettable memory

Some participants were unable to forget the pain that they experienced during labour and birth. Sub-theme two, *an unforgettable memory*, discusses this phenomenon and explores how participants experienced different emotions related to their pain. A few participants felt proud in retrospect, while others anguished over the experience. Many participants accepted accountability for their pain experience and viewed pain as a product of their choices. These participants were regretful of their pain management choices but nonetheless were hopeful for future pregnancies. In contrast, some other participants remembered the intensity of labour and birth pain but nonetheless identified feeling proud. They viewed labour and birth

as a major challenge that they had successfully navigated. This feeling of achievement gave rise to pride:

> *I feel so proud of me.- Vanya*

Some of these participants provided specific details for the reasons they were proud. One source of pride was the decision not to choose pharmacological pain management during labour. Participants who made this choice were not opposed to the use of pharmacological options for labour *per se* and often had considered back-up options if they were unable to bear the pain. Nonetheless, the fact that these participants were able to manage pain without the use of pharmacological options generated a feeling of pride:

> *I feel so proud actually, …I'm so happy that I have done this thing and I didn't take any painkillers. - Tanvi*

For a few participants, managing pain without pharmacological support against the expectations of friends and family was also pleasing. Consider this statement from Sang:

> *…I'm proud I didn't ask for epidural because everybody is like; look at you, I think you'll be asking for it [epidural]. Trust me the pain is really bad, but I didn't [have an epidural] so I'm proud of myself. - Sang*

A few participants also viewed the pain as a symbol of their strength. After having managed the pain they had a newfound confidence. They believed that they were able to manage anything after being able to manage labour pain. For these participants, pain provoked a sense of pride and represented their strength and resilience in challenging conditions:

> *I didn't know that I was that strong that I can take it. Because I never had that kind of thing ever in my life before that I have to feel the pain... It just made me strong and more confident that I'm not that weak. I have that confidence in me now that I can do anything. If I can give birth to a child and have that much pain, I can do anything. - Tanvi*

For a few other participants, reflecting on labour and birth pain generated distress weeks after birth, and these participants felt that they did not want to experience labour and birth again, and thus did not want further children:

> *I'm just thinking she is my first baby… she is enough for me. No more! Because of that pain …and stitches…[the] back pain, [and] sitting problems. - Meera*

These participants probably felt that the pain was too severe and their pain experiences too traumatising. One participant, Qui, felt more scared now after the birth and would not consider another child because she was so fearful. Qui described feeling overwhelmed by the pain and viewed her labour as a time of torment:

> *…When it's such long hours of suffering with the painful [contractions], almost I given up. …I couldn't tolerate anymore. And I just think, no more baby. Just one enough for me. I still think like that. Still scared. - Qui*

Mostly, participants who did not forget about the pain indicated some regret regarding the decisions they made during labour to reduce the pain. They viewed their pain as severe and they were reluctant to experience this severe pain again. They thought that their experience would have been less traumatic if they had chosen alternative options to help relieve the pain. A few participants who had an epidural to help manage labour pain felt, on reflection,

that they should have requested the epidural earlier. These participants viewed pain as a negative influence on their experience and felt that they suffered unnecessarily. Consider this statement by Neha:

> *… I should have [had the] epidural…initially. Because why you want to feel the pain? The artificial pain (from induction) is very unbearable. - Neha*

A few participants stated plainly which pain relief techniques had not worked for them, but they did not appear to dwell on this. They were quick to declare that they would consider alternative options for their next child. Often these participants viewed the pain as an obstruction that inhibited them from experiencing birth in the way they wished. In a previous example, Anh explained that pain negatively influenced her ability to make initial connections with her newborn and on reflection she felt that she would choose alternative means to manage labour pain for a future birth:

> *I don't think I'll go natural again. …because it was very painful. …To me, I think it took it away [from the experience] because …I couldn't concentrate on anything else, I'll probably go drugs next time. - Anh*

These participants all wished they had made alternative choices during labour to help manage the pain, because they felt that the pain had a negative influence on their experiences. Nonetheless, instead of dwelling on their regret, they focused on the choices that they would make for future births.

Regardless of what participants thought about labour and birth, many were reluctant to share their thoughts with friends who had not yet had children. They were fearful that their stories would scare their friends:

I don't want to share it with anyone because …it's very painful. …It's dependent on person's body and pain and time. Some people feel no… pain, …and baby came out it's normal, but I take nearly 2 and half days, then caesarean... When I told to someone…I think it's change people's minds, so I don't want to share this.- Ira

Some even considered that their next experience would not be as painful as the previous one:

...if [I had] another baby, my body a little bit different so, maybe easier. - Ly

Other participants glossed over the details of birth when sharing their experience with family and friends, but also emphasised the importance of adequate pain management to ensure a positive experience:

…my friends who are pregnant now, I don't scare them. I say it's a very nice experience, …but just have the epidural at first! [laughs] ... Don't wait for long. - Neha

Many participants indicated that it was very challenging to prepare for childbirth and understand the experience in advance. It was very difficult to explain to someone who has never experienced childbirth:

…even if people tell you, going through it is entirely different …What happens at that moment it is beyond words. I don't think anybody can explain that to you…. You can never ever imagine it…. You can never be prepared unless you go through that by yourself. - Heera

To recap, sub-theme two explored how some participants felt that their pain was a *unforgettable memory* and that they were either proud or distressed, or regretful but optimistic, when they reflected on their labour and birth. A few participants viewed their pain as an accomplishment and felt proud of their ability to manage labour and birth pain. Just as many were haunted by their pain experience and were left feeling anguished. Because of pain, they were fearful and often unwilling to consider a future child. Most participants perceived their pain as a controllable feature of labour, and they accepted accountability of their experience. This included feeling regrets about some of the choices they made; nonetheless, they did not feel ongoing distress from their experience. Instead they focused how they would better manage pain for future pregnancies. Figure 12 provides an overview of theme two.

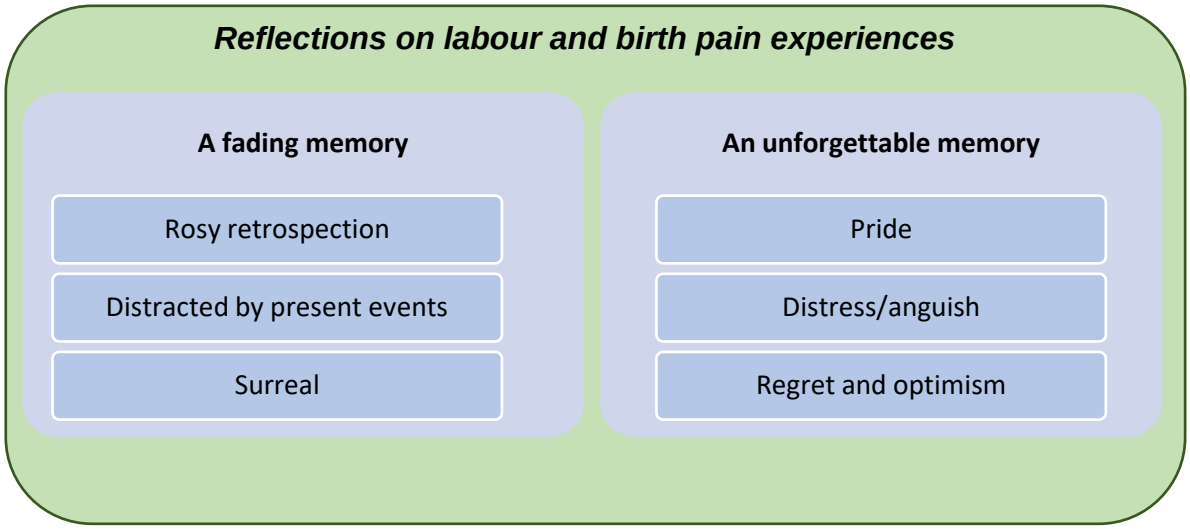


Figure 12: Reflections of childbirth

8.5 Summary

In chapter eight, participants' experience of pain in the weeks after birth has been explored, including the experience of postpartum pain, and participants' reflections on labour and birth pain. Theme one, *postpartum pain*, started by exploring the pain that participants unexpectedly faced after birth. Subsequently, factors that influenced experiences of pain in the hospital and at home after discharge were considered. Immediately after birth, participants' experiences of pain were most affected by the care provided by healthcare professionals, whilst on arriving home they were most influenced by family and culture. This theme also explored the consequences of labour and birth pain. For many participants, postpartum pain inhibited their ability to attend to daily activities and care of their newborn babies to varying degrees. For a few participants, this had more lasting and detrimental effects on their wellbeing. Theme two, *reflections on childbirth*, explored how participants reflected on their labour and birth pain after many weeks had passed. For some, the experience of pain was a fading memory and they reflected with rosy retrospection, being distracted from past pain by present events, or they viewed their pain experience as surreal. Those who identified their experience of pain as an unforgettable memory either felt proud, or distressed, or regretful but optimistic. When reflecting on their labour and birth, all participants implied that their pain influenced their transition to motherhood and they viewed their experience of pain as an intensely unique and transformational life experience.

Chapter Nine: Discussion

9.1 Introduction

Childbirth is a significant moment in a woman's life. For most women, it is an experience that develops into a major life story. That story is retold again and again, or for some, relived long after the event has passed. Women's birth stories are passed on over many generations and in this way become a part of the fabric of society. Nonetheless, experiences related to childbirth are unique and meaningful to the individual. Stories often portray childbirth as painful, perhaps more painful than any event ever before experienced. For first-time mothers, unfamiliar with the experience of childbirth pain, this cultural inheritance creates expectation and apprehension. Thus, for these social and emotional reasons, most women wish to be supported by family during pregnancy, birth and the postpartum. Support from family members has long been recognised for its benefits in helping pregnant women prepare for labour and to manage labour pain. Nonetheless, not all women have such a supportive environment, and migration, work commitments and contemporary life may impact on the numbers of women living far from family during pregnancy, birth and the postpartum.

This study has explored the experience of pain during pregnancy, birth, and the postpartum from the perspective of Indian and Vietnamese immigrant women living in Australia. Using an IPA methodology, which offers an in-depth exploration, this study has provided new insight and better understanding of the phenomenon of childbirth related pain. In this chapter, the findings from the study are discussed and insights are considered. The chapter starts with a review of the research aims, followed by discussion of the principal findings. The principal findings are presented as two key discussions: a culture in transition and

universal experiences. These findings are interwoven throughout the participants' experiences.

9.2 Research aims

This study aimed to explore the experiences of pain during pregnancy, birth and the postpartum for women living in Australia, whose cultural background was from India or Vietnam, and who presented for childbirth care at a large Melbourne metropolitan hospital.

9.3 Principal findings

This study identified two key findings that shaped participants' preparation during pregnancy, and their experiences of pain during labour and the postpartum. First and foremost, cultural factors had variable influences throughout the journey. In this section, labelled *a culture in transition,* the ways participants demonstrated changing cultural ideas about childbirth pain are described. Culture influenced participants' experiences during the complete experience of childbirth, from the ways in which they sought information to help them adapt to their new environments, to expressing pain during labour and managing pain after birth. In the second key finding, *universal experiences,* it is seen how women regardless of ethnicity and culture are united by childbirth pain related experiences.

9.4 A culture in transition

Culture had an unanticipated influence on participants' experiences of pain in this study. However, experiences discussed by participants were not related to their individual ethnic backgrounds, either Indian or Vietnamese. Indeed, similarity of experience rather than difference was demonstrated in both groups. Participants experienced a collective journey in which both Indian- and Vietnamese-born participants living in Australia departed from

childbirth pain traditions and moved towards a new way of understanding pain in childbirth. This fusion of traditions and changed approaches gave rise to new and dynamic experiences and indicated that women in this study were experiencing a transitioning culture. This suggests that the participants in this study were in the process of acculturation (see chapter two for definition). Although there are many definitions of it, acculturation is universally recognised as a process of cultural change that occurs as a result of the combination of two or more cultures (Berry et al., 2002). Research indicates that acculturation occurs when an individual or group immigrate from one country to another and subsequently adopt attitudes and practices of the new culture whilst also retaining attitudes and practices from their culture of origin (Schluter, Tautolo, & Paterson, 2011). Schluter et al. (2011) explain acculturation as a process that starts from *contact* between two cultures, usually the individual's culture of origin and the culture that they are adopting. After contact, *conflict* can arise between the cultures and eventually *adaptations* occur that result in harmonised convergence between the two cultures (Smokowski, Bacallao, & Evans, 2017). Whilst this is a simple explanation, the process of acculturation remains complex. Acculturation is a complex dynamic social ecosystem and the discourse regarding associated theories continues, particularly related to the adaptations stage. In this study, although collectively all participants were experiencing cultural transition related to experiences of pain, their individual experiences also indicated that they were at different stages of acculturation. This is not unusual, as Ward and Geeraert (2016) emphasised, because the process of acculturation occurs at different rates for different individuals and is dependent on a complex interplay of interpersonal, familial and societal factors. Findings from this study suggest that while their time in Australia may have varied from 6 months to 28 years, participants were mostly at the conflict stage. It cannot be assumed, therefore, that the acculturation of a women will reflect the length of time she has been living in Australia. The process of

acculturation as experienced by Indian and Vietnamese participants in the context of childbirth pain is described and discussed hereunder.

9.4.1 The experience of pain through a cultural lens

In this study, one of the most evident demonstrations of acculturation related to accessing information about birth pain. Participants all acknowledged the traditional views of female family members as the guardians of information about birth pain in both cultures. Males were generally excluded from this process. Participants also described in varying degrees the ways in which family members influenced their access to such information and how this possibly limited their preparation for labour and birth pain.

Some participants felt constrained when searching for information, nonetheless they gracefully accepted that information gathering was regulated by family and culture. In such cases, information from healthcare staff was accepted and valued but not necessarily sought, because the women considered information from families to be sufficient. These participants viewed information from outside the family as unnecessary and often declared that "...*in our culture we are not that much open with everyone. We can't talk all these things"* (p. 149). This finding, from a small group (n=3) of participants, is consistent with literature which indicates that the families of pregnant women feature as a key source of information during pregnancy (Edmonds, Cwiertniewicz, & Stoll, 2015). Further support is given by Yelland et al. (2013), who explored the experience of Afghan refugee families having a baby in Melbourne, Australia. These authors highlighted that women giving birth in a new country were more likely to access information from family members than healthcare professionals, and this was possibly related to cultural expectations, challenges with health literacy and language proficiency (Yelland et al., 2013). Likewise, other research indicates that

challenges to prenatal preparation are related to cultural influence. Higginbottom, Vallianatos, Shankar, Safipour, and Davey (2018) and Mohammed and Kandeel (2017), for example, found that women from CALD backgrounds were influenced by cultural factors in their acceptance of general prenatal information and nutritional advice. Such authors highlighted how culture shaped women's beliefs about general health practices, such as the food to eat and herbal formulations that would reduce swelling and pain. Overall, these authors suggested that culture influenced a woman's acceptance of information from others outside the family or ethnic background, and this was also true for a small number of participants in this study.

This was not however, a general experience. Indeed, in this study, most participants, while acknowledging that information gathering was challenging because of family and cultural influences, departed from tradition and explored the unfamiliar environment of information sharing. Cultural customs in India and Vietnam have been reported to discourage the sharing of pregnancy related information, especially between males and females, and outside of the immediate family (Amrita & Roy, 2018; Greenhalgh al., 2015; Raman, Nicholls, Ritchie, Razee, & Shafiee, 2016). While participants in this study made comments in accordance with these cultural customs, most also behaved contrary to expectations and partook in the sharing of information with male family members, indicating aspects of acculturation. Information seeking and avoiding has been previously linked to coping mechanisms. Miller (1989) describes two inherent coping styles, monitoring and blunting, that are commonly used by individuals to adapt to stressful situations. Monitoring refers to information seeking behaviour and blunting describes various techniques that individuals employ to support avoidance behaviour. It is possible that due to reduced family influence, women in this study resorted to their personal coping style.

Interestingly, when participants went against cultural conventions and shared information with others, it seemed to have a ripple effect on family and friends in Australia and in their country of birth. Women in this study were pleasantly surprised when their family and friends supported and encouraged their information sharing and related activities. In some circumstances they explained how they felt that their husbands were more involved in their pregnancy and birth because of their engagement in pregnancy related information. Participants also described a far-reaching effect, because it influenced families living in their birth country, causing them also to review their practices. Participants' motives for information sharing included a keen interest in searching, understanding and sharing evidence-based practices related to pregnancy preparation. This interest was likely fuelled by a lack of female family members nearby, who traditionally would have provided this information. These factors influenced participants to seek and share information in unaccustomed ways, including with male relatives and friends and in online forums.

With a more relaxed approach to communication and information sharing in Australia, women from Indian and Vietnamese backgrounds living in Australia have greater access to pain related information than what may be usual in their country of birth. Research in other fields, not specific to pain or childbirth, has provided other such examples. A South Australian study, for example, explored how Indian and Vietnamese immigrants shared general information during their settlement and found that individuals were more open to information sharing in their new land (Khoir, Du, & Koronios, 2015). Moreover, the authors attributed this new practice of information sharing to the individual's ability to sympathise with other newcomers in similar situations, which resulted in them becoming more willing to share information. It is very possible that similar reasons for greater information sharing are also relevant in this study. Much like this study, Khoir et al. (2015) also suggested that the changing practices related to information sharing signified a transitioning culture

(acculturation). The open style of communication and information sharing seen in this study, related to pain information, was unexpected and is a new finding among pregnant women from India and Vietnam living in Australia.

Another change from Indian and Vietnamese tradition that was reported by participants related to the psychosocial support they received during labour pain. Surprisingly, many husbands provided support and reassurance during labour, which is contrary to cultural norms for both cultural groups. Most participants had planned for female family members from overseas to provide labour support and did not expect their partner to be present, because of cultural taboos. Many participants believed that this long-standing tradition arose from concerns that men might not want more children if they saw their wives in pain, or if they themselves were traumatised the birth. Nonetheless, most husbands ignored tradition and remained present during the birth.

Whilst the husband's presence was unexpected for women in this study, it was viewed very positively. The findings from this study suggests that women from Indian and Vietnamese backgrounds, like others living in Australia, sometimes have the opportunity to benefit from psychosocial support from husbands during labour and this results in a more satisfying experience of childbirth pain. This is consistent with literature that indicates that inadequate social support during labour contributes to negative feelings of isolation, abandonment, lower control over pain and low childbirth satisfaction (Mukamurigo, Dencker, Ntaganira, & Berg, 2017; Sapkota, Kobayashi, Kakehashi, Baral, & Yoshida, 2012; Stankovic, 2017; Vehviläinen-Julkunen & Emelonye, 2014). The best person to provide social support to a woman during labour remains the subject of much debate. For example Boryri, Noori, Teimouri, and Yaghobinia (2016) undertook an Iranian study exploring women's social supports during labour and found that for some women, husbands provided the most

important support during labour while for others, a healthcare professional was the best person to help manage pain. Nonetheless, more specific research exploring spousal support during labour from the perspective of women from CALD backgrounds substantiates the view that spousal support during labour is unusual but welcome. For example, Owens et al. (2016) conducted a phenomenological study into the childbirth experiences of new immigrants including Indonesian, Pakistani, Vietnamese, Iranian, Sudanese and Thai women living in Australia. Women reported a similar experience to participants in this study, where their husband's unexpected presence at the birth gave rise to a positive childbirth experience.

Another new development highlighted by this study was related to labour pain expression. Anecdotally, women's expression of pain during labour has been linked to their cultural background. Participants in this study, from both Indian and Vietnamese backgrounds, nonetheless believed their expression of pain during labour was linked to their personalities and personal attributes rather than culture. Some viewed screaming as an expression of the severity of pain and were surprised to understand that screaming helped manage pain. This perspective brings new insight into the expression of pain from this group of women that is in contrast to current opinion. Literature suggests that there are cultural differences related to the expression of pain between Indian and Vietnamese women. For example, Indian women are considered to be more vocal and to cry out more during labour than Vietnamese women (Callister, 2003; Callister et al., 2003; English, 2009; Weber, 1996; Withers, Kharazmi, & Lim, 2018). Vietnamese women are considered to be more stoic in their expression of labour pain (McLachlan & Waldenström, 2005). Many healthcare professionals, likewise, are of the opinion that expressions of pain in CALD women is culturally influenced. Clearly, cultural sanctions can influence the expression of pain, however in this study women themselves had different perspectives. This finding suggests

that Indian- and Vietnamese-born women living in Australia express labour pain in a way that best suits their nature and needs. It is probable that this perspective is further evidence of a changing culture, and to date it is unacknowledged by other literature and the broader healthcare community.

Another new insight from this study highlighted this transitioning culture and suggested that in the postpartum period, women from Indian and Vietnamese backgrounds focused more on their own specific needs than on cultural expectations. Rather than following tradition blindly, participants made decisions whether, or to what extent, to follow expected customs after birth. Although they acknowledged traditional customs, many viewed them as myths or practices that were irrelevant in their present context and environment. For example, postpartum seclusion was a common postpartum cultural custom for Indian- and Vietnamese-born women. Women were discouraged from venturing outside for between 7 and 40 days after giving birth. The participants explained that these customs existed because of the belief that cold air and outside elements may negatively impact health in later life, causing headaches and joint pains. Additionally, there were other non-pain related reasons offered by participants. Although postpartum seclusion was encouraged by participants' families, the extent to which participants practiced it varied. This again suggests the blending of traditional customs and contemporary practices.

Some women remained indoors except when attending healthcare appointments or visiting friends. While postpartum seclusion is not customary to Australia, it is commonly practiced in other countries around the world, for example in Nepal (Sharma, van Teijlingen, Hundley, Angell, & Simkhada, 2016). A review of literature found that postpartum seclusion was also practiced in China, Malaysia, Myanmar, Singapore and Thailand (Withers et al., 2018). In China, for example, in the postpartum, women are encouraged to practice what is commonly

referred to as “doing the month” to encourage the “loose” bones to return to their correct position and prevent pain in later life (Dennis et al., 2007, p. 488). Dennis et al. (2007) emphasised that management of postpartum pain in the community is often related to anecdotal opinion and cultural influences.

Most participants in this study described feeling compelled, in varying degrees, to conform to postpartum practices. Nonetheless, some opted not to practice any traditional customs because they viewed the customs as irrelevant in their current living environment, while other participants, although unsure of the legitimacy of customs, followed them because of family pressure or respect for culture and family. Many participants made choices about which cultural customs were important for them. They were particular about which pain relief customs to adopt and often sourced additional evidence-based information via the internet or a healthcare professional to help them make informed choices. Although several literature searches were conducted, no recent Australian literature was found that explored the changing choices of women from CALD backgrounds in regard to postpartum pain customs, specifically the relinquishing of cultural customs, completely or partially, and whether this influenced women’s postpartum pain experience.

The literature located was not specific to postpartum pain but covered other topics related to postpartum cultural practices. For example, Melov and Hitos (2018) considered the medical complications associated with the postpartum cultural practice of “lying-in”, otherwise known as confinement or postpartum rest, and found that 85% of Indian and Chinese women living in Australia practiced the custom of “lying-in”, which was different to the current study where most participants had varying levels of commitment to postpartum cultural practices. In contrast, and more consistent with the findings from this study, other Australian studies showed how new mothers from CALD backgrounds adapted to their new

environment. In a metasynthesis of research about newly settled immigrant women's breastfeeding practices, Joseph, Brodribb, and Liamputtong (2019) highlighted that women merged contemporary Australian breastfeeding practices with tradition beliefs in order to best "fit in" with their new life. This suggests that the women in their study, similar to the participants in this study, were negotiating between tradition and contemporary social influences to best navigate their new experiences. This again demonstrated a culture in transition.

To recap, it is likely that living in Australia influenced Indian- and Vietnamese-born women's adherence to traditions. Departing from tradition also strengthened the notion that participants in this study, to varying degrees, were making decisions to meet their personal needs instead of relying solely on cultural recommendations. This suggests that participants were at various points in the process of acculturation and adaptation to their new cultural environment. Acculturation was an experience that was uniquely linked to an individual's adjustment to their current environment and life experiences. For Indian- and Vietnamese-born participants in this study, acculturation was complex, and participants often sought pain related information from less traditional sources.

9.4.2 The search for pain related information and cultural change

To help negotiate traditional practices related to birth pain, and contemporary life, participants sought information. However, the development of understanding of any subject matter, including birth pain, can be influenced by an individual's ability to access and then understand health related information. In the following section, the challenges specifically related to expectations, health literacy and emotional responses that participants encountered when accessing and understanding pain related information are discussed.

Expectations

Participants mostly prepared only for a normal childbirth and events not related to normal childbirth were not even considered. They expected labour to be painful, but they were alarmed if they experienced unexpected pain, such as during additional labour interventions. Consequently, such experiences influenced their overall satisfaction with childbirth pain. Participants were unaware of and unprepared for common painful childbirth procedures including intravenous cannula insertion, internal examinations, induction of labour, insertion of pessaries and artificial rupture of membranes.

As an example, consider labour induction. Many participants in this study were surprised at the severity of pain in induction, and some participants recalled induction of labour as more distressing than the labour itself. They believed their experience of labour pain was worse because they were induced, and this is a common belief among women and midwives. Although there is no consensus on this point, a recent study reported that there was no statistical difference in experiences of labour pain between women whose labour was induced or not induced. Nonetheless, in that study women who were induced chose epidural analgesia earlier than women in natural labour (König-Bachmann, Schwarz, & Zenzmaier, 2017). Overall, it is acknowledged in research that women are generally not well informed about labour induction by health care professionals (Jay, Thomas, & Brooks, 2018; König-Bachmann et al., 2017). Therefore, it is likely that women in this current study were also not well informed, and thus did not consider induction to be painful.

Another example occurred in the postpartum period, because participants did not expect to have postpartum pain. During pregnancy, participants focused on seeking information in preparation for labour pain and were likely not well informed about postpartum pain. It is

also plausible that they did not seek information because they just never considered postpartum pain as an issue. This is consistent with literature from the United States of America where Verbiest, Tully, Simpson, and Stuebe (2018) explored the lived experience of postpartum women. Although not specifically related to pain, Verbiest et al. (2018) ascertained that in the first 12 weeks after birth most women were unprepared, in general, for their experiences and considered the lack of information around the postpartum experience a significant contributing factor (Verbiest et al., 2018). It is possible that a similar situation occurred for participants in this study, as they too were surprised to experience pain in the postpartum. In addition to the lack of information influencing their postpartum experience of pain, it is likely that their understanding of this event was also influenced by limited health literacy.

Health literacy

Participants in this study were enthusiastic about seeking information to help prepare them for labour pain, but they were often unsure about where to source information. Uncertainty was probably a consequence of participants' aptitude for gathering information and this appeared also to be related to levels of health literacy. Participants had various levels of education from secondary school to university education, and information processing appeared to be related to individual education levels, where women with the highest education level had the most advanced information searches. Similarity, but not specific to pain, in other broader childbirth literature health literacy has been shown to influence the sourcing of information, and poor health literacy has been suggested as a reason why women from CALD backgrounds have low access to information during pregnancy (Peláez, Hendricks, Merry, & Gagnon, 2017; Riggs et al., 2017). Other authors suggest that because of limited health literacy, women from CALD backgrounds may be less able to seek

information from the internet compared with those with higher health literacy (Grimes, Forster, & Newton, 2014; Hughson et al., 2018; Shieh, Mays, McDaniel, & Yu, 2009). Thus, women in this study who had greater challenges with health literacy had more difficulty accessing information.

One point of difference in this study was that participants used internet searches to help formulate questions before discussions with healthcare professionals. There are many possible explanations for this approach including embarrassment, not knowing, and simply not knowing what information would help them prepare for birth pain. Limited health literacy may have also contributed, and participants may have sought basic information regarding labour pain and pain relief so that they felt equipped to generate a discussion with healthcare professionals. In this way, internet searches helped prepare participants for meetings with healthcare professionals, rather than simply making sense of information received. This was also recognised by Ramsay, Peters, Corsini, and Eckert (2017) but they also suggested that it was more common for individuals to use internet resources to extend research information given by medical professionals. Other authors have considered why women choose to seek information from the internet rather than from healthcare professionals (Berggren, Bergström, & Edberg, 2006; McLeish, 2005; Sayakhot & Carolan-Olah, 2016). These authors explained that women seek early internet information because they lack the confidence to discuss their worries with healthcare professionals. This might be relevant for women in this study as well. In the initial stages of pregnancy, most participants felt poorly prepared for birth pain and had limited family support, thus it is likely that the internet provided them with some information to better understand the expectations of labour pain.

Challenges related to health literacy also occurred in the postpartum. Participants tried to make sense of their postpartum pain and often attributed pain to other related events. For

example, back pain was frequently attributed to epidural analgesia, even if the back pain was related to post-birth musculoskeletal, sacroiliac joint pain or pelvic girdle pain. Indeed, there are many possible reasons for postpartum back pain, of which epidural analgesia is only one and likely not the most common reason. Bergström et al. (2014), for example, suggested that back pain and pelvic girdle pain were the most reported pain conditions during pregnancy and could continue in the postpartum. Additionally, postpartum back pain has been linked to caesarean sections with epidural anaesthesia but also to duration of first stage labour, age and ethnicity of mother (Christopher, McCullough, Snodgrass, & Cook, 2019). Thus, these findings indicate that the causes of postpartum back pain are much more complex than primarily related to epidural analgesia. It is possible that other reasons for postpartum back pain were not considered primarily because of the women's limited awareness and understanding. Overall, the findings from this study suggests that health literacy influenced participants' understanding and their access to information.

Many participants in this study experienced postpartum pain, however they did not seek advice about the pain. This finding is supported by research that has shown that women from CALD backgrounds report less postpartum pain than women from non-CALD backgrounds (Mahon, Merry, Lu, & Gagnon, 2017). This difference in seeking medical advice for postpartum pain may be because women from CALD backgrounds experience lower rates of postpartum pain, but this is unlikely. What is more likely, and shown in this study, was that women from Indian and Vietnamese backgrounds, living in Australia, were less likely to report pain because of limited health literacy and understanding. This is consistent with international research that has examined the relationship between acculturation, health literacy and seeking medical attention (Mantwill & Schulz, 2017). Those authors examined immigrants' health literacy and compared their understanding of health information in their language of origin and their adopted language. They found that

immigrants' health literacy in a language relevant to the country of settlement is a good indicator for self-reporting health concerns. No studies were found specifically related to the pain experience of Indian and Vietnamese postpartum women in Australia. Findings from the present study are in line with the view of Mahon et al. (2017), who in a Canadian study highlighted that new mothers with poor health literacy, particularly related to inadequate language skills, may be at greater risk of experiencing postpartum pain conditions because of lower access to resources.

The sourcing of information by participants in this study was influenced primarily by culture and health literacy. Cultural factors and health literacy also influenced participants' preparation for labour pain and their perceptions and understanding of childbirth and postpartum pain. Additionally, not all women have equal access to information and characteristics linked to reduced access to information during pregnancy include limited health literacy, less education, and lower socio-economic and cultural backgrounds (Bryant, Worjoloh, Caughey, & Washington, 2010; Raleigh et al., 2010). It is very likely that these same restrictions were at play in this study. Furthermore, for participants in this study, emotions influenced decisions and motivation to seek information.

Emotions

All participants in this study sought information to help them prepare for labour pain. Whether they continued to seek further information depended on how the information made them feel. When the information provoked feelings of worry or fear, participants were reluctant to seek further information, and instead avoided labour and birth pain information. At times worry and fear were bluntly acknowledged, while at other times, fear was described with an "I'll face it when I have to" attitude. This more complex response was also most likely the

result of fear related to birth pain, because it was communicated in the context of information avoidance. Research in the fields of psychology, communication and health has shown similar outcomes to this study. Specifically, research has indicated that individuals avoid information because of negative or unpleasant effects (Balaam et al., 2013; Case, Andrews, Johnson, & Allard, 2005; Howell & Shepperd, 2013; Sweeny, Melnyk, Miller, & Shepperd, 2010; Yang & Kahlor, 2012). Myrick (2017), for example, examined the emotions of individuals after sourcing health related information and found that when information provoked fear, the individual assumed that any future information seeking would also result in fear, and future searching was reduced. Another study suggested that women engaged in information avoidance when preparing for childbirth because they did not wish to hear others' negative birth experiences (Borrelli, Walsh, & Spiby, 2018). However, it seems that health information for health problems may result in a different strategy. Lee and Hawkins (2016) examined women's responses to health-related information related to breast cancer. They found that worry encouraged women to seek further information and this may have been related to the ongoing nature of cancer. While research on the relationship between fear and worry and information avoidance remains conflicting, participants in this study clearly avoided information either because it increased their fear, or they worried that it would increase their fear.

It is possible that participants in this study were more prone to experience fear and worry about labour pain. There is evidence that the greater the cultural gap between an individual's birth country and their current country of residence, the greater the challenge and stress for that individual (Ward & Geeraert, 2016). Acculturative stress occurs as a result of the psychosocial challenges associated with adjusting to a new country (Berry, 1992). For example, research exploring acculturative stress among international students highlighted loneliness as a prime influence to increasing acculturative stress (Alharbi & Smith, 2018).

The influence of loneliness could be considered in this study as well, as women were living far away from their family and friends and many highlighted this as a concern during preparation for birth. Additionally, during pregnancy, most participants in the current study believed and prepared for minimal spousal and family support during labour. Many eagerly awaited the arrival of their mothers from overseas to provide labour support, and worried that they would not arrive in time and that they would face labour pain alone. Although worry and fear of labour pain is commonly experienced by first-time mothers (Sioma-Markowska, Żur, Skrzypulec-Plinta, Machura, & Czajkowska, 2017), it is likely that women from CALD backgrounds, giving birth in Australia for the first time, experience higher levels of fear and worry than Australian-born women. Possible explanations include fear of the unknown, fear of pain, scant understanding of labour and birth processes because of limited health literacy and little preparation. There is support in the literature for this study's findings, suggesting that factors which contribute to increased fear include first labour, lack of knowledge about labour course, poor support from spouse and family, low education levels and inadequate prenatal education (Erkaya, Karabulutlu, & Çalık, 2017; Sioma-Markowska et al., 2017).

Participants in this study were challenging cultural norms in seeking information from the internet. Seeking support and reassurance from the internet is unusual within Indian and Vietnamese cultures. Other studies have shown how pregnant women discovered connections and support through attendance at prenatal education programs (Brady & Lalor, 2017; Nolan, 2017), yet in this study the internet was used as a medium to make connections with others during times of loneliness, and when there were challenges to accessing information in more conventional ways. Similarly, over the last decade there have been reports in other studies about pregnant women accessing the internet for social and emotional support (Alianmoghaddam, Phibbs, & Benn, 2019; Baker & Yang, 2018; Lupton

& Pedersen, 2016). For example, Lupton and Pedersen (2016) reported that a quarter of participants in their study engaged with the internet so that they could connect with other mothers. Participants in the current study also sought advice from healthcare professionals if online information created worry. Bjelke, Martinsson, Lendahls, and Oscarsson (2016) concur with this finding and explained that women who sought online information were also more likely to seek advice from a healthcare professional. Although seeking online information resulted in worry for some participants in the current study, others explained that online information helped to reassure them, particularly when they lacked support from family and friends. No studies were found that specifically explored the seeking of pain related support on the internet from the perspective of women from CALD backgrounds giving birth.

In contrast to information avoiding, information engaging in this study resulted in a very different scenario. When information generated feelings of empowerment, reduced worry and provided reassurance, a positive feedback loop occurred, and participants sought yet more information. After engagement with information on the internet, some participants gained confidence that their pregnancy was progressing as expected and that they had options to help manage pain. This finding may potentially be explained by research studying the effect of emotion on online information seeking (Beaudry & Pinsonneault, 2010; Lee & Hawkins, 2016). In those studies, findings indicated that emotions including excitement and happiness encouraged further information seeking. An increase in empowerment and confidence during pregnancy as a consequence of seeking internet information has also been reported in other studies. Those studies suggest that pregnancy related information sought from the internet reduced anxiety and led to greater confidence as the birth approached (Fabrizio et al., 2013; Javanmardi, Noroozi, Mostafavi, & Ashrafi-Rizi, 2018). Similar effects were seen in this study.

In summary, this study adds to existing research by highlighting that cultural expectations alone did not dictate how women from India and Vietnam responded to information during pregnancy. Whether they actively engaged with, or avoided, further information greatly depended on how the information made them feel. Participants who felt fear or worry avoided further information, while participants who felt empowerment and reassurance sought more information. This suggests that participants in this study were making decisions to best suit their needs and adapting to their changing landscape. While this study highlighted how women from CALD backgrounds may experience greater challenges in seeking information, it also draws attention to the fact that they have many experiences in common with other childbearing women.

9.5 Universal experiences

Women around the world describe familiar experiences related to childbirth pain. In the final section of this chapter the experiences of participants in this study that were similar to those reported by women everywhere are discussed. Along with other factors, such as cultural expectations, these common experiences add depth to our understanding of the experience of childbirth pain.

9.5.1 Well managed pain

Most participants did not know what to expect of labour pain, and this is consistent with other studies of first time mothers (Hastings-Tolsma, Nolte, & Temane, 2018; Lally, Thomson, MacPhail, & Exley, 2014). For many women, thinking about labour pain created uncertainty and worry (Borrelli et al., 2018; Gibson, 2014; Lally et al., 2014). Factors that helped women to prepare for birth pain included social supports, trust, a feeling of confidence and a positive attitude (Bäckström et al., 2017; Barkensjö, Greenbrook, Rosenlundh, Ascher, & Elden,

2018; Haines et al., 2012; Karlsdottir et al., 2018). Whilst all these factors were highlighted by participants in this study as helpful in preparing for labour pain, social supports were considered the most important of all.

Participants reported that social supports were essential in helping them build trust and provide reassurance in their ability to manage labour pain. They particularly emphasised the importance of husbands' support during labour. This was an unexpected finding considering the husband's presence during labour is unusual for these groups. Leading up to the birth, in anticipation of limited spousal support, participants experienced great uncertainty. Other researchers have also highlighted that adequate social supports encouraged confidence and reduced uncertainty in pregnant women as the birth approached (Bäckström et al., 2017). Such research emphasises how spousal support strengthens the relationship and encourages a sense of togetherness as the birth approaches.

Women in this study who had inadequate spousal psychosocial support during labour reported dissatisfaction with their experience of pain. This finding is also seen in the broader literature. For example, continuous individual support during labour, by spouse or a healthcare professional has been shown to reduce uncertainty and to empower a woman's ability to manage labour pain (Van der Gucht & Lewis, 2015). Further, in a study exploring women's experiences of continuous support in labour, Lunda, Minnie, and Benadé (2018) suggested that women prefer a support person who is known to them, someone with whom they have built a relationship and with whom they are comfortable. For these reasons, a husband's support during birth helps the woman manage pain. Additionally, research has shown that pain is reduced by a partner's touch (Goldstein, Shamay-Tsoory, Yellinek, & Weissman-Fogel, 2016). In this study, husbands provided invaluable support during labour including emotional support, reassurance and distraction. Similar findings have been

reported elsewhere (Boryri et al., 2016; Emelonye, Pitkäaho, & Vehviläinen-Julkunen, 2015; Gebuza, Kaźmierczak, Mieczkowska, Gierszewska, & Banaszkiewicz, 2016; Najafi, Roudsari, & Ebrahimipour, 2017). For example, in an Iranian study exploring labour supports, a women's spouse provided emotional reassurance by offering affection and words of encouragement during labour (Najafi et al., 2017).

In addition to support from husbands, other aspects were important in helping women to manage labour pain. For example, participants drew on spirituality to help with pain management, and spirituality has been recognised in other studies for its role in reducing fear of birth (Abdollahpour & Khosravi, 2018; Aziato et al., 2016; Boryri et al., 2016; Taghizdeh et al., 2017). For example, Aziato et al. (2016) reported that women in their study believed spiritual activities, particularly prayer, freed them from labour pain. Other authors concur with this finding and have highlighted that women use prayer as a means of creating a spiritual space that helped to relieve their pain (Boryri et al., 2016). Still other research has shown that for some women, spirituality provided meaning and consequently, helped them endure labour pain. For example, Taghizdeh et al. (2017) reported that women believed that if they endure labour pain, all their sins would be forgiven. Other activities also helped participants in this study to create meaning for labour pain.

For example, task setting was employed by participants to help manage pain during labour. In one case, a participant set small benchmarks to measure, hour-by-hour progress during labour, which inevitably ended with the birth of her child. For this participant, developing a meaning for labour pain and creating a strategy to manage the pain added to her overall satisfaction. Similar approaches have been described in other accounts where developing a focus and a meaning for labour pain helped create purpose and resulted in more positive emotions during childbirth (Whitburn et al., 2017). Additionally, it is possible that for women

in this study, setting benchmarks that were then achieved along the way increased their confidence that they were managing pain well and strengthened their feeling of control in a challenging situation. This strategy of setting and achieving tasks also encourages control, and studies have repeatedly shown that women want to maintain a feeling of control over decision-making, particularly related to pain relief in labour (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018).

Participants in this study, overall, were satisfied with the experience of labour pain when their pain was well managed, and this did not necessarily reflect on the degree of pain, because no participant had a pain free labour. Elsewhere, the relationship between childbirth satisfaction and pain has been extensively studied, and similar to this study, well managed labour pain was found to be integral to a satisfactory childbirth experience (Ampofo & Caine, 2015; Jafari, Mohebbi, & Mazloomzadeh, 2017; Karlsdottir et al., 2018). Overall, this study concurred with other studies that have explored the factors that aid in preparing for birth pain, and highlighted that women from CALD backgrounds have similar needs to other women around preparing for and managing labour pain (Van der Gucht & Lewis, 2015).

9.5.2 Unmanaged pain

Participants in this study described labour pain as unique and unlike any other pain that they had experienced previously and this finding has been reported in other studies (Callister et al., 2003; Whitburn et al., 2019). In the current study, labour pain generated a myriad of complex and contrasting emotions and feelings, many of which were not at all positive. Similar findings have been reported elsewhere. For example, in a phenomenological study, Hall, Foster, Yount, and Jennings (2018) reported that women experienced intense variations of emotions during labour that symbolised either “keeping it together” or “falling

apart" and that these fluctuating emotions influenced a woman's ability to manage pain in labour.

Most participants in this study explained that pain influenced their ability to concentrate, think clearly and make decisions. This finding was also reported by Ampofo and Caine (2015) in a study that explored the experience of labour pain from the perspective of Ghanaian women. Along with difficulty in decision making, participants in current study reported feeling trapped by the pain, and for a few this resulted in feelings of hopelessness. Similarly, in other studies, uncontrolled pain in labour has been linked with feelings of powerlessness and isolation (Hastings-Tolsma et al., 2018; Stankovic, 2017; Whitburn et al., 2014). In turn, feelings of hopelessness and uncontrolled labour pain have been linked to the phenomenon of childbirth fear and postpartum depression that affected relationships with families and the newborn baby (Ferber, Granot, & Zimmer, 2005; Nieminen et al., 2015). In the current study, two participants declared that pain had a negative effect on their ability to connect with their baby and husband during labour and immediately after birth. Other emotions reported by participants, for example, anger and frustration, are also commonly reported in other studies of labour (Preis, Lobel, & Benyamini, 2019).

Some participants were clear in articulating how fear and disappointment featured strongly during labour and these emotions were associated with feelings of regret after birth. Participants feared labour pain because they had yet to experience it. Essentially, they feared the unknown and chose pain relief before experiencing severe pain because of that fear. The work of Reed et al. (2016) may offer a possible explanation for this phenomenon. Those authors suggest that some women experience a phase during childbirth where they are filled with self-doubt and are overwhelmed with intense negative emotions. This in turn ignites fear leading to use of analgesia. On the other hand, Preis et al. (2019) reported that

empowerment and less fear were associated with reduced guilt and resulted in greater childbirth satisfaction, a finding echoed in this current study. Some participants regretted requesting pharmacological options for managing pain, when, with hindsight, they realised that the birth was imminent. Similarly, another study found that feelings of regret can evolve after birth when women reflect on their experience and wish they had made alternative choices or been more involved in decision making (Cole, LeCouteur, Feo, & Dahlen, 2019; Thomson et al., 2019). In this study, both fear and disappointment led to regret.

Additionally, exhaustion overshadowed participants' experiences and contributed to unmanageable pain. Exhaustion affected participants' ability to make decisions and be active during childbirth. Some participants were overcome with exhaustion when they gave birth. They perceived that the pain, length of labour, and lack of sleep and rest primarily influenced their exhaustion more than any other aspect. Little other research was found to support this perception, although it has been acknowledged that the duration of second stage labour and pushing influences exhaustion at birth (Chang et al., 2016). In all, many factors can influence a woman's overall satisfaction of childbirth and adequate pain management is central to a positive experience.

Participants in this study felt their pain was not managed well if they felt overwhelmed. This is consistent with other research findings that suggest eliminating pain in labour does not always lead to a satisfactory childbirth experience. For a satisfactory experience, pain should be controlled and not escalate to a point where pain is overwhelming (Whitburn et al., 2019). In the literature, a women's perception of pain severity during labour has been linked to childbirth satisfaction, and uncontrolled pain during labour has been identified as a primary indicator for childbirth dissatisfaction (Jafari et al., 2017; Gregory et al., 2019). It is therefore not surprising that participants who were dissatisfied with their childbirth

experiences commonly described having uncontrolled pain. As shown in this study and others, a negative experience of childbirth pain can result in an array of emotions. Lack of support, inadequate pain relief, loss of control and exhaustion can all lead to negative birth experiences (Henriksen et al., 2017; Hollander et al., 2017). Participants in this study experienced similar emotions to other women as a result of labour pain. Nonetheless, for participants, it is likely that cultural expectations contributed additional complexity in this quest for a satisfactory childbirth experience. This study demonstrated that women from India and Vietnam experience uncharacteristic challenges during the childbirth journey and require focused and individualistic support from their midwife and healthcare team.

9.6 Summary

Exploring the experience of childbirth pain from the perspective of women born in India and Vietnam now living in Australia has proven to be a worthy journey. While these women share many common experiences with childbearing women from all over the world, their experiences are also unique, because of the cultural differences between India, Vietnam and Australia. For participants in this study, preparing for labour pain and the management of labour and postpartum pain was fraught with challenges. Away from their families and friends, participants departed from tradition and adopted more global social trends, like the use of the internet for sourcing pain related information. Thus, this study recognises that for Indian-born and Vietnamese-born women, giving birth in Australia leads to cultural transitions. Experiences related to childbirth pain were a fusion of personal choice, influenced by exposure to new ideas and cultural customs with the background of a new environment in which they were still gaining confidence. Participants did their best to adapt and meet their individual needs while they navigated the new experiences of birth pain.

Chapter Ten: Conclusion

10.1 Introduction

In this final chapter, a summary of the thesis is presented. First, the strengths and limitations of the study are addressed and the overall significance of the study, in relation to current knowledge, is described. Clinical implications and suggestions for practice are then discussed, specifically in relation to women born in India or Vietnam who give birth in Australia. Lastly, the chapter concludes with suggestions for future study, and a closing statement.

10.2 Addressing the strengths and limitations

This study did not take place without its share of challenges and limitations. These included cultural challenges, limitations of English language skills, and personal challenges for the researcher that were managed through the process of reflexivity. Each of these features had the potential to influence the outcome of this study. However, the researcher aimed to minimise their impact. This section also discusses the strengths of this study with emphasis on its longitudinal nature and the sample size.

10.2.1 Cultural sensitivities

One of the most obvious challenges in this study, which was identified very early on, was related to cultural differences between the researcher and participants. The participants had all been born in Asia, while the researcher is eighth-generation Australian-born. Thus, there was some concern about participants' comfort in sharing their experiences with someone outside their culture. With this in mind, the researcher focused on developing confidence

and trust with the participants during the recruitment period and early in the interview process. The researcher also conveyed her sincerity regarding her desire to develop a better understanding of participants' experiences of childbirth pain and to share contemporary knowledge with other professionals, thus encouraging more targeted care for women from CALD backgrounds. The participants recognised this intent, and rapport between the researcher and the participants led to the development of deep, rich and meaningful data.

Another challenge related to culture was the possible influence that husbands and families had on participants, because they were often present during interviews. In some cases, participants' husbands were keen to participate in the interviews. The researcher dealt with this challenge by acknowledging the husbands' thoughts and comments, and then redirected the interview focus back to the participants. On a few occasions, family members, including extended family members of both genders, were present in the interview environment. Participants appeared to speak openly during these times, and this was acknowledged by all as untraditional. At times, these members would provide an opinion, but they were respectful that the interview focused on the participant and her experiences. The dynamics of the interview environment were at times challenging and the researcher was aware of these difficulties and minimised the possible influences as best as she could, by returning to the participant and clarifying her experience.

10.2.2 English language skills / health literacy

For this study, pregnant women who possessed conversational English language skills were recruited and women without conversational English were excluded, because language supports were beyond the scope of the study. This was a limitation, because women without English language may experience even greater difficulties around pain management.

Additionally, difficulty surfaced during the analysis stage related to the English language skills and health literacy of the participants. It was difficult for the researcher to understand some of the women's statements, so she invited two midwifery colleagues, one Indian-born and the other Vietnamese-born, to review the transcripts and clarify meanings. Additionally, participants did not always understand terminology used by the interviewer. For example, participants were unsure of the classification of tertiary education and often viewed secondary school as tertiary education. To minimise such misunderstandings, the researcher provided extra time during interview to clarify statements and used the second interview to clarify unclear statements from the first interview. She additionally sought guidance from supervisors and colleagues from Indian and Vietnamese backgrounds.

10.2.3 Reflexivity

The following discussion highlights the challenges faced by this researcher with insider/outsider perspectives, both of which were thoroughly considered in order to promote trustworthiness in this research study. It was challenging to manage the conflicting roles of pain management nurse and researcher. This challenge occurred when participants were informed by the midwife that participating in the study would provide them with greater opportunities to source pain management information. The researcher became aware of this belief during prenatal interviews where participants indicated that they had participated in the study in the hope of receiving more information on birth pain management strategies. One participant indicated that "the midwife had said that I could ask you because you are the specialist in this". The following is an extract from the researcher's journal and highlights how this encounter was managed.

Journal Entry dated February 26th2018

During two interviews, when I was faced with the impression that the participants had consented to participate because of a shared benefit, I assured the participant that I was happy to provide pain management advice at the end of the interview but also re-enforced the idea that the interview was to gain an understanding of the participant's experience. Both women respected this response and were happy to continue with the interview.

After these encounters, the researcher discussed the situation with the midwife who introduced prospective participants to the study and emphasised that providing pain management information was not the intention of the researcher, but if the woman requested information then the researcher would provide the information. As suggested by Lalor, Begley, and Devane (2006) requested information was provided at the end of the interview, "so as not to have an impact on the participants' experience" (p. 610). This was an unexpected experience that the researcher did not consider in advance.

Other challenges to the insider/outsider role were expected, for example the conflicting roles of researcher and pain management nurse. It was at times challenging to maintain the research perspective whilst interviewing women. The following is an excerpt from the researcher's reflective journal that articulates this conflict.

Reflective Journal Entry dated March 16th 2018

…. Listening skills are vital when interviewing within the research role and for myself this exercise was reasonably effortless, most likely because of my experience in listening during patient consultations. However, not providing

> *instruction during the participant interview required diligence. Prior to undertaking the participant interviews, I did not appreciate the complexity of the insider/outsider perspective. I was vitally aware during the interviews, that I had placed an imaginary line which separates these two roles and the line was constantly challenged and at risk of blurring, by myself and the participant. Nonetheless, it was my duty of care, as a nurse, to provide information if requested. However, I waited until the interview was complete and then provided the requested information. At times, this information ignited greater discussion and often the participants' accounts deepened after the information. The notion as to whether this data would have emerged if I was not a Pain Management Nurse continues to occupy my thoughts.*

This example demonstrates how the researcher in this IPA study considered the context of the study and was aware of her biases and preconceived ideas. Similar to the way described by Tuohy et al. (2013), this awareness helped the researcher to recognise the impact of personal influences on the narrative. Although in IPA it is considered advantageous to have expert knowledge in the area being studied, it is nonetheless important to ensure quality of data. To achieve this aim and as recommended by Flood (2010), the researcher used reflexivity to help develop self-awareness.

The challenges that have been discussed in this section were managed in such a way that they are considered to strengthen the rigor of the study. Other features of this study also added to the overall rigor, including the longitudinal nature and the sample size.

10.2.4 Its longitudinal nature

Each participant in this study took part in two interviews, one during pregnancy and the second in the postpartum period. The longitudinal nature of these interviews provided an opportunity to capture data at these two points of time. Thus, patterns of change emerged over time, whilst also maintaining the individual's lived experience at the centre of the exploration. Calman, Brunton, and Molassiotis (2013) support this idea, and suggest that qualitative longitudinal research and IPA are fitting methodological approaches when exploring an experience where change and time underpin that experience. On a more practical level, a second interview provided the opportunity to clarify or revisit information that was offered in the first interview. This practical characteristic associated with longitudinal research has the advantage of increasing the study's rigor when combined with qualitative methodologies, like IPA (McCoy, 2017).

10.2.5 The sample size

Another strength of this study was related to the sample size of 24 participants. The reason for this sample size was to ensure adequate representation of themes and awareness of diversity within the narratives. Essentially, Indian- and Vietnamese-born women were represented in significant numbers to ensure sufficient saturation of themes in both groups. Thus, the decision to recruit a larger sample in this study rested on the need to have sufficient participants in each cultural group. As the study progressed, it became apparent that the sample size was not only adequate to represent the themes but also encouraged rich and meaningful data across both ethnic groups.

10.3 Significance of the study

This study explored the experience of pain during pregnancy, birth and the postpartum from the perspectives of first-time mothers born in India or Vietnam, who were living in Australia. This study appears to be the first of its kind, as extensive searching has not located any published IPA studies exploring the experience of childbirth pain from the perspective of Indian or Vietnamese women living in Australia. There is earlier research in Australia into the impact of culture on the experiences of birth pain, particularly related to pain expression, the meaning of pain and support in managing pain (Callister, 1995; McLachlan & Waldenström, 2005). As such, in the initial stages of this study, it was anticipated that culture would also influence participants' experience of birth pain. Nonetheless, as the study progressed, it became apparent that the influence of culture on the experience of pain was different than expected, or as previously described in the literature. Principally, this study highlights how Indian- and Vietnamese-born women living in Australia were undergoing a cultural transition in relation to their experience of pain at birth. All participants, to varying degrees, experienced acculturation. Their experiences of preparing for labour pain and managing labour and postpartum pain were influenced by cultural factors from both their country of birth and from Australia. This finding contributes to current knowledge about preparing for childbirth pain and understanding the experiences of birth and postpartum pain from the perspective of women from CALD backgrounds.

10.4 Clinical implications and suggestions for practice

This study provides insight into the complexity of experiences for women born in India or Vietnam giving birth in Australia. In the following discussion, there is consideration of how such new insights impact on the experiences of pain during birth within the clinical context. There are also suggestions for future program development and clinical practice improvements that would improve the provision of meaningful care.

10.4.1 Culturally sensitive, individualised care

Findings from this study overwhelmingly support the concept that “one size does **not** fit all”. This study demonstrated that Indian- and Vietnamese-born women’s experiences of pain varied depending on where they were situated on their path of acculturation. Thus, women from CALD backgrounds giving birth in Australia have differing needs, and healthcare professionals should be aware and sensitive to these needs so that they can provide optimal care. Within the clinical context, greater awareness about an individual’s stage of acculturation is needed to provide authentic and culturally sensitive, individualised care. In this way, care is centred on the person, for the person. Providing such care is challenging when the clinical resources related to birth pain are scant, and what is available is based on generic information. Consider, for example, the ethnic profile developed by the Queensland government to aid healthcare professionals provide childbirth care for women born in India (Appendix K - Cultural dimensions of pregnancy, birth and postnatal care - an Indian profile). Whilst such resources aim to improve a carer’s awareness of cultural sensitivities, they tend to compartmentalise women into ethnic groups. This approach does not necessarily support the individual, although it acknowledges the need for care that is culturally sensitive. Care must also be relevant and tailored to the individual.

Person-centred care is an approach where the carer and the individual being cared for work together to meet the needs of the individual (Delaney, 2018). Resources are available and in use in other health disciplines to support healthcare professionals when assessing an individual's cultural needs. The implementation of a clinical tool that aids in assessing the needs of pregnant women from a CALD background would provide a foundation for healthcare professionals to plan care based on those needs. Many of these tools, for example the *ABCD mnemonic for cultural assessment* (Appendix L), are used in the palliative care environment, and assess an individual's attitude, beliefs, context and decision-making style (Kagawa-Singer & Blackhall, 2001). Such an assessment tool could be modified for use with pregnant women, specifically focusing on birth and pain. Long term, such a tool would help healthcare professionals understand the needs of pregnant women from CALD backgrounds. It would also provide guidance for healthcare professionals to help meet those needs by planning a strategy to best suit the individual's needs.

For example, a healthcare professional using such as assessment tool might highlight that a woman from a CALD background needs greater access to evidence-based information that is relevant for her level of health literacy and that specifically addresses her concerns about postpartum customs. Another avenue to support culturally sensitive individualised care might include an online information source that provides reliable and accessible information to women from CALD backgrounds. Additionally, as shown in this study, a "ripple effect" was occurring and women often shared new and unfamiliar information with family and friends. If this information was more readily accessible and promoted by healthcare professionals, then women might share the information in their community and encourage greater openness and discussion. To encourage such discussions within a woman's community, healthcare professionals could encourage awareness about specific challenges, such as difficulties after discharge from hospital. Cultural challenges could be

similarly addressed. Such information may empower women to question longstanding customs.

10.4.2 Challenging cultural stereotypes

The findings from this study challenge cultural stereotypes from both the women's perspective and the healthcare professional's viewpoint. Consider the following examples of psychosocial supports and pain expression in labour. Many participants did not plan for husbands to be present during birth. Nonetheless, contrary to cultural and personal expectations, most husbands remained present during labour and birth. For most women this was a surprise. Following the birth, participants felt that the husband's presence in labour provided significant support in managing pain and contributed to satisfaction with their experience of childbirth. With this new knowledge, healthcare professionals might encourage pregnant women from India and Vietnam to consider the positive effects of spousal support during labour. Additionally, healthcare professionals may recount other instances when the husband attended the birth despite age-old customs.

Participants in this study believed that their expression of pain was a representation of the severity of pain and this was influenced by their personality. This finding challenges the current view that culture is the primary determinant of expression of pain. Healthcare professionals who are aware of Indian- and Vietnamese-born women's views might adjust their presumptions. Ultimately, clinical practice and expectations might change. Greater awareness of these findings is important within the clinical setting to improve care for Indian and Vietnamese women giving birth in Australia.

10.4.3 Developing a positive source for information sharing

This study highlighted the need for an information source that is evidence based and that women from CALD backgrounds can access and understand. Indian and Vietnamese participants accessed the internet for pain related information, and this created a dilemma, because there were cultural and educational barriers to understanding. This is consistent with the literature, and research highlights that women do not arrive for childbirth care as "empty vessels" ready and waiting to absorb knowledge from healthcare professionals (Sanders & Crozier, 2018, p. 24) . They arrive with individual pre-existing ideas and concepts based on information drawn from a mass of sources. A healthcare professional, for example a midwife, is well placed to assess a women's information needs early in the pregnancy and direct her to reputable health information, appropriate for her level of understanding. Internet-based information is very popular with contemporary women and a reputable website that provides pain information for women with a low level of health literacy would be one step towards providing necessary information. Opportunities to discuss questions and concerns with a healthcare professional might also assist, especially early in pregnancy. Online resources that provide women with basic pain related information also provides opportunities for women to discuss concerns, for example, challenges in the postpartum period and options for future births.

10.5 Suggestions for future research

This study generated questions for further exploration. Many of these questions are linked by the common thread of birth pain and acculturation. The process of acculturation related to women's experiences of birth pain is novel and exploring the experiences further, particularly in relation to information seeking, could provide better insight. Exploring the non-traditional pathways of information seeking could be a stimulating project. For example, how does engaging in non-traditional sources of information seeking affect preparing for birth pain for Indian and Vietnamese women, living in Australia? Additionally, how does shared information influence the beliefs and practices of the immediate family?

Exploring and better understanding the experiences and influences related to psychosocial support of managing pain, from both the perspectives of women and their husbands from CALD backgrounds, is another possible area for research that as yet is poorly addressed. For example, questions such as what are the birth support expectations of women and partners from CALD background? Such knowledge would help healthcare professionals prepare pregnant women from CALD backgrounds and their partners for birth. It is likely that improved support during pregnancy would also reduce the uncertainty that first-time parents face as birth approaches.

Another area where further study is needed is the concept of unexpected postpartum pain. Most women in this study were surprised to experience so much pain in the postpartum. Exploring how pregnant women from CALD backgrounds prepare for the postpartum period could provide valuable insight into this dilemma. This is an important area to address because some women indicated that pain negatively affected their postpartum experience.

10.6 Concluding statement

Women from CALD backgrounds present for childbirth care with varying preparation for labour pain and management. This study has shed light on this dilemma and uncovered factors that shape the experience of birth pain for women from CALD backgrounds.

Firstly, women in this study felt uncertain and had limited understanding of labour pain and pain management. This was because of their limited health literacy, cultural factors and social influences. To overcome these challenges, they engaged with non-traditional means of information seeking, including the internet. This finding suggests that existing resources about birth pain are unsuitable or inaccessible for women from CALD backgrounds. This study highlights the need for information that all women can access and understand, regardless of background or English language skills.

Secondly, women in this study merged traditional customs and contemporary Australian practices to best meet their individual needs during pregnancy, birth and the postpartum and in doing so they were experiencing a process of acculturation. In this way, findings from this study describe a powerfully unique journey through childbirth pain from the perspective of Indian- and Vietnamese-born women. Women felt free to express their pain and their desire for psychosocial birth support and postpartum care. This went against expectations derived from societal cultural assumptions and traditions. This significant finding helps in developing a better understanding of cultural transition in this changing landscape and provides a foundation for further study.

Thirdly, whilst the experience of birth pain was unique to each woman, some features were universal. Regardless of ethnicity and culture, women in this study felt fearful, regretful, trapped, overwhelmed, exhausted and joyful. Similar feelings about birth pain are expressed

by women giving birth all over the world. However, women in this study experienced additional complexities related to navigating this unfamiliar landscape to best suit their needs, and, simultaneously, many were challenged by limited health literacy and understanding.

Based on this study, the researcher suggests that healthcare professionals are well placed to provide culturally sensitive individualised care for women from CALD backgrounds. To support this aim, policy makers and healthcare stakeholders should focus on developing and implementing strategies that reflect the dynamic landscape in which women from CALD backgrounds prepare for and manage childbirth pain. This study provides a foundation for future research, for better awareness, for greater understanding, and for an opportunity to improve care.

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Appendices

Appendix A – Journal

15th March 2017 – Defining my worldview

Today, I attended a presentation on ethnography, provided by a guest speaker. It was thought provoking as it encouraged me to re-consider my definition of CALD.

During this presentation, I was suddenly struck with the awareness that I had a different notion of CALD than that was expected in the world of ethnography. The experience of the individual creates the definition of CALD. It is therefore expected the different people will represent various meaning of the one concept. To prevent conflict however it is important to firstly discuss the term and the meaning of the term to the audience. If the explanation of what we see as simple or common knowledge is not made transparent by the researcher, then audience will not have the opportunity to view the experience through the same lens as the researcher. Defining and explaining the researcher's lens encourages the audience experience the journey from the researcher's viewpoint. The reflection and the resulting insight gained from this session has helped resolve my inner conflict of the definition of CALD and highlighted the importance of understanding one's worldview and associated methodological approach.

28th April 2017 – Methodology decisions

I am coming to understand that Phenomenology has many faces and the two predominate approaches are Descriptive and Interpretative Phenomenology. Both of these approaches are founded on an individual's lived experience, however there are some subtle but core differences. It is these difference that I need to understand and appreciate in order to make a choose of which methodology will most suit my research.

Initially, I was confused about the variations in phenomenological approaches. Descriptive Phenomenology, also termed Husserl's Phenomenology, focuses on describing the lived experiences of a participant. Alternatively, Interpretative Phenomenology moves beyond pure description and seeks meaning behind the described experience. While I found these initial descriptions helpful, I remained unsure of the most suitable pathway. I decided to forge ahead and embed myself in learning these two approaches, whilst also considering the context of my research and my research aims.

I thought it might be a good exercise to consider a another's childbirth transcript but unfortunately there seemed to be a disconnection between the theoretical approach and emerging material, and confusion was mounting. It was reading a recommended article that encouraged the turn of events, transforming me from information overload to reconnect, restructure and re-creation.

My epiphany came when I learnt to appreciate how I viewed text, or what lens I used to interpret incoming information. To understand this, I needed to have an emotional awareness of self, including a professional awareness. The segregation of the thoughts and considerations rendered the repacking process time-consuming but also relatively seamless. My personal and professional views considered two aspects, objective and subjective truth, to form an educated

decision and inform my practice. Take pain for example; when assessing pain in a patient I used both subjective or narrative data from the patient and objective data, information that I viewed, like body language, tone and pain behaviour. This process highlighted a tendance towards Interpretative Phenomenology, which mergers the researcher's knowledge and the individual's interpretation. When interpreting the narrative's, using a hermeneutic approach, the researcher interprets the experience while appreciating the union between the individual and their experience.

Engaging with the practice transcript highlighted to me the importance of having a clear and articulate methodological framework to guide the lens and associated research process.

In the developmental stages of this study, prior to cementing IPA as the preferred methodology for this study, discussions entertained Phenomenology, or IPA, as methodologies suitable to achieve this study's global aims. Employing either methodology would bring about an exploration into the meaning and understanding of childbirth pain. However, it was my desire to move beyond the superficial and explore a deeper meaning. Meanings that may not be explicit to the birthing woman, and therefore would not be uncovered using a phenomenological approach, thus tending towards IPA as the methodology of choice. Just having the desire to perform an IPA study does not provide an adequate foundation to embark on an IPA study. It is also considered advantageous for the researchers to have speciality knowledge within the area being studied. Collectively, in the research team there is extensive professional experience in the fields of midwifery and pain management. This professional expertise, in combination with the desire to explore a deeper meaning of childbirth pain from the perspective of Vietnamese and Indian women, that provided the opportunity to embark on this IPA study.

20th August 2017 – Finding meaning in text

Today I thought it was time to start to practice reviewing transcripts of others experiences of childbirth. I googled a few blog type experiences and choose two transcripts that detailed women experiences of childbirth.

I noted that during the initial reading of the transcript, I wanted to jump to the themes that I felt was coming out of the discussion instead of focusing the words, meanings and the feelings portrayed in the language and text. I believe I might need to practice the "unpacking" side of the analysis. The unpacking process reminded me of the pictures that when you look and make your eye cross you can see a pattern. As I was reading the transcript, I had to consciously tell my brain not to jump to conclusion or analysis, but just to collect information. I am not practiced at this technique. As a nurse, on a daily basis I read a patient's record and make treatment decisions based on the documented information. I believe, I am proficient at making quick judgments based on the written word. But really unpacking the document so to understand and appreciate the inner and underlying meaning was a new venture. One that I hope, with practice, will come with greater easy. Until then I will continue to engage my transcripts with cross eyes!

20th June 2017 - The woman's voice

As this study uses an interpretive paradigm, it is vital to ensure that the women in this study are at the core of the interpretations. With this in mind, I am acutely aware of the differences that exist between myself, an Anglo-Saxon, red-haired, 9th generation Australian and the women in my study, who may have only recently immigrated to Australia. Our cultures are literally worlds apart. To stay true to the methodology and to the women, I needed to consider how this could impact on the richness and sharing information. I used many of my well-developed nursing skills to overcome these challenges. When I was first introduced to women, I always attempted to convey my genuine desire to learn and share their journeys. I found staying attentive and open during this initial stage of recruitment provided a solid foundation for the next few interactions, when the interview took place. All women showed appreciation that I was interested in their stories.

During the first few interviews, I found that I was consciously aware of encouraging the women to share their story. When entering a woman's, home I maintained cultural respect by acknowledging their home practices and inquired about these practices in an open, casual and endearing tone as to set the climate for the open style of communication in the interview. After a few interviews, I stopped thinking about acting like an inductive researcher and it became more natural, or more effortless. To my surprise, most women eagerly and openly shared their stories. Maybe this was because they felt isolated and were happy to chat with someone, or maybe the wanted their stories to be told as much as I did. The cultural diversity between myself and the participant, that I anticipated may have caused a problem, faded into the background as the women launched into describing their life experience.

Two circumstance during prenatal interviews, I was challenged by the language barrier. When I had difficulty interpreting the language, I encouraged the woman to

expand on their story. I found after the interview, listening to the recording and whilst also reviewing the transcript helped to create transparency in the meaning of the discussion.

26th February 2018 – Challenges during data collection

Over the previous weeks some challenging situations have arisen during the data collection. These challenges mostly related to the participants request for further pain management information, and this occurred because the participants had been informed by the midwife that participating in this study would provide the woman with a better opportunity to source pain management information or the participant had a genuine interest in learning more about childbirth pain management.

In this last two weeks, during two prenatal interviews, the participants voiced that they had participated because they hoped to receive more information on childbirth pain management strategies as "the midwife had said that I could ask you because you are the specialist in this". When I was faced with the impression that the participants had accepted consent because of a possible benefit unrelated to the research, I assured the participant that I was happy to provide pain management advise at the end of the interview but also re-enforced that the interview was to gain an understanding of the participant's pregnancy experience. Both of the women respected this response and were happy to continue the interview when this question was posed.

After these encounters, the I discussed this situation with the midwife who introduced the participant to the study and highlighted that it was premature to inform women that if they participate in the project, they could receive more pain management information. It was emphasised that providing pain management information was not my intention, but if requested by a participant, I would not refuse. This was an unexpected experience, as I did not consider that the midwives were so accustomed to characterising myself in the role of the Pain Management Nurse, and it took some effort in the beginning to alter this perspective and have

the midwives overlook the Pain Management nurse role and accept the research role in isolation.

16th March 2018 - The dualism between Pain Nurse and Research roles

During the early prenatal interviews, the conflict between the Pain Nurse and research roles was at the forefront of my reflexivity.

I have only recently participated in research, as all of my adult life I have been a nurse and nursing has strengthened many attributes, including listening and instructing skills. The listening skills are vital when interviewing within the research role and for myself this exercise was reasonably effortless, most likely due to my experience in listening during patient consultations. However, not providing instruction during the participant interview required diligence. Prior to undertaking the participant interviews, I did not appreciate the complexity of the insider/outsider perspective. In this case the insider is the pain nurse role, whilst the outsider is the research role. I was vitally aware during the interviews, that I had placed an imaginary line which separate these two roles and the line was constantly challenged and at risk of blurring, by my myself and the participant. At times the participants would request information regarding childbirth pain management and I would acknowledge their request and state that I will give them information after the interview. In my professional opinion it was not ethical to withhold information from a woman even if I was not consulting the woman in a nursing capacity. It was my duty of care, as a nurse, to provide information if requested. When information was requested, I would always wait until the interview had closed and then provide the requested information. During the first two interviews where this occurred, I had stopped the recording and then provided the requested information. In both cases, I needed to restart the recording as the information provided ignited greater discussion about childbirth pain and often the participants discussion deepened after the information. For fear of missing data, I decided to continue the recording until after any questions had been answered. The notion as to whether this data would have emerged if I was not a Pain Management Nurse continues to preoccupy my thoughts.

Appendix B - Ethics approval documents

[redacted] LOW RISK HUMAN RESEARCH ETHICS PANEL
APPROVAL TO CONDUCT RESEARCH AND
SITE SPECIFIC ASSESSMENT (SSA) AUTHORISATION

19 October 2017

Ms. Davina Taylor
Clinical Nurse Consultant
Pain Management
[redacted]

Dear Ms. Taylor,

LREP Project Number: LNR/17/WH/144

Project Title: The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences

LREP Approval Date: 10 October 2017 **SSA Approval Date:** 10 October 2017

Principal Investigator/s: Ms. Davina Taylor

Associate Investigator/s: Professor Mary Carolan-Olah, Professor Sharon Andrew

Student Supervisor/s: Professor Mary Carolan-Olah, Professor Sharon Andrew

I am pleased to advise that the above project has been given ethics approval by the Western Health Low Risk Ethics Panel (LREP). The LREP confirms that your proposal meets the requirements of the National Statement on Ethical Conduct in Human Research (2007).

This project has also been issued with site specific approval to be conducted at Western Health.

Ethics & Governance approval for this project applies at the following sites:
[redacted]

Conditions of Ethics Approval and Governance Authorisation:

You are required to submit to the LREP:

- The actual start date of the project at Western Health.
- An Annual Progress Report (that covers all sites listed on approval) for the duration of the project. This report is due on the anniversary of LREP approval date. Continuation of ethics approval is contingent on submission of an annual report, due within one month of the approval anniversary. Failure to comply with this requirement may result in suspension of the project by the LREP.
- A comprehensive Final Report upon completion of the project.
- Submit to the LREP for approval any proposed amendments to the project including any proposed changes to the Protocol and Participant Information and Consent Form/s.
- Notify the LREP of any adverse events that have a material impact on the conduct of the research.
- Notify the LREP of your inability to continue as Principal Investigator.

- Notify the LREP of the failure to commence the study within 12 months of the LREP approval date or if a decision is taken to end the study at any of the sites prior to the expected date of completion.
- Notify the LREP of any matters which may impact the conduct of the project.

Approved/Noted Documents:

Document	Version	Date
Low & Negligible Risk National Ethics Application Form (LNR NEAF); AU/13/7B3039		24 August 2017
Western Health LNR Risk Assessment Form	2	23 September 2017
Western Health Site Specific Form		18 August 2017
Participant Information and Consent Form	3	22 September 2017
Protocol; Protocol No. LNR/17/WH/144	2	22 September 2017
Statement of Approval – Department of Surgical Services-Acute Pain Management Service		05 August 2017
Statement of Approval – Women's and Children's Department		24 August 2017
Clinic Advertisement	1	21 July 2017
Interview Schedule	1	21 July 2017
First Contact Script	2	21 July 2017
Candidature Confirmation Email		01 August 2017
Curriculum Vitae & WH Researcher Code of Conduct (2012) • Mary Carolan-Olah • Sharon Andrew		 01 May 2017 09 August 2017

The Office for Research may conduct an audit of the project at any time.

The Office for Research Western Health wishes you and your colleagues every success in your research.

Yours sincerely,

[redacted]

Dr. Tilini Gunatillake
Research Ethics and Governance Administration Officer

[redacted]

[redacted]

[redacted]

MEMO

TO Prof Mary Carolan-Olah
Ms Davina Taylor
College of Health & Biomedicine
[redacted]

DATE 13/12/2017

FROM Associate Professor Deborah Zion
Chair
[redacted] Human Research Ethics Committee

SUBJECT Ethics Application – HREC Approved Application External to Victoria University

Dear Professor Carolan-Olah and Ms Taylor,

Thank you for submitting this request for ethical approval of the project entitled:

Western Health ***"The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences"***

(Project approved by [redacted] – Project no. LNR/WH/144)

The proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Chair of the [redacted] University Human Research Ethics Committee. Approval has been granted from **13 December 2017 to 13 December 2019.** Any variations to the protocol must be approved through the original approving HREC and notified to VUHREC.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment. It should also be noted that it is the Chief Investigators' responsibility to ensure the research project is conducted in line with the recommendations outlined in the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007).'

On behalf of the Committee, I wish you all the best for the conduct of the project.

Kind regards,

Associate Professor Deborah Zion
Chair
[redacted] a University Human Research Ethics Committee

Appendix C - Participant information and consent form

Participant Information and Consent Form

Version3 Dated 22.09.2017
Site: [redacted]

Full Project Title: The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences

Principal Researcher: Ms Davina Taylor
Associate Researcher(s): Professor Mary Carolan-Olah
Professor Sharon Andrew

This Participant Information and Consent Form is 6 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.
This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.
You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to explore childbirth pain from the perspective of women from India and Vietnam. The researcher wishes to understand how women prepare for childbirth pain, experience and cope with childbirth pain and what they experience of pain after childbirth.
A total of 24 people will participate in this project.

There is little research on childbirth pain management experiences of women from multicultural backgrounds living in Australia. Previous experience has shown that women from multicultural backgrounds are less likely to attend antenatal education class. Understanding of the childbirth pain management experiences will assist clinicians in the planning and delivery of childbirth pain management care and education.

You are invited to participate in this research project because you have chosen to give birth at Western Health. It is hoped that your participation will ultimately lead to a better understanding of how women from India and Vietnam manage childbirth pain.

This research project is being undertaken as part of a PhD study and the outcome of this research may be used to help researcher, Ms Davina Taylor, to obtain this degree.

3. Procedures

Participation in this project will involve two interviews. The first interview will take place before your baby is born, between 32-38 weeks gestation. The first interview will take 30-45 minutes of your time and will focus on your expectations of pain management during birth, your wishes regarding pain relief, and how you have prepared for birth. The second interview will take place between 2-4 weeks after birth and will take about 1 hour of your time. This interview will focus on your experience of childbirth pain and how well your expectations were met. We will discuss the first month after birth and the effect of pain in adjusting to new motherhood.
Both interviews will be audiotaped using a digital recorder and will only be accessed by the researcher, Ms Davina Taylor. Both interviews will take place in a location that suits you.

4. Possible Benefits

We cannot guarantee or promise that you will receive any benefits from this project however your participation will provide a better understanding of women's childbirth pain management needs. This in turn, will encourage better understanding pain management experiences and will improve pain management strategies for future birthing women.

5. Possible Risks

Possible risks, side effects and discomforts are minimal. If at any time during the interview if you feel distressed or uncomfortable you may pause the interview. In this circumstance, you may continue the interview at a later stage or withdraw from the study. The researcher is a nurse and is able to provide you with basic emotional support and as such may offer you access to counselling either via Western Health or your Maternal and Child Health connection. Alternatively consider accessing an independent support network like:

Beyondblue
https://www.beyondblue.org.au/home
Ph: 1300 22 4636

Lifeline
https://www.lifeline.org.au/
ph: 13 11 14

6. Alternatives to Participation

Your participation in this project is completely voluntary and not participating will not affect

the care that you receive.

7. Privacy, Confidentiality and Disclosure of Information

Audiotaped interviews will be only accessed by the researcher, downloaded electronically and then deleted. Any identifying information on the audiotape will be deleted. Each participant will be given an alias/another name that will be used for the transcribed interview and interviews will not be identifiable. Any information shared will be received in confidence. All recorded and transcribed information will be stored on the researcher's password protected computer, for a period of 5 years, after which time all information will be destroyed. Access to data is limited to Ms Taylor, Professor Carolan-Olah and Professor Andrews.

Any information obtained in connection with this project and that can identify you will remain confidential If you give your permission by signing the Consent Form, I plan to discuss the finding with my supervisors, compose a manuscript/thesis and publish the outcome. In any publication, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named on page 4, if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information. This new information may mean that you can no longer participate in this research. If this occurs, the person(s) supervising the research will stop your participation. In all cases, you will be offered all available care to suit your needs and medical condition.

9. Results of Project

Please contact Ms Taylor if you are interest in the outcomes of this study and a summary of the key findings will be sent to you. After completion of this study the results will not be provided directly to the participants, as all information will be de-identified. At the time of the interview, participants may request a copy of their transcript and it will be provided to them.

10. Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher or the associate researcher. The researchers contact details are on page 4.

11. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Position:	Manager, [redacted] Office for Research
Telephone:	(03) 8395 8073
Email:	[redacted]

(You will need to tell the Manager the name of one of the researchers given in section 16)

12. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.
Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with [redacted].
Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.
If you decide to withdraw from this project, please notify a member of the research team before you withdraw. After consenting, at a later stage you change your mind and withdraw from the study. After you withdraw, data will be destroyed only if it is able to be identified and extracted. De-identification occurs after the second interview, therefore it would not possible to recognise an individual's dataset, and not possible to extract and discard an individual's collected dataset. Extracting and destroying collected data can only be possible before your second interview.

13. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethical aspects of this research project have been approved by the [redacted] Low Risk Human Research Ethics Panel and by [redacted] University Ethics Committee.

14. Reimbursement for your costs

You will not be paid for your participation in this project. However, your participation is appreciated and a $20 Coles/Myer gift voucher will be given to you following each interview.

15. Researchers Contact Details

Principal Researcher
Ms Davina Taylor
Email: Davina.taylor@wh.org.au
Ph: 03 83450187

Associate Researcher/Supervisor
Professor Mary Carolan-Olah
Email: Mary.Carolan@vu.edu.au

Associate Researcher/Supervisor
Professor Sharon Andrew
Email: Sharon.Andrew@vu.edu.au

16. Consent Form

Version *2* Dated *05.09.2017*
Site: [redacted]

Project title: The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences

I have read and I understand the Participant Information version *3* dated *22.09.2017*.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) ……

Signature…… Date

Name of Witness to Participant's Signature (printed) ……

Signature…… Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature…… Date
* A senior member of the research team must provide the explanation and provision of information concerning the research project.
Note: All parties signing the Consent Form must date their own signature.

REVOCATION OF CONSENT FORM

Revocation of Consent Form

Full Project Title: The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Western Health.

Participant's Name (printed) ……

Signature…… Date

Appendix D - Pain relief in labour and childbirth pamphlet

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Pain Relief in Labour and Childbirth

Every woman experiences pain in a different way. The way you experience pain depends on your emotional, psychological, social, motivational and cultural circumstances. Every woman responds and copes differently with the pain of labour and childbirth.

Preparation for birth can help to reduce the experience of pain and reduce anxiety, which can help you to better cope with labour.

Gather information about labour - talk to your midwife or doctor and attend antenatal classes. Discuss your preferences for pain-relief with your care providers and support-people before you go into labour. You can also record your preferences for pain relief in your birth plan.

Options for pain relief

There are a number of methods you can use to help you cope with your labour pain.

Like the labour experience, this is an individual decision. Some women are keen to avoid medications, others are happy to consider all available options. You need to choose the best coping technique or combination that suits you and your needs. Remember, your plan may change when you are in labour.

During your labour, the midwife will continue to guide you and work with you according to your wishes.

Natural pain relief

Relaxation
Being relaxed in labour has many benefits. Your body will work better if you're relaxed. Your natural hormones that help your labour progress (oxytocin), and those 'natural pain-relief hormones' (endorphins) that help you cope with labour, will be released more readily.

Fear, tension and resistance are a normal response when you feel out of control or you are not sure what to expect next. On the other hand, relaxing and trusting that your body knows what to do will help you manage your pain. Learn how to relax, stay calm and breathe deeply. Breathing techniques may help you to 'ride the waves' of each contraction. Remember that a relaxed mind is a relaxed cervix. If your face is relaxed, the muscles through your pelvis are too.

Active birth
Moving around and changing positions is one of the most helpful things you can do to manage the pain of labour and birth. Being able to move freely and rocking your pelvis can help you to cope with the contractions. If you stay upright, gravity will also help your baby to move down through your pelvis.

Heat and water
The use of heat can help to ease tension and discomfort in labour. Both hot and cold packs are useful, as is being immersed in water in either a shower or a bath. Healthy women with uncomplicated pregnancies may find that having a warm bath in labour helps with relaxation and pain relief. A warm bath increases relaxation and production of endorphins (your body's natural pain relief hormone). It reduces the pain of contractions and the pressure on your pelvis and muscles.

Touch and massage
Feeling stressed and anxious makes pain seem worse. Massage can reduce muscle tension as well as providing a distraction between and during contractions. Practise with your partner during your pregnancy and find out how you like to be massaged. At different stages during labour, massage and touch will feel good and at other times you may find it distracting or annoying.

Complementary therapies
Alternative therapies such as acupuncture, acupressure or aromatherapy can also be very effective, but should only be practised by qualified practitioners.

Non-medical pain relief

TENS
The TENS machine is a small, portable, battery-operated device that is worn on the body. The box is attached by wires to sticky pads that are stuck to the skin on your back. The machine has dials that you can adjust to control the frequency and strength of small electrical pulses that are transmitted to the body. These pulses stimulate your body to release your endorphins.

Water injections for back pain
Many women have lower back pain that persists throughout their labour. Midwives can use a technique where sterile water injections are given in four different places in your lower back, just beneath the skin. The injections cause a strong stinging sensation, like a bee sting. The sting will last for up to 30 seconds before disappearing along with the back pain. The injections can provide a few hours of pain relief to your lower back without any side effects for you or your baby.

Medical pain relief

Nitrous oxide gas
Often known as 'laughing gas', women in labour can breathe a mixture of nitrous oxide and oxygen through a mouth piece or mask. The gas is inhaled during a contraction and helps take the edge off the pain. Many women choose the gas as it makes them feel in control of their pain-relief and provides them with something to focus on to get through each contraction. There are no after-effects for you or your baby. The mixture of gas can be changed during different stages of your labour to provide better pain relief or if you feel a little nauseous or light-headed.

Pethidine or morphine injection
Pethidine and morphine are strong painkillers given by injection. You may be offered one of these medications, which work by mimicking the effects of endorphins.

Although they help reduce the severity of the pain, they do not take it away completely. Women have varying responses to morphine and pethidine. Some women will say the injection provided pain relief, while others will say it had no effect at all on their level of pain.

The injections can take up to 30 minutes to work and can make you feel quite nauseated. Because these drugs cross the placenta to your baby, your baby may become sleepy. Sometimes pethidine may contribute to breathing problems in your baby if given within two hours of birth.

For this reason and due to its relatively short period of effect, it is mostly helpful for women who are in well-established labour but not too close to giving birth.

Epidural
An epidural is a procedure where an anaesthetic (a drug that gives either partial or total loss of sensation) is injected into the small space in your back near your spinal cord by a specialist anaesthetist. Information about the use of epidural anaesthesia for pain relief can be found at www.anzca.edu.au/Patients.

After an epidural, you will have altered sensation from the waist down. How much you can move your legs after an epidural will depend on the type and dose of anaesthetic used. A very thin tube will be left in your back so the anaesthetic can be topped up. Sometimes the tube is attached to a machine so that you have control over when the epidural is topped up.

The benefits of an epidural are that it takes away the pain of contractions, it can be effective for hours and can be increased in strength if you need to have an emergency caesarean. In a long labour, it can allow you to sleep and recover your strength. Epidurals can cause a fall in blood pressure, so you will usually have an intravenous drip (a bag of liquid that enters your body through a tube) put into your arm or the back of your hand, and your blood pressure will be monitored more closely. You may also lose the sensation to pass urine, so you will have a catheter tube inserted into your bladder to drain your urine.

Because of the potential side effects such as low blood pressure, the baby's heart rate will need to be continuously monitored by a CTG machine following an epidural. Further information about monitoring the baby's heart rate in labour can be found on the RANZCOG website under patient information. The chance of you needing assistance with the birth of your baby increases once you have had an epidural. A stronger epidural or 'top up' will help relieve the pain of these procedures.

Not all birth places can offer every method of pain management. You might like to talk to your care provider about the pain relief options available to you at your planned place of birth and which methods of pain relief can and can't be used together. You can choose one method or a few, or you change from one to another during labour. Remember it is important to keep an open mind and have a positive attitude and confidence in your ability to labour.

College House,
254-260 Albert Street
East Melbourne,
Victoria 3002, Australia.

Ph: +61 3 9417 1699
Fax: +61 3 9419 0672
Email: ranzcog@ranzcog.edu.au
ranzcog.edu.au

Appendix E - Clinic flyer

Research Project

Ms Davina Taylor

PhD (int) candidate & CNC Pain Management

The Childbirth Pain Management Journey: making meaning from Indian and Vietnamese women's experiences

I am conducting a research study exploring childbirth pain from the perspective of women from India and Vietnam. I aim to understand how women prepare for childbirth pain, manage childbirth pain and experience pain after childbirth.

If you are consulting with a women that you believe would be interested in participating in this study and fits the criteria please request their permission to:

1. Note the woman's contact details

2. Contact Davina on:
Mobile 042 113 4404
Ext 50187
Email: davina.taylor@wh.org.au
and communicate the woman's details.

Inclusion Criteria:

- women born in India or Vietnam
- expected vaginal delivery
- first pregnancy
- conversational English
- singleton pregnancy
- uncomplicated pregnancy
- pregnant women over 18 years

This poster is for display in the clinical area only.

LNR/17/WH/144: Clinic Advertisement
Date: 21/07/2017 Version 1

Appendix F - First contact script

Version 2 Date: 21.07.17 – First contact script

Hi, my name is Davina Taylor and I am a nurse at [redacted] and a PhD student. I am calling you because the midwife that saw you in clinic mentioned that you might be interested in participating in the research study that I am undertaking. The study is about how women from India and Vietnam prepare for childbirth. I am also interested in how women experience and cope with birth.

Participating in this study you would be required to:

• Take part in two interviews.

o The first interview will take place before the birth of your child and will take 30 mins.

o The second interview will take place 2-4 weeks after the birth of your child and take about 60 minutes of your time.

Please take your time reading the Participant information and consent form.

Do you have any questions at the moment?

Would you be happy to meet with me to discuss your participation in this study? *(arrange time and place)*

Thank-you for your time.

Appendix G - Interview schedule

Interview 1: Prenatal – 30 minutes

1. Can you tell me about your pregnancy experience so far?
2. How have you prepared for childbirth?
3. Have you thought about childbirth pain?
    a. (prompt) Where have you found your information?
    b. (prompt) What have you been told by your family/friends?
    c. (prompt) Who will support the birth?
    d. (prompt) Why this person/people
    e. (prompt) What are your wishes regarding the pain management during your childbirth?

Interview 2: Postnatal – 60 minutes

1. Can you tell me about your birth?
2. How was the pain?
    a. (prompt) Was it as expected?
    b. (prompt) Did you feel prepared?
    c. (prompt) How did you cope with the pain?
    d. (prompt) What worked for you?
    e. (prompt) What helped with the pain/what didn't help with the pain?
    f. (prompt) Can you think of anything that could have helped?
    g. (prompt) How is your pain now, you are at home?
    h. (prompt) Can you tell me about the last pain experience that you can remember, before birth?
3. Looking back now, what would you have done differently?

Appendix H - Example of analysis stage 1: participant 4 (postnatal)

SUB-THEME	NOTES	QUOTE	P
My childbirth pain experience Thinking positive Disappointed in midwife support	In the beginning of the postnatal interview Garima described her experience very matter of fact. She did not use many descriptive words to express her experience, besides saying that it was difficult or hard for her to manage the pain. Advice from Mother in law - reassurance Much later, in the interview, Garima described her pain experience in more detail. She experienced more pain than she expected and surmised that the midwives were not helping her during her labour because they did not relief the pain by encouraging a caesarean section. At the time she found this destressing but on reflection, after birth, she was glad that the midwives did not help her. Garima believes that thinking positive during this time was the best coping strategy.	My pain started in the morning at 4 o'clock, and I had a yellowish liquid in the morning when my husband was going to his job. After that, I felt small, small pains after half an hour and I was not feeling sleepy. and in the morning at 10 o'clock again it came, the yellowish liquid and whole day I felt the normal pains like whenever sitting, my husband helped me in my household work. I called him from the job. I told him that and I think I am in the pain and the time is near and he came and he worked for me at home, prepared things for me. In the evening, it started hard, very hard for me to what could I say that. It was very hard for me and at 12 o'clock my mother in law called me and she told that it's normal. I think you should go to the hospital. We called the hospital 3 times in the day and they told it's not just the normal pains and when pains come after 5 minutes, after every 5 minutes then you can come. At 12 o'clock she called me and she told that you should go now and it's soon I think that you should go. It's the right time. Then, I went to the washroom and the water discharged. And we called to the nurse, she told that we should come now and we went to the hospital and they told that the baby is coming out and it's 5 cm. They told that.... and at 7 o'clock in the morning you will get your baby. And after that, I got two vomitings and the labour started at 4 o'clock and they told that at 5:30 we got delivered. …It was terrible. The pain was terrible. I didn't want much pain. That pain I didn't want. I just wanted baby	1 8

		should come out now. But when that pain was coming, I was thinking positive. I was thinking positive only. It will be OK. Sometimes it feel really terrible and the midwives were not doing anything and were not helping me in any way, only my husband was doing massage on my back. In India, if we have much pain and the lady can't handle that, they do the operation. They bring the baby out. But it was good that they didn't help me. It was a normal delivery. Otherwise I would have got the stitches in my tummy. It was OK.	
Conflicted about birthing support	Garima describes the pain as the most difficult part of the labour. She voices that her birthing supports were busy with other tasks and at times she was helped by her husband but likely she felt alone during her labour and isolated in her pain. In other statements Garima is clear to acknowledge the support of her husband during labour.	… the pains. That was the most difficult part. Because it was really difficult to handle that pain. It was not that difficult for him to come out but it was really difficult for the pains that are coming because after every 5 mints, my husband have to rub my back and he was busy with his phone also, phone was ringing and the nurse was also saying something to him. … my sister in law was also calling. So he was basically the phone all the time. Also he was giving me water, sometimes rubbing my back. Yeah, it was really a busy time	1

The pain paradox A strengthening experience In reflection love transcends pain	Garima talked about the childbirth experience providing her with a new inner strength or resilience, knowing that she handled such challenging pain. She also voices the paradox of lose and gain??? Garima also expresses the phenomenon of overpowering love when the pain is surpassed by the feeling of love.	…I think I can handle that pain….It's OK. We have to gain something and we have to lose something. Yeah. We got a baby. …That pain is nothing in front of him. Yeah. …..if we have to gain something we have to lose something. But when I see his face, I forget everything. It's OK. My baby. Yeah. When they laid him on my chest, everything got well. My pains got vanished.	2 10
Instruction, reassurance, and a feeling of pride	Garima felt well instructed by the midwives when it was time to push. She felt proud with the positive feedback from the midwives and felt rewarded when her baby birthed in a short time after she had started pushing	…the nurses were also happy that I did so well. Because it was my first time, I have never experienced this and I did well. Whenever they said stop, I stopped. Whenever they said start pushing, I start pushing the baby…. In 15 minutes, I got the baby. But I was sometimes pushing the baby when I didn't get the contractions. Yeah. They said "Don't push like that, when you will get the contractions, push at that time". they have a machine they put it on my stomach and whenever it gives the voice like "doo doo doo" then I started pushing. Yeah. It was not that difficult but difficult was the pains that I had to handle.	2
Inner strength to carry on	Garima expressed despair towards the end of her labour, she was exhausted and thought her was unable to carry on. She found inner strength as she did not want to experience any further pain.	… I don't know how I got the strength at that time. I was really tired at 5:15 I said no, I'm not going to do this. I am unable. But suddenly, I don't know from where but I got the strength and I said that now I will push finally. Now I will not stop. Yeah….	2 4

		Uh, I didn't want to feel that pain again. So I don't know. This is the last time. And after that, I don't know. I pushed and he came out! [laughs	
Mixed feelings about birthing support. Challenging times during the labour	Whilst in earlier conversation, Garima expressed to feel alone during her birth she also explains that her husband supported her well during her labour. Garima articulates this by giving examples of how well her husband worked to provide for her during the birth. Some events during labour and birth can be distressing. Garima was upset when her husband needed to leave the birthing room to fetch the bags from the car. Garima expresses the time that her was away by the number of contractions that she experiences without him there. Although the midwife was present and attempted to provide support, the absence of her husband was not able to be replaced with another. Garima voiced this as one of the most challenging times during her labour.	He (husband) helped a lot. He helped a lot. ….Whenever the pain started, I started shouting like "Ahhhh" like this and whenever I say that, he rub, rub and then he rubs my back. And when I say that just massage that, and then he said everything what I told him. He did that. And every minute or second he was with me. He helped me a lot. He was my strength on that day. And he got tired really tired his hands got vein and his feet were also swell. For all night, he was standing with me. And next day, when he got the baby, they changed ward, we went to the ward maternity room and after that at 2:00 he came here at home and slept and slept. I really thank him. Mmmm. I really thank him. I am very thankful to him. He did a lot for me. ,..Sometimes, it (the pain) was worse because he (husband) went to the... he went outside from the hospital for bringing my bags from the car. We went to the hospital. It was my bags were left in the car so he went to bring that and I think he was lost in the hospital. He didn't get there. He didn't come back for 15 minutes and I was waiting for him and two labour pains came. In that span of time. I was searching him, where is he so that he can rub my back but the nurse also help me. The midwife came and she rub my back. That was the worst.	3
Postpartum pain		For one week I was unable to sit but I have to because I have to feed him. That week was difficult for me….Not much, it was OK. I had difficulties in eating also, in sitting. But it's OK…. no painkillers. Nothing. Just Panadol and one more was the Brufen	4

Advice to others	Garima considers the advice she would now give to other pregnancy women	..I would say that have faith in God, everything will be fine. Be positive and take deep breaths. Don't eat anything [both laughs] if you already have labour pains, you will get vomitings. Only drink water, water, water. That's it. Be positive.	5
I could not have done it alone!	God and Garima's husband features considerably is discussions pertaining to support during birth. Om reflection Garima's pain was not so bad Although Garima voices that she found inner strength to carry on she also attributes her ability to get through the labour to her husband and her faith; not to her own abilities. Garima believes that her ability to birth was because her husband and God was with her. She accepts no credit for the birth. Although at times during the interview Garima voiced that she felt unsupported by her husband, mostly she voiced the she felt pampered by him. In a light-hearted way she explained how she was instructing him on how to provide care for her and whilst Garima's pain was challenging to manage she found this role for her husband amusing. Garima thought this was an unusual role for her husband.	My husband and God… .. It was all OK. I felt happy that it all goes well now. Nothing got wrong. God helped me a lot, my husband helped me a lot. I didn't felt much pain. Later on, that everyone handles. I didn't felt much pain. My faith in God and in my husband. He prepared me a lot. He helped me a lot. …my husband controlled them (the pains), he just rubbed my back and it goes back. Then after 5 minutes again, after 5 minutes again. It was really difficult. The time from 12 to 4:30 you can see. That time was difficult because I had pain after 5 minutes, after 5 minutes. So I prayed to God that if I did any mistake, please forgive me for that. Just bring that time that baby comes out. At 4:30 I was just like no, now this is the end. Please do it early, do it fast .. …everything went well because of God because of my husband… No, not because of me…No. They (husband and God) were with me. That's why I did well. I didn't do anything. God helped me a lot. He helped me…God gave me strength to do that well. Otherwise I can't do anything. I think so that. I will get obstacles but I really have great faith. In 9 months, I really had great faith in god in 9 months. When the time came near, my faith got stronger. Stronger and stronger. ..It was difficult to handle that pain. Not scary. Terrible… When the pain was coming, then I would say "Oh, it's coming again, it's coming again" [laughs] then I have to call my husband, "Rub my massage, rub my	2 4 5 8 11 10 12

	On reflection	back, rub my back!" He got tired too. Really tired. ..I will never forget that night. Never. He was confused what to do. Yeah. My husband was really confused what to do…I gave him instructions like "Do like this, do like this" then he did like that. "Give me water, give me something to eat" I felt hungry but I was unable to eat something. Now I laugh when I think about that time. Yeah. Now I laugh. When pains come, he come to me. It was so messed up, everything was messed up.	
Influences on behaviour during birth	Garima followed cultural advice regarding behaviour in labour. Garima always follows advice from her mother because see views her mother a wise and experienced. Garima believes that when she does not follow her mother's advice then she will regret it,	Yeah. My mother gave me advice that don't push too hard, don't make too much noises. .. I chanted my God's name at that time, I didn't shouted much. ..Because it have effect on my throat. They say that don't make much noise, it gives effect on throat and we can get our nerves. It hurts our nerves. …. Best advice was not to shout much and I did that and it didn't affect my throat. I close my mouth when I pushed him and then I forced and I pushed. …. Yeah, she (mother) always gives me good advice and when I don't hear her advice then I do mistakes. Yeah. And I always regret. I have not heard hear advice. I always regret.	5 6 7
Pregnancy and childbirth was not challenging	postivity	Uh, just be positive, everything will be alright. It's not that difficult to have a baby. Yeah. It's not that difficult. Because the time I have seen it was all good, because I had no problems, no medicines, no pains in 9 months. I did my whole household work myself. Nobody helped me. And now also I'm doing everything my own. There's people, it's not that hard to have a baby.	
Unsure of midwife role	Garima was unsure of the role of the midwife during labour. She was	…they (the midwives) have advised me a lot that you can take the gas, we can give you painkillers like this	9

	grateful for the advice from the midwife to regarding pain relief options but viewed their influence as limited.	but I was only the one who said that no, I don't want. Yeah. … They have nothing... nothing I think so they can't do anything to help me yeah. They can only give me advice. Mmmm. Yeah. Only my husband can do that. They helped me in each and every way, I think so. Midwives helped me a lot. Because they have given me every advice to me that you can reduce your pain in this way and in that way. They gave me the ball to sit on that but it was ... the pain was not controllable with the ball also. I had to face that.	
Fear changed behaviour	Prior to arriving to the hospital Garima became scared at home and because of this she believes her behaviour was out of character, but her husband made her feel secure.	I got scared that's why. I was giving him instructions like "Do this, take that bag, bring that bag too, take this too, take that also" and he was calling mama so he was doing a lot of things at one time. Yeah. And then when he was not listening to me, then I was shouting at him [both laugh]…he was surprised…He said that "Relax, nothing is going to happen wrong. Relax" He was giving me positive instructions. "Take deep breaths" he say, "I am there with you"…: Yeah, helped. It really helped.	12

Appendix I - Example of analysis stage 3: towards acceptance (prenatal)

SUBTHEME	NOTES	QUOTES	PAGE	PART.
Reassurance from family and friends	**Stories from family and friends help in easing prenatal worries**	I think it will make me feel better. At least I understand more so I can prepare for what is going to maybe happen for me. And I'm active anyway, I'm active I don't sit. So hopefully I can deliver baby better. And some of the food that other people like friends, aunties, my mum, tell me eat before the time expecting like 37, 38 weeks, I start to eat that food. Helping the cervix open easier.	9	Qui
Reassurance	Anticipating the unknown but getting reassurance from prayer and the health care team.	First time I see it's like how it's going to be with me because it's my first time. Then I call on God. I don't know what's going to happen on that day, how I'm going to endure the pain because that lady she was really... she was in a lot of pain I see the video. But as the doctor said and the midwife told me there are so many women doing the same in the whole world, why can't we? You know? So let's see, I don't know what's going to happen on that day. I'm going to endure the pain, how I will be. I don't know yet.	4	Neha
Reassurance	**Tanvi found the information from the midwives reassuring** The internet gave mixed information particularly about epidurals but good, clear information from the midwife decreased anxiety and provided support	... I was a bit concerned about epidurals because... Google gives you all the mixed information. I spoke to one of my midwives in hospital, The midwife explained to me that it can give you a bit of a headache after the delivery but there are cure for that, it's not permanent. Even the back pain, if you will get it, there's very little chance but it's not like it's going to stay for your	3	Tanvi

		life. There is cure for that. So yeah, it helps, it gives me confidence for that as well so I can take it if I want.		
Missing the Support and guidance of family	Kim highlights that it is challenging preparing for a new baby, in a new country without the support of family. **Not having her mother here, upset her. Kim feels that she lacks experience and needs the support of her mother, who she views as having a lot of experience**.	She just ask me like do you want me to come to help you? But because she is too busy over there and I can't sponsor her to come here. It's really hard. …She is upset as well. She just ask me if you want something just call me and ask. I want to buy something to send to the kid for you. Just giving me a lot of experience, we're chatting a lot… She said that like, after giving birth, I'm going to have a lot of stress because I'm not going out anywhere and the baby, the first one, I have no experience. You have to talk. If the baby is crying, if the baby is not good, unwell, it's the normal thing. Don't be stressed. Just talk.	8-9	Kim
Missing the Support and guidance of family	Trust in elders for guidance in helping prepare for birth and care after birth	So all the things are homemade things that we follow. That's the reason we want elders to be there at home, because we don't know much. They know very well.	6	Eva
Missing support from Mother in India	Ira talks about not having her immediate family in Australia, and other members of her family living nearby, reached out to her and provided her with support. They provided company, advice and meals, all which helped Ira feel cared for and loved. Advice and reassurance from family is important to Ira in preparing for childbirth.	My cousin living just 2 kms, he came to meet me and ask me how are you, give me some food and visit. She have two children. They play with me, it was very nice. … Yeah, she gave me lots of information. You feel like that, you eat this, this is good for you, I make for you this because she had very good experience. She had her mother in law, she's from India and she told me the things	2 6	Ira

Missing the best person for support	Merra feels that she is missing out on the best care that she could have, with her mother still in India. Meera feels lonely and possibly lost because of the lack of emotional support. She explains that in India, when a woman becomes pregnant she moves back to her mother's home, because her mother knows her the best and is the best person to care for the newly pregnant woman. From this Meera is reminded and recalls her thoughts from when she first arrived in Australia**. Meera relates to the feelings of melancholy in her current situation** (Note: Meera and her husband have been married for a short time and while her mother-in-law has come to support their new family, Meera eagerly awaits for her mother to arrive from India).	We are from Southern part of India. After marriage when the girl gets pregnant, so within the few months, girl will be sended to the mother's home instead of keeping in mother-in-law's home. They will be sent to their mother's home because their mother knows about the girl, new mother, very well more than the mother-in-law. So, they can treat her easily and guide her easily so as we... . They can see her from along. So, how is she going to listen and how is she going to do what will be her flaws, what will be her strengths, they know better than mother-in-law house or husband so we prefer, most of south Indians do, to send the new mother to her mother. ….I felt very.... I mean bad. I mean I was very sad. I mean to leave parents it's like a different country, a different home. Everything. Altogether new person so it was like so sad for me. After coming here also for 2, 3 months I was like depressed. I missed my home, my mum and family.	4 5	Meera

Appendix J - Customary practices associated with childbirth

Customary practices associated with childbirth for Indian and Vietnamese women

(during pregnancy and up until 90 days postpartum)

Women from India

Childbirth is not discussed in public or with males.

No males (including husband) in birthing room

Family elders are the decision-makers

Specific to the postpartum period

- Ayurvedic practices -dietary advice including herb and spices (for example, intake of ghee and ginger)
- Postpartum isolation - remain indoors for 40 days after birth
- Regular message for new mother
- Postpartum wrapping of mother's abdomen
- New mother is cared for by her mother or mother-in-law in the postpartum
- Reduced physical activity for new mother
- New mother encouraged to drink milk
- Non-oily diet for mother with additional of whole meal flour, dried fruit and nuts
- New baby is given a taste of sweet food
- New clothes every 40 days for new baby
- Mother encouraged to drink water with carob, fennel and black cardamom

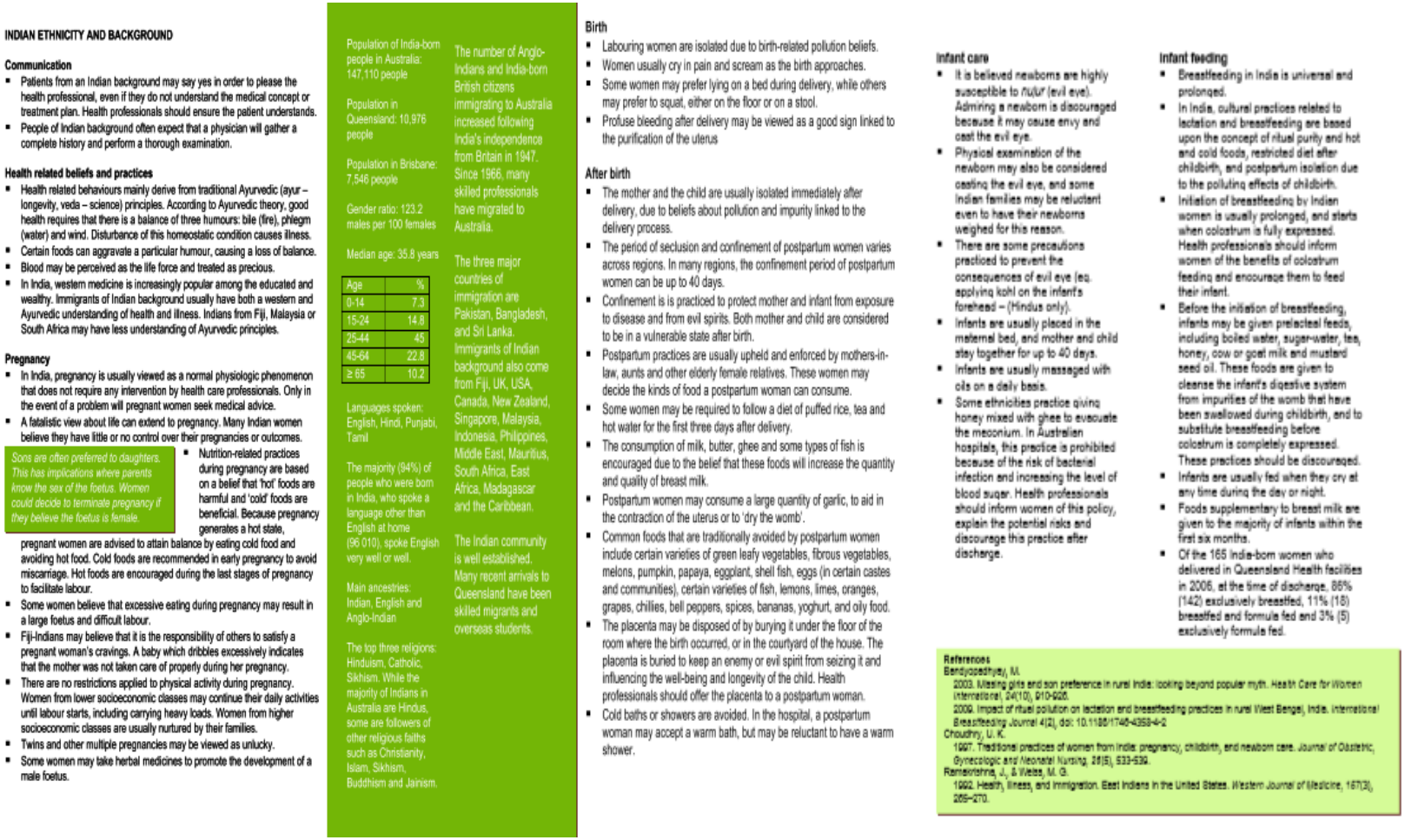
Women from Vietnam

No family in birthing room

Specific to the postpartum period

- Postpartum isolation -remain indoors for 30-90 days after birth
- Postpartum social isolation for 30 days for mother and baby (with the exception of immediate family)
- Dietary advice (for example, no seafood, no coconut water, no pineapple, no mango)
- Do not wash hair or shower for 30 days postpartum
- Cotton wool placed in new mothers' ears
- New mothers encouraged to wear warm clothes postpartum (inside the home); for example, hat/beanie, scarf, stockings
- Steam baths with traditional herbs for hygiene

Appendix K - Cultural dimensions of pregnancy, birth and postnatal care - an Indian profile



INDIAN ETHNICITY AND BACKGROUND

Communication

- Patients from an Indian background may say yes in order to please the health professional, even if they do not understand the medical concept or treatment plan. Health professionals should ensure the patient understands.
- People of Indian background often expect that a physician will gather a complete history and perform a thorough examination.

Health related beliefs and practices

- Health related behaviours mainly derive from traditional Ayurvedic (ayur – longevity, veda – science) principles. According to Ayurvedic theory, good health requires that there is a balance of three humours: bile (fire), phlegm (water) and wind. Disturbance of this homeostatic condition causes illness.
- Certain foods can aggravate a particular humour, causing a loss of balance.
- Blood may be perceived as the life force and treated as precious.
- In India, western medicine is increasingly popular among the educated and wealthy. Immigrants of Indian background usually have both a western and Ayurvedic understanding of health and illness. Indians from Fiji, Malaysia or South Africa may have less understanding of Ayurvedic principles.

Pregnancy

- In India, pregnancy is usually viewed as a normal physiologic phenomenon that does not require any intervention by health care professionals. Only in the event of a problem will pregnant women seek medical advice.
- A fatalistic view about life can extend to pregnancy. Many Indian women believe they have little or no control over their pregnancies or outcomes.

Sons are often preferred to daughters. This has implications where parents know the sex of the foetus. Women could decide to terminate pregnancy if they believe the foetus is female.

- Nutrition-related practices during pregnancy are based on a belief that 'hot' foods are harmful and 'cold' foods are beneficial. Because pregnancy generates a hot state, pregnant women are advised to attain balance by eating cold food and avoiding hot food. Cold foods are recommended in early pregnancy to avoid miscarriage. Hot foods are encouraged during the last stages of pregnancy to facilitate labour.
- Some women believe that excessive eating during pregnancy may result in a large foetus and difficult labour.
- Fiji-Indians may believe that it is the responsibility of others to satisfy a pregnant woman's cravings. A baby which dribbles excessively indicates that the mother was not taken care of properly during her pregnancy.
- There are no restrictions applied to physical activity during pregnancy. Women from lower socioeconomic classes may continue their daily activities until labour starts, including carrying heavy loads. Women from higher socioeconomic classes are usually nurtured by their families.
- Twins and other multiple pregnancies may be viewed as unlucky.
- Some women may take herbal medicines to promote the development of a male foetus.

Population of India-born people in Australia: 147,110 people

Population in Queensland: 10,976 people

Population in Brisbane: 7,546 people

Gender ratio: 123.2 males per 100 females

Median age: 35.8 years

Age	%
0-14	7.3
15-24	14.8
25-44	45
45-64	22.8
≥ 65	10.2

Languages spoken: English, Hindi, Punjabi, Tamil

The majority (94%) of people who were born in India, who spoke a language other than English at home (96 010), spoke English very well or well.

Main ancestries: Indian, English and Anglo-Indian

The top three religions: Hinduism, Catholic, Sikhism. While the majority of Indians in Australia are Hindus, some are followers of other religious faiths such as Christianity, Islam, Sikhism, Buddhism and Jainism.

The number of Anglo-Indians and India-born British citizens immigrating to Australia increased following India's independence from Britain in 1947. Since 1966, many skilled professionals have migrated to Australia.

The three major countries of immigration are Pakistan, Bangladesh, and Sri Lanka. Immigrants of Indian background also come from Fiji, UK, USA, Canada, New Zealand, Singapore, Malaysia, Indonesia, Philippines, Middle East, Mauritius, South Africa, East Africa, Madagascar and the Caribbean.

The Indian community is well established. Many recent arrivals to Queensland have been skilled migrants and overseas students.

Birth

- Labouring women are isolated due to birth-related pollution beliefs.
- Women usually cry in pain and scream as the birth approaches.
- Some women may prefer lying on a bed during delivery, while others may prefer to squat, either on the floor or on a stool.
- Profuse bleeding after delivery may be viewed as a good sign linked to the purification of the uterus

After birth

- The mother and the child are usually isolated immediately after delivery, due to beliefs about pollution and impurity linked to the delivery process.
- The period of seclusion and confinement of postpartum women varies across regions. In many regions, the confinement period of postpartum women can be up to 40 days.
- Confinement is is practiced to protect mother and infant from exposure to disease and from evil spirits. Both mother and child are considered to be in a vulnerable state after birth.
- Postpartum practices are usually upheld and enforced by mothers-in-law, aunts and other elderly female relatives. These women may decide the kinds of food a postpartum woman can consume.
- Some women may be required to follow a diet of puffed rice, tea and hot water for the first three days after delivery.
- The consumption of milk, butter, ghee and some types of fish is encouraged due to the belief that these foods will increase the quantity and quality of breast milk.
- Postpartum women may consume a large quantity of garlic, to aid in the contraction of the uterus or to 'dry the womb'.
- Common foods that are traditionally avoided by postpartum women include certain varieties of green leafy vegetables, fibrous vegetables, melons, pumpkin, papaya, eggplant, shell fish, eggs (in certain castes and communities), certain varieties of fish, lemons, limes, oranges, grapes, chillies, bell peppers, spices, bananas, yoghurt, and oily food.
- The placenta may be disposed of by burying it under the floor of the room where the birth occurred, or in the courtyard of the house. The placenta is buried to keep an enemy or evil spirit from seizing it and influencing the well-being and longevity of the child. Health professionals should offer the placenta to a postpartum woman.
- Cold baths or showers are avoided. In the hospital, a postpartum woman may accept a warm bath, but may be reluctant to have a warm shower.

Infant care

- It is believed newborns are highly susceptible to *nuUr* (evil eye). Admiring a newborn is discouraged because it may cause envy and cast the evil eye.
- Physical examination of the newborn may also be considered casting the evil eye, and some Indian families may be reluctant even to have their newborns weighed for this reason.
- There are some precautions practiced to prevent the consequences of evil eye (eg. applying kohl on the infant's forehead – (Hindus only).
- Infants are usually placed in the maternal bed, and mother and child stay together for up to 40 days.
- Infants are usually massaged with oils on a daily basis.
- Some ethnicities practice giving honey mixed with ghee to evacuate the meconium. In Australian hospitals, this practice is prohibited because of the risk of bacterial infection and increasing the level of blood sugar. Health professionals should inform women of this policy, explain the potential risks and discourage this practice after discharge.

Infant feeding

- Breastfeeding in India is universal and prolonged.
- In India, cultural practices related to lactation and breastfeeding are based upon the concept of ritual purity and hot and cold foods, restricted diet after childbirth, and postpartum isolation due to the polluting effects of childbirth.
- Initiation of breastfeeding by Indian women is usually prolonged, and starts when colostrum is fully expressed. Health professionals should inform women of the benefits of colostrum feeding and encourage them to feed their infant.
- Before the initiation of breastfeeding, infants may be given prelacteal feeds, including boiled water, sugar-water, tea, honey, cow or goat milk and mustard seed oil. These foods are given to cleanse the infant's digestive system from impurities of the womb that have been swallowed during childbirth, and to substitute breastfeeding before colostrum is completely expressed. These practices should be discouraged.
- Infants are usually fed when they cry at any time during the day or night.
- Foods supplementary to breast milk are given to the majority of infants within the first six months.
- Of the 165 India-born women who delivered in Queensland Health facilities in 2006, at the time of discharge, 86% (142) exclusively breastfed, 11% (18) breastfed and formula fed and 3% (5) exclusively formula fed.

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Appendix L- Kagawa-Singer & Blackhall's ABCD cultural assessment model – palliative care

Relevant Information	Questions and Strategies for the Health Care Provider
Attitudes of parents and families: • What attitudes does this ethnic /cultural group in general – and the patient and family in particular – have about truth telling with regard to diagnosis and prognosis? • What is their general attitude towards discussion of death and dying? • Do they have positive or negative attitudes about particular aspects of care?	• Increase one's knowledge about the values, beliefs, and attitudes of the cultural group most frequently seen in your practice. • Determine the patient and family's perception of an illness: *"What does your illness/sickness mean to you?"* • Determine if the patient uses traditional healing practices and for what problems. • Determine if the patient or family has positive or negative attitudes about a particular aspect of care being addressed, such as advance directives.
Beliefs: • What are the patient's and family's religious and spiritual beliefs, especially relating to the meaning of death and dying, the afterlife, and miracles?	• *"Spiritual or religious strength sustain many people in times of distress. What is important for me to know about your faith or spiritual needs?"* • *"How can we support your needs and practices?"* • *"Where do you find your strength to make sense of what is happening to you?"*
Context: • Determine the historical and political context of the patient's and family's lives, including place of birth, refugee or immigrant status, poverty, experience with discrimination, health disparities, language spoken, and degree of integration within their ethnic community and the degree of assimilation into Western culture.	• *"Where were you born and raised?"* • *"How long have you lived in the United States?" What has your experience been since coming to the U.S. (or the city)?"* • *"How has your life changed since coming to the U.S.?"* • *"What language are you most comfortable using when talking about your health care?"* • *"What were other important times in your life that might help us better understand your situation?"*
Decision-making style: • What is the general decision-making style of the cultural group and specifically of the patient and family? • Is the emphasis on the individual decision-making process or the family decision-making process?	• *"How are decisions about health care made in your family?"* • *"Who is the head of the family?"* • *"Is there anyone else I should talk to in your family about your condition?"*

From: Cultural Relevance in End-of-Life Care http://ethnomed.org/clinical/end-of-life/cultural-relevance-in-end-of-life-care

Kagawa-Singer, M., & Blackhall, L. J. (2001). Negotiating cross-cultural issues at the end of life: you got to go where he lives. *JAMA, 286*(23), 2993–3001.